
Outcome Evaluation
Summary Report:
WHO/UNODC
Global Initiative on
Primary Prevention
of Substance Abuse

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WHO/UNODC
Global Initiative (1999-2003) on
Primary Prevention
of Substance Abuse

Mental Health: Evidence and Research Team and
Management of Substance Abuse Team
Department of Mental Health and Substance Abuse

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Secretariat

Mrs Mwansa Nkowane
Dr Shekhar Saxena
Ms Giovanna Campello

World Health Organization, Geneva
World Health Organization, Geneva
United Nations Office on Drugs and Crime, Vienna

Copy-editing

Ina Stahmer

Contact addresses

Dr Shekhar Saxena
Mental Health: Evidence and Research
Department of Mental Health and Substance Abuse
World Health Organization
Avenue Appia 20, CH-1211 Geneva 27,
Switzerland
Email: saxenas@who.int

Ms Giovanna Campello
Prevention, Treatment and Rehabilitation Unit
United Nations Office on Drugs and Crime
PO Box 600, A-1400 Vienna,
Austria
Email: giovanna.campello@unodc.org

Project website:

http://www.who.int/substance_abuse/activities/global_initiative/en/
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Abstract

The WHO/UNODC Global Initiative on the primary prevention of substance abuse (Global Initiative) was a joint project of the United Nations Office on Drugs and Crime (UNODC)—formerly known as the United Nations Drug Control Programme (UNDCP)—and the World Health Organization (WHO). The Global Initiative took place in **three regions**: Southern Africa, South-East Asia, and Central and Eastern Europe. The project was run in **eight selected countries**, namely the Republic of Belarus and the Russian Federation in Central and Eastern Europe; the Republic of the Philippines, the Kingdom of Thailand and the Socialist Republic of Viet Nam in South-East Asia; and the Republic of South Africa, the United Republic of Tanzania and the Republic of Zambia in Southern Africa. Because of practical difficulties, the project sites in the Philippines and Viet Nam were excluded from the overall evaluation of the outcomes of the Global Initiative.

The overall **aim** of the project was to prevent and reduce the use of psychoactive substances and related problems among young people (persons between approximately 7 and 24 years) through the mobilization of communities and the development and sharing of good practices on primary prevention. Community mobilization was central in ensuring the cultural relevance/acceptability and sustainability of the prevention actions.

A **strategic plan** guided the project implementation consisting of interrelated and logically ordered activities that included (1) training of local/country project partners, (2) a situation/needs assessment, (3) primary prevention action, (4) documentation of project activities, (5) sharing of experiences on good practices, and (6) process and outcome evaluation. The results of the outcome evaluation, which consisted of in-depth pre- and post-project situation assessments of the project communities, were compared to ascertain whether the envisaged outcomes were achieved. Practical constraints resulted in the overall evaluation of the outcome of the project being restricted to two sites per project country, except in the Russian Federation where three sites were evaluated because of the vastness of the country.

The overall evaluation showed that the project achieved **positive outcomes** in various respects. These outcomes are remarkable, considering that they took place amidst broad socioeconomic “pressures” towards psychoactive substance use, such as widespread economic debility, limited essential services and positive conditions for trading in psychoactive substances in the project sites. Effective project delivery undergirded the positive outcomes. Indeed, the results of the process evaluation generally showed that the project was implemented as planned and well received by the target groups.

Positive outcomes manifested across the evaluation sites regarding psychoactive substance use-related issues among young people. Where psychoactive substance use among young people did not (markedly) decrease, other positive developments occurred: the age of onset of psychoactive substance use rose; youth psychoactive substance use remained stable and/or decreased in certain demographic/age groups; attitudinal support for a lowering of youth psychoactive substance use manifested among young people and/or their seniors; and/or adults themselves lowered their psychoactive substance use. Preventive activities generally reached widely into the evaluation communities. Existing prevention services were strengthened and in some cases new services and partnerships were established. Project participants (e.g. young people trained in rendering peer support) reported personal growth in constructive life skills and knowledge in facilitating prevention in the course of the project.

The fact that the Global Initiative largely proceeded as planned and generally produced positive outcomes highlight the relevance and feasibility of countries experiencing rapid change—including developing countries with limited resources—employing prevention strategies that have been successful in other parts of the world. The positive outcomes of the Global Initiative in effect suggest that countries in rapid transition and with limited resources could fruitfully develop prevention projects that are science/evidence based (e.g. tailored to the results of pre-project situation assessments); operate on the level of individuals as well as communities; and are planned/executed with the active participation of target groups (e.g. young people). Cognizance needs to be taken that the local/country projects in the Global Initiative not only (1) provided individuals (e.g. young people and their parents) with information on the risks of psychoactive substance use; but also (2) raised the personal/social competence (life skills) of the target groups; (3) drew target groups into constructive social support networks (e.g. peer support groups) and leisure/vocational activities and in this way improved access to educational and employment

opportunities; and (4) increased broad community support for prevention action. By adopting a mix of individual- and community-oriented preventive activities, the projects acknowledged social science evidence that individual behaviour is an outcome of a complex interplay between individual- and community/environment-oriented factors.

Project participants highlighted various **enabling and constraining factors**. They stressed, for example, that regular contact between the global and regional coordinators/technical officers and the local project teams/partners, as well as the presence of a national focal partner/coordinating body in each project country contributed significantly to (1) positive relationships between project participants; and (2) hands-on and timely assistance when shortfalls emerged and project adjustments were required. The difficulties experienced taught them perseverance and challenged them to think and act innovatively.

Against the background of their experiences, the Global Initiative participants highlighted a variety of **lessons** as to what works in primary prevention, i.e. “good practice”. In Southern Africa, for example, participants noted that an approach consisting of the following five consecutive stages works well in community-oriented prevention programmes: (1) situation/needs assessment in the area/community (baseline assessment); (2) design of a strategic prevention action plan that is based on the identified needs, and includes a monitoring and evaluation plan; (3) implementation of the planned intervention; (4) programme evaluation; and (5) adaptation of the intervention in terms of the evaluation results. The project participants in the other project regions *inter alia* highlighted that (1) by designing prevention programmes in terms of a carefully planned and participatory assessment of the local situation/needs in the prevention community, relevance and wide community support are ensured; and that (2) a culture of continuous learning among prevention agents—and thus the practice of developing programmes with strong monitoring and evaluation components—ensures strong prevention action. Participants in all the project regions stressed that a strong institutional framework is essential to sustain and expand prevention programmes.

The project participants also made **recommendations** for continued action. These included the need to continue (1) strengthening and expanding information sharing among Global Initiative participants (e.g. through the UNODC’s Global Youth Network); (2) strengthening and expanding prevention partnerships within civil society and between the latter, business and government; (3) research on what works in the primary prevention of psychoactive substance use and related problems; (4) development and distribution of training manuals; (5) obtainment of technical/financial support from international and local/country agencies; and (6) advocacy for the placement of psychoactive substance use-related prevention on national/international socioeconomic development agendas.

PART 1

Orientation

Introduction

1.1 BACKGROUND

Globally, the use of psychoactive substances and related problems pose difficult challenges to public health (United Nations International Drug Control Programme 1999). (The term “psychoactive substance” refers to any substance that modifies perception, mood, cognition, behaviour and motor functions when taken by a person. Examples are alcohol, tobacco and marijuana (World Health Organization 2000d).) Many people are affected by the adverse social and health consequences of psychoactive substance use such as poverty, injury, ill-health and death. In effect, psychoactive substance use has the potential to impede human development. For the year 2000 the World Health Organization (2002c), for example, estimated the burden of deaths for respectively males and females in high-mortality regions such as Southern Africa (1) due to tobacco at 7.5% and 1.5%; (2) due to alcohol at 2.6% and 0.6%; and (3) due to illicit psychoactive substances at 0.5% and 0.1%. For low-mortality developing regions (e.g. parts of South-East Asia such as Thailand and parts of the Western Pacific Region such as the Philippines and Viet Nam) the related estimates were higher, i.e. 12.2% and 2.9% for tobacco; 8.5% and 1.6% for alcohol; and 0.6% and 0.1% for illicit psychoactive substances. The comparative figures for developed regions (e.g. Central and Eastern Europe) were even higher, especially for tobacco use and male use of alcohol (i.e. 26.3% and 9.3% for tobacco; 8.0% and -0.3% for alcohol; and 0.6% and 0.3% for illicit psychoactive substances).

Regions experiencing dramatic societal change especially manifest an increase in psychoactive substance use and related problems (United Nations Office on Drugs and Crime

2005; International Narcotics Control Board 2004; Room et al. 2002; Jernigan 2001; Adelekan 2000; Riley & Marshall 1999; United Nations Office for Drug Control and Crime Prevention 1999). Moreover, young people—and adolescents in particular—are particularly at risk of psychoactive substance use and related problems, as adolescence is a time of experimentation, curiosity and identity searching, which involve risk taking. However, young people can be helped to develop attitudes and social practices that promote health and social progress, especially during their early years when their attitudes and beliefs towards life take shape.

1.2 COMMUNITY ACTION

Experience in some Western/developed countries has shown that community-wide action can be effective in preventing and reducing psychoactive substance use-related problems among young people (United Nations International Drug Control Programme 1999). Such actions mobilize wide and concerted participation in identifying and redressing the problems, and focus on young people and significant others in their lives such as their parents, teachers, moral or religious agencies/authorities, local government authorities/agencies, the police, and health service agencies. Moreover, the effective prevention/reduction of psychoactive substance use and related problems requires action that (1) addresses individual-oriented factors (e.g. attitudes and practices that are accepting of psychoactive substance use) and environment-oriented factors (e.g. the debilitating broad socio-economic conditions in which individuals live), and action that (2) is supported by research and training. Effective communication and cooperation, exchange of information,

and sharing of experiences among prevention agents are also essential.

Grassroot organizations engaged in the prevention of psychoactive substance use (e.g. NGOs) can play an important role in mobilizing communities towards the prevention of psychoactive substance use and related problems, as acknowledged and advocated in the Bangkok Declaration adopted by the 1994 Nongovernmental Organizations World Forum of Drug Demand Reduction. In 1998 the Special Session of the UN General Assembly also adopted a political declaration that called upon communities and NGOs to work together in actively promoting a society free of psychoactive substance use-related problems. Grassroot community agents, however, may need an initial investment in material resources and training on the part of non-community members to kick-start a process of developing, implementing and documenting effective prevention actions/strategies, i.e. good practices. The development of a knowledge base on effective prevention action would be relevant to not only grassroot programme managers and implementers but also to policy-makers and researchers. Policy-makers need to be guided by scientific information and evaluation results when allocating resources for prevention action. In turn, researchers need contact with programme managers and implementers as well as decision-makers to formulate pertinent research questions.

1.3 THE GLOBAL INITIATIVE

The WHO/UNODC Global Initiative on the Primary Prevention of Substance Abuse (Global Initiative) was a joint project of the World Health Organization (WHO) and the United Nations Office on Drugs and Crime (UNODC)—formerly known as the United Nations International Drug Control Programme (UNDCP). (Although different definitions of the term “substance abuse” exist, the workbook (World Health Organization 2000d) used in the training of local/country Global Initiative partners refers to it as taking a psychoactive substance continuously notwithstanding the resultant problems. This workbook also notes that “primary prevention” refers to the prevention or discontinuation of psychoactive substance use or delaying onset of use.)

The Global Initiative was implemented in three regions: Southern Africa, South-East Asia, and Central and Eastern Europe. Priority was given to developing countries and those undergoing dramatic or rapid socioeconomic change and experiencing psychoactive substance use-related problems. The countries selected were Belarus and the Russian Federation in Central and Eastern Europe; the Philippines, Thailand and Viet Nam in South-East Asia; and South Africa, Tanzania and Zambia in Southern Africa.

The **aim** of the project was to prevent and therefore reduce the use of psychoactive substances and related problems among young people in a range of geographical, cultural, social and economic settings where rapid change was

in progress (United Nations International Drug Control Programme 1999). The project objectives—or envisaged means for achieving the mentioned aim—were (United Nations International Drug Control Programme 1999): (1) to mobilize communities towards primary prevention by supporting local/country partners (e.g. through training, technical assistance, funding and contacts with other relevant groups/agents); and (2) to develop, document and exchange information on good practices, i.e. successful models of primary prevention. Community mobilization was central in ensuring the sustainability, cultural relevance/acceptability and feasibility of the prevention actions.

The Global Initiative, furthermore, **expected** the following medium-term benefits/**outcomes** (United Nations International Drug Control Programme 1999): (1) A visible decline in psychoactive substance use and related problems, especially among young people; (2) heightened and widespread awareness of the risks of psychoactive substance use; (3) a pool of experienced primary prevention workers who could help train others; (4) An organizational network as a vehicle for further expansion of prevention programmes; (5) feasible and tested models of primary prevention for wider use; and (6) public awareness of the availability and feasibility of psychoactive substance use-related prevention programmes.

To achieve the above aim and objectives, a **strategic plan** was designed. This plan included the following five sets of interrelated activities and phases:

- An initial/preparatory phase, which provided for coordination of project activities; recruitment and training of (focal) local partners; selection of local prevention sites; and pre-project situation/needs assessments.
- An expansion phase, which provided for the documentation of project activities as well as the review and funding of selected local prevention plans.
- A consolidation phase, which provided for (1) local partners taking full responsibility for implementing prevention projects for 18 to 24 months; (2) formal monitoring/recording of project activities and local partners’ sharing of project experiences; and (3) post-project situation assessment, systematic evaluation of the implemented activities and dissemination of the results for wider use.

The **targets** of the Global Initiative’s preventive activities were (pre-) adolescents (persons between approximately 7 and 21 years) and significant others in their communities, e.g. other young people, parents and teachers. In a sense, the project communities may be said to have been the target in that the project insisted on community-wide preventive activities. The **local/country partners** (see the annex for a list of these partners) in the project countries who implemented preventive activities (1) were well-established and recognized service providers; (2) had well-established administrative and managerial infrastructures; (3) had

access to administrative, financial and professional support networks; and (4) had experience in working for and with young people.

Based on reviews of what works in primary prevention (e.g. World Health Organization 2004a, 2004b, 2004c, 2002a, 2002b; Centre for Addiction and Mental Health 1999; Spooner 1997; US Department of Health and Human Services 1991), the Global Initiative supported local/country partners to develop and implement **preventive activities** that (1) attended to licit and illicit psychoactive substances as well as to contributors to the use of these substances at the level of the individual (e.g. deficient socialization, poor coping skills/competencies), family/peer group (e.g. lack of positive attachments) and the broad socioeconomic environment (e.g. limited recreational, educational and employment opportunities); (2) coopted young people into project planning/activation; (3) focused on community-wide mobilization of prevention action; and (4) built on existing structures/expertise.

The Global Initiative identified **good practices** on the basis of the documentation of the prevention activities undertaken by the local/country partners. The documentation was generated by two main kinds of activities: (1) The production of project documentation by local/country partners in the course of implementation, i.e. the project proposals, which included the results of needs assessments, and the interim and final reports, which included descriptions of activities, feedback from participants and the results of self-evaluations; and (2) experience-sharing meetings, which were undertaken to allow local/country partners to document and reflect on specific components of their prevention activities, namely the needs assessment, alternative activities, and monitoring and evaluation. Finally, the results of the overall evaluation of the Global Initiative contributed to the identification of good practice. A project website, email and ordinary mail supported the implementation of project activities as well as the dissemination of good practices.

The overall **management** of the project was carried out by two global technical officers (hereafter alternatively referred to as global coordinators), representing the Head Office of respectively the WHO and UNODC. The WHO technical officer took overall responsibility for project activities in Southern Africa, apart from overseeing training, project evaluation and communication in the Global Initiative. The UNODC project coordinator oversaw regional experience-sharing meetings, apart from taking overall responsibility for project activities in the Central and Eastern Europe and South-East Asia. A regional technical officer (hereafter alternatively referred to as regional coordinator) in each of the project regions coordinated the project at the regional level. Moreover, at country level, focal points (selected by the Ministries of Health and/or the National Drug Control Agency in the respective project countries) and the WHO and UNODC Offices facilitated implementation of the project, apart from facilitating liaison with local international partners.

1.4 THE EVALUATION PLAN

The strategic plan of the Global Initiative included an evaluation plan that focused on project delivery (process evaluation) and the effects/outcomes of the project. As defined by the European Monitoring Centre for Drugs and Drug Addiction (1998:191), **process** evaluation focused on “how and if the prevention intervention took place ... and whether the designated target group was reached ... [as well as] the quality of the intervention”. Concern was, thus, also with the monitoring of project activities, i.e. the tracking/recording of what and how planned activities were delivered and resources were used. The process evaluation plan of the Global Initiative, consequently, entailed (1) an organizational plan that set out what and how resources and activities needed to be configured and deployed; and (2) a service utilization plan that dealt with whether and how the target population received the intervention. Indeed, the plan identified (1) the criteria (e.g. timeliness, adequacy, quality) by which the respective implemented project activities and resources expended had to be assessed; (2) what qualitative/quantitative information had to be collected/recorded and submitted as well as by whom, how and when it had to be collected/recorded. To facilitate comparison across project regions, countries and sites, the plan provided for standardized data collection/entry.

The project **outcomes** were evaluated by means of a comparison of in-depth pre- and post-project situation assessments of the project communities. Independent and well-established research institutions in each of the project countries conducted the pre- and post-project assessments. These were respectively conducted in 2001 and 2003, except in Belarus where the pre-project assessments were done in 2000. **Data collection** methods included a KAP (knowledge, attitudes and practices) sample survey and two community profiles. (See Table 1 for a detailed outline of the recommended variables.)

- The KAP Survey provided insight into psychoactive substance use among respectively young people and adults in the individual communities.
- Community Profile 1 provided information on the assessed community's commitment to countering psychoactive substance use-related problems among young people and on their understanding of the issues concerned. Data collection methods included key informant interviews and focus group discussions.
- Community Profile 2 (desktop study), using mostly secondary (existing) data, provided information on broad socioeconomic conditions in the communities assessed.

The assumption that psychoactive substance use is an outflow of the complex interaction between the individual, psychoactive substances and the context in which these substances are used underpinned data collection. Note was also taken of indications that easy access and exposure

Table 1. Summary of variables, indicators and data collection methods focused on in the pre/post-project situation assessments

Variables	Indicators	Data collection procedures/methods
<p>Youth KAP Survey</p> <p>Knowledge, attitudes/beliefs and practices (KAP) of young people (10-21 year olds) by gender and age</p>	<ul style="list-style-type: none"> • Type of psychoactive substance use: lifetime use (“ever used”); use in the past 12 months/30 days before the relevant survey • Quantity of use: number of cigarettes (past 12 months) • Frequency of 5 or more alcoholic drinks at a time (past fortnight) • Frequency of experiences of alcohol “dependence” symptoms (past 12 months) • Frequency and context (place, company) of psychoactive substance use (past 12 months) • Experiences of psychoactive substance use-related problems (past 12 months) • Reasons for current (past 30 days) psychoactive substance use • Onset of psychoactive substance use (age, reason, provider of first psychoactive substance, place of first use) • Awareness of current psychoactive substance use among acquaintances • Normative expectations/values regarding psychoactive substance use by people in general/young people in particular • Prevailing adult/youthful psychoactive substance use customs (occasions) • Knowledge of and attitudes regarding the prevailing legal status of various psychoactive substances • Beliefs as to whether adult/youthful psychoactive substance use is harmful • Beliefs as to the availability of psychoactive substances • Beliefs as to the use of psychoactive substances by parents/older siblings • Socioeconomic characteristics of respondents 	<ul style="list-style-type: none"> • Household survey in Southern African and South-East Asian project communities: stratified probability sampling of 200 10-21 year olds and 100 adults (22 years or older); interview-administered, closed-ended questionnaire • School/educational institution survey in the project countries in Central and Eastern Europe: stratified probability sampling of 300 learners (10-21 year olds) at schools, technical colleges and universities in project communities*
<p>Community Profile 1</p> <p>Nature/extent of commitment/mobilization and understanding of psychoactive substance use-related issues of organized social units (not) directly involved in the primary prevention of psychoactive substance use-related problems; as well as the views of ordinary community members of different age groups and gender on psychoactive substance use and related issues in the community</p>	<ul style="list-style-type: none"> • Type and number of formally organized social units (e.g. primary health care clinics, hospitals, schools, tertiary institutions, religious organizations, sports clubs, recreational clubs/facilities, businesses, women/parent clubs, labour and professional organizations/unions, political organizations, organizations specializing in counter-ing psychoactive substance use-related problems) • Psychoactive substance use-related (primary prevention) projects, programmes, strategies, target groups/issues, material/human resources, type and extent of networking/cooperation/partnerships, reasons/rationale for existence • Nature and extent of formally organized activism/advocacy projects/programmes • Organizational leaders’ beliefs as to the nature and extent of psychoactive substance use in the community, normative expectations regarding psychoactive substance use (onset age, quantity, frequency, place, company, occasions), reasons for use, extent of and contributors to psychoactive substance use-related problems 	<ul style="list-style-type: none"> • Key informant interviews: community/organizational leaders (about 15 persons interviewed) • Focus group interviews: groups of about 6-12 persons, comprising males and/or females, and persons of different age categories and background
<p>Community Profile 1</p> <p>Psychoactive substance use-related knowledge, attitudes/beliefs and practices of adults (persons 22 years and older) by gender and age (Adult KAP Survey)</p>	<ul style="list-style-type: none"> • Type of psychoactive substance use: lifetime use (“ever used”); use in the past 12 months/30 days before the relevant survey • Quantity of psychoactive substance use: number of cigarettes (past 12 months) • Frequency of taking 5 or more alcoholic drinks at a time (past 14 days) • Frequency of experiences of alcohol “dependence” symptoms (past 12 months) • Frequency of psychoactive substance use (past 12 months) • Experiences of psychoactive substance use-related problems (past 12 months) • Normative expectations/values regarding psychoactive substance use by people in general/young people in particular • Prevailing adult/youthful psychoactive substance use customs (occasions) • Beliefs as to whether adult/youthful psychoactive substance use is harmful • Knowledge of and attitudes regarding the prevailing legal status of various psychoactive substances • Beliefs about the availability of psychoactive substances • Psychoactive substance use practices of spouse/cohabitant • Socioeconomic characteristics of respondents 	<ul style="list-style-type: none"> • Household survey in the project countries in Southern Africa and South-East Asia: stratified probability sampling of 200 households and 100 adults (≥22 years); interview-administered questionnaire • School/educational institution survey in the project countries in Central and Eastern Europe: systematic sampling of 100 parents of the 300 sampled learners (10-21 year olds) at schools, technical colleges and universities in project communities*

<p>Community Profile 2</p> <p>Broad socioeconomic and demographic structures and processes, with special focus on alcohol, tobacco and other psychoactive substances as well as on young people</p>	<ul style="list-style-type: none"> • Population density, composition, growth and fertility rate, and household composition • Rate of (household) access to basic services (e.g. formal housing, sanitation, electricity, safe water, refuse disposal, primary health/hospital care, schools, police stations/prisons) • Economic status: rate of employment, dismissal, productivity, poverty; household income; gross domestic product; tax revenues • Education: rate of literacy, primary/secondary school enrolment, tertiary enrolment • Health: life expectancy at birth, mortality, morbidity • Communication: extent of formal roads, types of transport, access to communication media, type/extent/cost of advertising • Criminal justice: type/rate of offences, convictions, sentences • Policy: formal policies, legislation, regulations, implementing agencies for psychoactive substance use and related problems 	<ul style="list-style-type: none"> • Desk review of existing/secondary data, e.g. census figures • Direct observation • Social mapping
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* Because of the high level of criminal activity in the Russian Federation and, thus, household owners' hesitance to talk to strangers, the sampling frame of the youth and adult survey in the project sites included young people (10-21 year olds) enrolled at educational institutions in the project communities and a sample of the parents of the sampled young people instead of young people/adults in households.

to psychoactive substances (e.g. through family members and/or friends), permissive attitudes towards psychoactive substance use, incorrect and/or limited information about the nature, extent and development of psychoactive substance use as well as limited prevention resources contribute towards initiation into psychoactive substance use (see Stockdale 2001; Calafat 2000). Based on the argument that multiple lines of independent evidence diminish uncertainty in research, the various datasets were examined for areas of convergence and complementarity (the extent to which datasets informed one another) in the course of **data analysis and interpretation**. Moreover, analysis of the results of the KAP Surveys (e.g. the nature and extent of psychoactive substance use among young people/adults) focused on patterns and trends in the distribution of figures rather than on absolute figures. It is also important to note that the complexity of the subject and, thus, the importance of avoiding shortsighted conclusions, necessitated as detailed an analysis as possible.

Practical issues subjected the overall evaluation of the project outcome to the following **constraints**: The in-depth pre- and post-project situation assessments were restricted to a subgroup of project sites, namely two sites in each priority country, except in the Russian Federation where three sites were included because of the vastness of the country, and the Philippines and Viet Nam where all the project sites were excluded. Furthermore, selective reporting of the results of the pre- and post-project assessments and preventive activities in the respective evaluation sites on the part of participating local/country research institutions and preventive partners inhibited to some extent comprehensive comparisons, including comparisons across sites/countries. The changes that manifested among the assessed/target

groups over the intervention period may also have been the outcome of a variety of factors, including (1) the project activities; (2) differences in the composition or characteristics (e.g. age, educational qualification) of the project samples/groups assessed in the pre- and post-project situation assessments; (3) processes already in operation within the project sites and/or the project regions; and (4) related programmes/projects running parallel with the Global Initiative prevention actions. Finally, the low level of occurrence of certain factors (e.g. illicit psychoactive substance use) in some project sites, and comparatively small samples in the survey component of the pre- and post-project situation assessments in some project sites compromised, statistical tests of the significance of observed differences.

1.5 CONCLUDING REMARKS: STRUCTURE AND CONTENT OF THE REPORT

Against the background of the socioeconomic context within which the Global Initiative was initiated, the project's aim and objectives, and the manner in which it was developed, the next part of this report summarizes the key outcomes of the project with reference to six case studies. These case studies respectively relate to the countries and sites included in the overall evaluation of the Global Initiative, namely the evaluation sites in the Russian Federation and the Republic of Belarus in Central and Eastern Europe; the Kingdom of Thailand in South-East Asia; and in the Republic of South Africa, the United Republic of Tanzania and the Republic of Zambia in Southern Africa.

The case studies are presented per region, i.e. the studies on the project in the Russian Federation and the Republic

of Belarus in Central and Eastern Europe are presented first; the Kingdom of Thailand study is second; and the case studies on the project countries in Southern Africa are presented last. The case study on the project in the Russian Federation introduces the six case studies because it provides the most detailed overview of the outcomes in the Global Initiative. Furthermore, (1) to facilitate comparisons across countries and sites, each case study is presented in a largely uniform way; the available data on each of the variables concerned

for the sites discussed in each case study are tabulated together; and (2) to facilitate future use the detailed results (where available) of the KAP Surveys are presented in tables. Each case study also briefly discusses the key results of the local/country partners' evaluation of the process followed in the implementation of their preventive activities within the relevant outcome evaluation sites. The report concludes with a discussion of the implications of the project outcomes for prevention action.

Project outcome in the evaluation sites in the Russian Federation

2.1 INTRODUCTION

This chapter discusses key findings of the overall evaluation of the outcome of the implementation of the Global Initiative in selected sites in the Russian Federation. The evaluation was restricted to three urban sites: (1) Lublino District in the capital city of Moscow; (2) Ivanovo (capital of Ivanovo Province) situated about 200 kilometres north of Moscow on the main road between Kostroma in the north and Vladimir in the south; and (3) Irkutsk (capital of Irkutsk Province) situated on the River Angara, east of the Ural Mountains in southern Siberia and near the central northern border of Mongolia. Irkutsk—a major industrial city—is connected to the main centres in the Russian Federation by road and the Trans-Siberian Railway. In Ivanovo—also an industrial city—most of the households with minor children live below the poverty line and teenage crime tends to be disproportionately high. Residents in Lublino District in Moscow are mostly poverty-stricken and immigrants. This district also has a disproportionately high rate of psychoactive substance use and related crime.

The chapter first provides an overview of the main sociodemographic characteristics of the evaluation sites, including key changes that occurred during the intervention period. It then describes the main characteristics of the agencies that were selected as the local Global Initiative partners in the evaluation sites, as well as the main preventive activities that they initiated as part of the Global Initiative. The chapter continues with a comparison of the key results of the pre- and post-project situation assessments in the respective sites. It concludes with an integrated summary

(e.g. in tabulated format) of the key findings of the overall evaluation of project implementation in the evaluation sites in the Russian Federation.

2.2 EVALUATION SITES, LOCAL PARTNERS, PREVENTIVE ACTIVITIES AND BROAD SOCIOECONOMIC DEVELOPMENTS

Table 2 presents the key demographic characteristics of the evaluation sites in the Russian Federation more or less at the time when the Global Initiative was initiated. The table shows a largely similar age and gender distribution across sites, except that in Irkutsk the younger age groups were overrepresented and the older groups underrepresented in comparison with the other two sites.

Broad socioeconomic conditions changed somewhat in the evaluation sites over the intervention period. For example, in Irkutsk and Ivanovo the proportions of households with incomes below the living wage increased; the proportion of homeless children increased by about 40.0% between 2000 and 2002 in Ivanovo; and in Irkutsk mortality caused by psychoactive substance use as well as the number of inpatients treated for psychoactive substance use in hospitals increased between 2001 and 2002. Positive developments in Irkutsk were a general decrease in the availability of illicit psychoactive substances as well as in psychoactive substance use-related crime among young people. A positive development in Ivanovo was that the mass media had to some extent become more interested in the problem of psychoactive substance use among young people and in particular in addressing it in depth.

Table 2. Key demographic features of the project sites (2000 census figures, with the Lublino District figures based on figures for Moscow) (percentages)

Variable	Irkutsk	Ivanovo	Lublino District (Moscow)
Gender			
Males	44.7	45.0	44.9
Females	55.3	55.0	55.1
Age			
14 years or younger	18.5	14.5	15.3
15-49 years	56.7	54.1	51.5
50-64 years	15.1	17.6	18.5
65 years or older	9.6	13.8	14.7
Mean age of the population (years)	36.9	39.7	40.2
Total population (N)	589 683	456 357	898 800

Table 3. Description of local partners and the nature and outcome of their preventive activities

Irkutsk	Ivanovo	Lublino District (Moscow)
<p>Local partner</p> <p>The non-government organization, the Baykal Regional Union of Women (ANGARA), was the local Global Initiative partner in Irkutsk. A small group of women initiated this organization in 1992 in Irkutsk. Over the years the organization expanded into various branches so that by the year 2004 26 branches existed in various other centres. The organization provided mainly informational support on various matters (e.g. leadership, gender issues, children's rights, social problems) to women and young people and doing so through seminars, roundtable discussions and the distribution of information material.</p> <p>Problem</p> <p>The results of the pre-project assessment of the project launched by ANGARA highlighted a dramatic rise in HIV/AIDS in the city due to an increase in the injection of psychoactive substances; showed that besides alcohol and tobacco, heroin and marijuana were the most commonly used psychoactive substances among young people; and underlined that the starting age had declined to 11-12 years for alcohol and tobacco use and to 13-15 years for illicit psychoactive substance use in Irkutsk.</p> <p>Aim</p> <p>The project mainly aimed to contribute towards the involvement of a community free of psychoactive substance use by encouraging widespread involvement of community members in prevention action.</p> <p>Preventive activities</p> <p>At the beginning of the project, a coordination group was established, comprising city administrators, social workers, teachers, parents and young people. This group prepared a plan of action and met regularly to discuss challenges and achievements. Activities included seminars and meetings with community members (e.g. parents and specialists working with young people) to raise awareness on the risks posed</p>	<p>Local partner</p> <p>The regional organization "Duchovnoe zdorovje" was the local Global Initiative partner in Ivanovo. The organization named the project "No, thanks".</p> <p>Problem</p> <p>The pre-project assessment of the community indicated that the most popular psychoactive substances among young people were beer, marijuana, heroin, stimulants and inhalants (glue, petrol). The starting age for tobacco use was 9-11 years, for drinking (beer) 10-12 years, for the use of opioids and marijuana 13-15 years, and for inhalants 8-10 years. The main reasons for using psychoactive substances were the desire to be like everyone else, to escape from everyday problems, peer pressure and curiosity.</p> <p>Aim</p> <p>The project mainly aimed to enable young people to resist psychoactive substance use through interactively training them in general life/social skills, and developing a pool of young peer educators. The project was envisaged to contribute towards negative attitudes towards psychoactive substance use and healthy/constructive behaviour among young people.</p> <p>Preventive activities</p> <p>Two groups of 20 students were prepared as training coordinators. These groups conducted about 20 seminars for young people (13-16 years old) in 10 schools in Ivanovo. Some of the participants in the seminars started working as peer educators, conducting mini training seminars in the 10 schools for 9-12 year olds. The project also targeted the parents of the young people reached, holding five three-day seminars for them and establishing a parent club where parents had an opportunity to meet and discuss</p>	<p>Local partner</p> <p>The Research Institute on Mental Health in Moscow was the local Global Initiative partner in Lublino District. The Institute conducts research in the field of mental health to enhance the social and psychological health of the community, especially children and young people.</p> <p>Problem</p> <p>The pre-project assessment of Lublino District pointed to a high level of alcoholism and illegal psychoactive substance use in the community, including psychoactive substance use-related crimes. The age of initiation into tobacco use and drinking was 10-12 years, and into heroin and marijuana use 13-14 years.</p> <p>Aim</p> <p>The project targeted young people between 10 and 21 years, their parents and teachers in three schools. It aimed to increase awareness of the risks of psychoactive substance use, enable young people to resist psychoactive substance use and increase involvement in preventive activities.</p> <p>Preventive activities</p> <p>Young people (divided into 3 age groups) received training in general life/social skills, in particular the skill to cope with daily responsibilities/activities and to be assertive. These young people then conducted peer education activities in the targeted schools. The peer education activities included about 20 mini training sessions in the targeted schools, a thematic discotheque event and a summer camp.</p> <p>Parents and teachers were invited to seminars that focused on the role of family and school in psychoactive substance use-related prevention, and they also participated in some of the activities organized by the youth.</p> <p>The project also developed a computer programme with tests and plays on psychoactive substance use-related issues, which programme</p>

Irkutsk	Ivanovo	Lublino District (Moscow)
<p>by psychoactive substance use. A lawyer was also invited to discuss current legislation on psychoactive substance use at the meetings/seminars. Altogether 300 young people, 400 parents and 20 professionals in the community were reached through the seminars and meetings. A group of young leaders were also trained in prevention work and conducted about 50 different preventive activities in the community, including peer education training in the schools, a youth summer camp, talk shows and theatre performances. These young leaders won a youth competition arranged by the city administrators and two of their projects were granted funding. One of these projects was the establishment of a Youth Frisbee League that expanded into five teams and 80 participants (14-20 years old) by early 2004.</p> <p>Project leaders' evaluation of project delivery and outcomes</p> <p>Records indicated that project delivery occurred as planned.</p> <p>Self-completed questionnaires returned by target groups and focus group discussions with them showed that awareness of the risks of psychoactive substance use and anti-substance use attitudes were widespread among the targeted parents, young people and other community members. Target groups, however, showed little interest in participating in prevention actions. The feedback of the young people reached in the project was positive. They noted that they particularly liked the leadership training and the establishment of the Frisbee League. They learnt a new sport and skills, built self-esteem, made new friends and were given opportunities for spending their free time constructively.</p>	<p>psychoactive substance use-related issues and receive support.</p> <p>Through the activities 40 students (aged 23-30), 300 young people (aged 13-16), 600 children (aged 9-12) and 120 parents were reached.</p> <p>Project leaders' evaluation of project delivery and outcomes</p> <p>The records of the project activities showed that the activities took place as planned, both in terms of time and target groups reached.</p> <p>The feedback of the young people involved in the programme was very positive. They showed much interest in school-based peer education, e.g. because of the high quality of the peer education training.</p> <p>The results of a sample of structured interviews conducted 5-6 days after each event/activity underlined that awareness of the risks of psychoactive substance use increased in the target community.</p>	<p>was accessible for young people through an internet café.</p> <p>The target groups reached through the project activities included young people aged 10-20 years (1 000), teachers (60) and parents (60).</p> <p>Project leaders' evaluation of project delivery and outcomes</p> <p>The records showed that the project proceeded as planned.</p> <p>The results of self-completed questionnaires and focus group discussions showed that the young people and adults (parents and teachers) who participated in the programme acquired more information and developed new skills, especially greater assertiveness.</p> <p>The project activities reached a large number of young people. Doubts were raised about the extent to which young people participated in the planning/implementation of activities, i.e. the extent to which they participated as equals rather than as assistants.</p>

Table 3 profiles the Global Initiative partners and their particular preventive activities in the evaluation sites. Although these activities focused on the use of education in the prevention of psychoactive substance use within the school community, concern was also with the wider community in each site, e.g. parents and non-school professional groups. Table 3 also shows that the relevant Global Initiative partners' preventive activities generally proceeded as planned and achieved the expected outcomes, e.g. increased awareness of the risks of psychoactive substance use among target groups. In the course of the intervention period various government and non-government agencies in Irkutsk initiated a number of psychoactive substance use-related prevention programmes and started to cooperate with one another in this respect. Similarly, in Ivanovo and Lublino District various prevention projects and programmes evolved during the intervention period and a variety of agencies joined prevention efforts. For example, in Lublino District prevention programmes within kindergartens were initiated and agencies such as the Town Council, the municipal Centre for Street Children, the youth centre "Doors", the Orthodox

Church and libraries joined efforts to prevent psychoactive substance use.

2.3 COMPARISON OF THE PRE- AND POST-PROJECT SITUATION ASSESSMENT RESULTS

This section compares the key results of the pre- and post-project situation assessments and in particular the key results of the Adult and Youth KAP Surveys as well as the focus group discussions and key informant interviews in the evaluation sites.

2.3.1 DEMOGRAPHIC PROFILE OF RESPONDENTS

Table 4a shows that in all three sites and with regard to both the 2001 and 2003 KAP Surveys, females were in the majority except in the youth sample in Lublino District and to a lesser extent in Irkutsk where more or less similar

Table 4a. Demographic features of the respondents in the Youth and Adult KAP Surveys of 2001 and 2003 (percentages)

Variable	Irkutsk				Ivanovo				Lublino District (Moscow)			
	Adult KAP		Youth KAP		Adult KAP		Youth KAP		Adult KAP		Youth KAP	
	2001	2003	2001	2003	2001	2003	2001	2003	2001	2003	2001	2003
Gender												
Males	27.3	17.8	46.8	35.6	26.0	34.0	43.7	38.7	20.8	23.4	51.6	48.4
Females	72.7	82.2	53.2	64.4	74.0	66.0	56.3	61.3	79.2	76.6	48.4	51.6
Age (adults)												
22-39 years	52.5	48.0	-	-	35.0	29.0	-	-	31.1	51.0	-	-
40-45 years	24.2	28.0	-	-	39.0	45.0	-	-	33.0	18.0	-	-
46 years or older	23.2	25.0	-	-	26.0	26.0	-	-	35.8	25.0	-	-
Age (youth)												
10-13 years	-	-	36.8	28.2	-	-	37.3	37.3	-	-	25.5	31.7
14-16 years	-	-	35.5	44.7	-	-	25.7	37.6	-	-	46.2	47.4
17-21 years	-	-	27.8	27.2	-	-	37.0	25.0	-	-	28.3	20.9
Total N	99	101	299	309	100	100	300	300	106	94	314	287

Table 4b. Demographic features of the respondents in Community Profile 1

Irkutsk				Ivanovo				Lublino District			
Pre-intervention assessment (2001)		Post-intervention assessment (2003)		Pre-intervention assessment (2001)		Post-intervention assessment (2003)		Pre-intervention assessment (2001)		Post-intervention assessment (2003)	
Method	Respondents	Method	Respondents	Method	Respondents	Method	Respondents	Method	Respondents	Method	Respondents
Focus group with college students	6 males and 5 females	Focus group with 10-15 year old school children	4 males and 6 females	Focus group with 14-15 year olds	3 males and 3 females	Focus group with 14-15 year olds	3 males and 3 females	Focus group with adults	4 males and 3 females	Two focus groups with adults	Mix of males and females
Focus group with 24-51 year olds	3 males and 7 females	Focus group with 18-21 year old university students	8 males and 2 females	Focus group with 40-50 year olds	3 males and 4 females	Focus group with 40-50 year olds	3 males and 4 females	Focus group with adults	3 males and 4 females	Focus group with 11-14 year olds	Mix of males and females
Key informant interviews with 22-65 year olds with higher education	4 males and 6 females	Focus group with 44-54 year olds	5 males and 3 females	Focus group with 14-15 year olds	3 males and 3 females	Focus group with 14-15 year olds	3 males and 4 females	Focus group with adults	Mix of males and females	Focus group with 15-20 year olds	Mix of males and females
-	-	Focus group with 30-46 year olds	4 males and 4 females	Focus group with 40-45 year olds	3 males and 4 females	Focus group with 40-45 year olds	3 males and 4 females	Focus group with high school pupils	1 male and 5 females	Key informant interviews	Mix of males and females (15)
-	-	Key informant interviews with 28-61 year olds	7 males and 8 females	Key informant interviews with various agencies	Medical, welfare and youth affairs officers; church and non-profit agency representatives	Key informant interviews with various agencies	Medical, welfare and youth affairs officers; church and non-profit agency representatives	Key informant interviews: specialists in substance use prevention	Mix of males and females (18)	-	-

proportions of males and females were sampled. The ages of the respondents in the Adult KAP Survey distributed as follows:

- In Irkutsk the 22-39 year old group was the single largest age group in both the 2001 and 2003 samples;
- In Ivanovo the 40-45 year old group was the single largest age group in both the 2001 and 2003 samples;
- In Lublino District persons 46 years or older formed the single largest age group in the 2001 sample, and 22-39 year olds in the 2003 sample.

In the Youth KAP Survey the ages of the respondents distributed as follows:

- In Irkutsk 17-21 year olds formed the smallest single age

group in the 2001 as well as 2003 sample (whereas the 10-13 years and 14-16 years age groups in the 2001 sample were of about equal size, 14-16 year olds were overrepresented among 10-16 year olds in the 2003 sample);

- In Ivanovo 14-16 year olds formed the smallest single age group in the 2001 sample, and 17-21 year olds in the 2003 sample (the other age groups in the respective samples had about equal proportions);
- In Lublino District 14-16 year olds formed the single largest age group in both the 2001 and 2003 sample.

Table 4b shows that the participants in the focus group discussions and key informant interviews included males and females in different age groups.

Table 5. Respondents in the Adult KAP Surveys of 2001 and 2003 reporting selected patterns of psychoactive substance use among people in general and young people as entailing moderate or great risk (percentages)

Patterns of psychoactive substance use	Use among people in general						Use among young people					
	Irkutsk		Ivanovo		Lublino District		Irkutsk		Ivanovo		Lublino District	
	2001	2003	2001	2003	2001	2003	2001	2003	2001	2003	2001	2003
Smoke 10 or more cigarettes a day	65.7	74.3	81.0	74.0	71.7	66.0	79.8	85.1	92.0	90.0	87.7	74.5
Take marijuana/hashish occasionally	77.8	79.2	86.0	84.0	84.0	75.5	83.8	88.1	94.0	93.0	95.3	79.8
Take marijuana/hashish regularly	86.9	89.1	96.0	95.0	93.4	80.9	86.9	93.1	95.0	93.0	98.1	84.0
Take cocaine once/twice	78.8	80.2	87.0	85.0	84.0	72.3	85.9	88.1	94.0	90.0	94.3	79.8
Take cocaine occasionally	83.8	84.2	90.0	87.0	84.0	79.8	85.9	89.1	92.0	90.0	93.4	80.9
Take 1 or 2 drinks several times a week	56.6	63.4	60.0	59.0	50.0	51.1	73.7	80.2	88.0	88.0	85.8	73.4
Take 5 or more drinks once or twice a weekend	69.7	80.2	83.0	81.0	82.1	74.5	79.8	88.1	90.0	91.0	95.3	76.6
Take amphetamine once/twice	70.7	78.2	79.0	77.0	80.2	68.1	79.8	87.1	92.0	91.0	90.6	71.3
Take amphetamine occasionally	73.7	81.2	87.0	83.0	83.0	69.1	79.8	88.1	93.0	91.0	97.2	75.5
Take heroin once/twice	81.8	88.1	91.0	93.0	92.5	76.6	85.9	89.1	94.0	94.0	98.1	78.7
Take heroin occasionally	84.8	89.1	95.0	94.0	92.5	79.8	86.9	90.1	95.0	91.0	99.1	83.0
Take inhalants once/twice	78.8	83.2	88.0	88.0	84.9	73.4	81.8	86.1	93.0	90.0	94.3	75.5
Take inhalants occasionally	75.8	83.2	93.0	90.0	84.9	72.3	82.8	89.1	93.0	91.0	97.2	80.9
Take hallucinogens once/twice	71.7	79.2	86.0	83.0	81.1	74.5	77.8	87.1	92.0	90.0	95.3	74.5
Take hallucinogens occasionally	75.8	85.1	91.0	87.0	87.7	77.7	80.8	88.1	93.0	91.0	99.1	81.9
Total N	99	101	100	100	106	94	99	101	100	100	106	94

Table 6. Respondents in the Adult KAP Surveys of 2001 and 2003 reporting selected patterns of psychoactive substance use among people in general and young people as entailing moderate or great risk (percentages)

Patterns of psychoactive substance use	Irkutsk		Ivanovo		Lublino District	
	2001	2003	2001	2003	2001	2003
Smoke 10 and more cigarettes a day	58.6	55.4	73.0	72.0	66.0	46.7
Take marijuana/hashish occasionally	84.8	84.2	94.0	95.0	89.6	57.1
Take marijuana/hashish regularly	86.9	87.1	95.0	95.0	88.7	63.1
Take cocaine once/twice	83.8	82.2	91.0	91.0	85.8	61.3
Take cocaine occasionally	80.8	78.2	93.0	93.0	91.5	62.7
Take 1 or 2 drinks several times a week	57.6	59.4	62.0	66.0	57.5	44.3
Take 5 or more drinks once/twice a weekend	72.7	73.3	84.0	91.0	81.1	52.3
Take amphetamine once/twice	74.7	79.2	84.0	91.0	79.2	60.3
Take amphetamine occasionally	75.8	78.2	80.0	80.0	82.1	61.3
Take heroin once/twice	81.8	84.2	94.0	96.0	87.7	64.8
Take heroin occasionally	77.8	84.2	95.0	96.0	91.5	65.9
Take hallucinogens once/twice	75.8	80.2	89.0	90.0	84.9	61.0
Take hallucinogens occasionally	75.8	83.2	90.0	92.0	89.6	61.7
Total N	99	101	100	100	106	94

2.3.2 PSYCHOACTIVE SUBSTANCE USE-RELATED ATTITUDES AND PRACTICES AMONG ADULTS

Table 5 presents the views of the respondents in the 2001 and 2003 Adult KAP Surveys in the evaluation sites in the Russian Federation as to whether selected patterns of psychoactive substance use among people in general and among young people in particular entailed moderate or great risk. In all three sites the respondents in both the 2001 and 2003 Adult KAP Survey mostly replied affirmatively to the question of whether the listed patterns of psychoactive substance use entailed moderate/great risk, especially with

regard to usage among young people and to a lesser extent with regard to “taking 1 or 2 drinks several times a week”. In both the 2001 and 2003 surveys the “regular use of hashish/marijuana” and the “use of heroin” were especially indicated as entailing moderate/great risk. Table 5 also shows that in Irkutsk adults were generally more inclined in 2003 than in 2001 to assign moderate/great risk to the listed patterns of psychoactive substance use. In Ivanovo and especially in Lublino District the surveyed adults were generally less inclined in 2003 than in 2001 to attach moderate/great risk to the listed patterns of psychoactive substance use.

Table 6 shows the extent to which respondents in the 2001 and 2003 Adult KAP Surveys in the three sites (strongly) disapproved of selected patterns of psychoactive substance use among young people. In line with the above response patterns regarding the riskiness of selected patterns of psychoactive substance use, the respondents in both the 2001 and 2003 surveys in all three sites generally (strongly) disapproved of the listed patterns of psychoactive substance use, to a lesser extent “taking 1 or 2 drinks several times a week” and “smoking 10 or more cigarettes a day”. The response patterns in the 2003 surveys in Irkutsk and Ivanovo were also generally more or less similar to those in the related 2001 surveys. In Lublino District respondents tended to be less inclined in 2003 than in 2001 to (strongly) disapprove of the selected patterns of psychoactive substance use among young people.

Tables 7-9 show the extent to which respondents in the 2001 and 2003 Adult KAP Surveys in the evaluation sites in the Russian Federation admitted to using psychoactive substances at particular periods in their life, i.e. at some time in their life (lifetime use), in the 12 months (past 12 months’ use) before a particular survey and the 30 days (past 30 days’ use) before a survey concerned. Table 7 indicates a general decline over the intervention period in reports of lifetime, past 30 days’ and to a lesser extent past 12 months’ use of tobacco in general in Irkutsk. Especially notable is the decrease in (almost) daily use of cigarettes among the surveyed adults in Irkutsk—in the 2001 survey 33.3% of the respondents admitted (almost) daily use of cigarettes in the 12 months before the survey and in the 2003 survey 22.0% admitted such use. In Ivanovo more or less similar proportions admitted the use of tobacco in the 2001 and 2003 survey. However, although (almost) daily cigarette use decreased among males (from 30.8% in 2001 to 11.8% in

2003), it increased among adult females in Ivanovo (from 9.5% in 2001 to 18.2% in 2003). Reports of the use of tobacco were generally more common in the 2003 than in the 2001 survey in Lublino District.

Table 7 also shows that reports of the use of alcohol in general decreased over the intervention period in Irkutsk (lifetime use declined from 92.9% to 76.0%, and past 12 months’ use from 82.8% to 71.0%) and in Lublino District (lifetime use declined from 97.2% to 92.6%, and past 12 months’ use from 92.5% to 80.9%). In Ivanovo the proportions who admitted the use of alcohol in general remained more or less the same over the intervention period. Moreover, Table 8 shows that Lublino District experienced a reduction in the use of a variety of alcoholic beverages—lifetime use of hard liquor declined from 78.3% to 52.1%, malt beer from 78.3% to 37.2%, champagne from 89.6% to 44.7%, wine from 87.7% to 45.7% and homebrews from 45.3% to 20.2%. Reported use of hard liquor also decreased over the intervention period in Irkutsk and Ivanovo, but to a lesser extent than in Lublino District. In Irkutsk the decline in the use of hard liquor was accompanied by a reduction in the use of malt beer (lifetime use declined from 50.5% to 42.6%, past 12 months’ use from 32.3% to 27.7% and past 30 days’ use from 29.3% to 20.8%).

Table 9 shows that the proportions who reported the use of illicit psychoactive substances in the relevant 2003 surveys, though comparatively low, were somewhat higher than in the related 2001 surveys—lifetime use increased from 2.0% in the 2001 survey to 4.0% in 2003 survey in Irkutsk, from 1.0% to 2.0% in Ivanovo and from 3.8% to 8.5% in Lublino District. In contrast, reports of the non-medical use of medicine such as painkillers, tranquillizers and sedatives generally decreased over the intervention period in all three sites.

Table 7. Respondents in the Adult KAP Surveys of 2001 and 2003 reporting alcohol and tobacco use during particular periods in time (percentages)

Alcohol and/or tobacco use	Irkutsk		Ivanovo		Lublino District	
	2001	2003	2001	2003	2001	2003
Tobacco generally						
Lifetime use	44.4	37	44.0	38.0	50.0	59.6
Past 12 months’ use	25.3	21	21.0	23.0	24.5	30.9
Past 30 days’ use	21.2	14	17.0	17.0	22.6	29.8
Past 12 months’ frequency of cigarette use: (Almost) daily	33.3	22	15.0	16.0	20.8	24.5
Alcohol generally						
Lifetime use	92.9	76	86.0	86.0	97.2	92.6
Past 12 months’ use	82.8	71	84.0	82.0	92.5	80.9
Past 30 days’ use	68.7	54	83.0	81.0	75.5	64.9
Past 12 months’ frequency of use:						
(Almost) daily	-	2.0	4.0	5.0	-	4.3
3-4 times a week	1.0	2.0	-	-	4.7	4.3
1-2 times a week	8.1	5.9	9.0	8.0	13.2	9.6
2-3 days a month	20.2	18.8	23.0	21.0	16.0	18.1
Once a month	29.3	20.8	29.0	30.0	24.5	25.5
Less than once a month	34.3	27.7	31.0	30.0	31.1	30.8
No alcohol use in lifetime	7.1	9.9	14.0	14.0	2.8	7.4
Total N	99	101	100	100	106	94

Table 8. Respondents in the Adult KAP Surveys of 2001 and 2003 reporting the use of selected types of alcohol during particular periods in time (percentages)

Selected types of alcohol use	Irkutsk		Ivanovo		Lublino District	
	2001	2003	2001	2003	2001	2003
Hard liquor/spirits						
Lifetime use	61.6	46.5	67.0	60.0	78.3	52.1
Past 12 months' use	31.3	27.7	35.0	30.0	52.8	29.8
Past 30 days' use	25.3	16.8	29.0	26.0	33.0	21.3
Malt beer						
Lifetime use	50.5	42.6	50.0	48.0	78.3	37.2
Past 12 months' use	32.3	27.7	36.0	38.0	62.3	30.9
Past 30 days' use	29.3	20.8	44.0	50.0	39.6	27.7
Champagne						
Lifetime use	49.5	47.5	55.0	53.0	89.6	44.7
Past 12 months' use	33.3	37.6	51.0	55.0	62.3	34.0
Past 30 days' use	14.1	10.9	15.0	16.0	21.7	16.0
Wine						
Lifetime use	50.5	40.6	46.0	48.0	87.7	45.7
Past 12 months' use	32.3	37.6	46.0	48.0	67.9	43.6
Past 30 days' use	20.2	24.8	43.0	45.0	42.5	24.5
Homebrews						
Lifetime use	31.3	21.8	33.0	35.0	45.3	20.2
Past 12 months' use	5.1	7.9	12.0	13.0	8.5	5.3
Past 30 days' use	-	4.0	6.0	9.0	3.8	-
Total N	99	101	100	100	106	94

Table 9. Respondents in the Adult KAP Surveys of 2001 and 2003 reporting the use of illicit psychoactive substances, injection use and the non-medical use of painkillers/tranquillizers/sedatives during particular periods in time (percentages)

Psychoactive substance use	Irkutsk		Ivanovo		Lublino District	
	2001	2003	2001	2003	2001	2003
Illicit substances						
Lifetime use	2.0	4.0	1.0	2.0	3.8	8.5
Past 12 months' use	-	1.0	-	-	-	3.2
Past 30 days' use	-	-	-	-	-	2.1
Injections						
Lifetime use	2.0	1.0	1.0	2.0	0.9	3.2
Past 12 months' use	-	-	-	-	-	-
Past 30 days' use	-	-	-	-	-	-
Painkillers/tranquillizers/sedatives						
Lifetime use	45.5	40.6	49.0	41.0	52.8	42.6
Past 12 months' use	22.2	23.8	36.0	34.0	35.8	26.6
Past 30 days' use	15.2	9.9	19.0	16.0	17.0	16.0
Frequency of past 12 months' use of painkillers						
(Almost) daily	-	-	-	-	-	-
3-4 times a week	1.0	-	-	-	1.9	-
1-2 times a week	1.0	-	6.0	8.0	0.9	3.2
2-3 days a month	9.1	5.9	3.0	2.0	3.8	9.6
Once a month	12.1	5.0	15.0	14.0	9.4	2.1
Less than once a month	14.1	31.7	23.0	18.0	23.6	23.4
Frequency of past 12 months' use of tranquillizers						
(Almost) daily	-	1.0	1.0	2.0	-	-
3-4 times a week	-	-	-	-	-	-
1-2 times a week	-	-	-	-	-	1.1
2-3 days a month	-	-	1.0	1.0	0.9	1.1
Once a month	-	-	-	-	0.9	2.1
Less than once a month	2.0	5.0	6.0	6.0	13.2	10.7
Frequency of past 12 months' use of sedatives						
(Almost) daily	-	-	-	-	-	-
3-4 times a week	-	-	-	-	-	-
1-2 times a week	-	1.0	-	-	0.9	1.1
2-3 days a month	-	-	1.0	1.0	0.9	2.1
Once a month	-	-	-	-	0.9	-
Less than once a month	1.0	7.0	1.0	2.0	7.4	6.4
Total N	99	101	100	100	106	94

2.3.3 PSYCHOACTIVE SUBSTANCE USE-RELATED ATTITUDES AND PRACTICES AMONG YOUNG PEOPLE

Tables 10-12 show the responses in the 2001 and 2003 Youth KAP Surveys in the three evaluation sites as to whether selected patterns of youth psychoactive substance use entailed moderate or great risk. In all three sites and with regard to both the 2001 and 2003 surveys the respondents mostly indicated that the relevant patterns of psychoactive substance use entailed moderate/great risk, except in the case of “taking 1 or 2 drinks several times a week”. Generally, response patterns did not change markedly in Irkutsk and Ivanovo over the intervention period, except for some gender differences (Tables 10-11). In Irkutsk, for example, males were generally more inclined and females less inclined in 2003 than in 2001 to report the listed patterns of psychoactive substance use as entailing moderate/great risk (Table 10). In Ivanovo (Table 11) females were distinctly less inclined in 2003 (64.7%) than in 2001 (74.0%) to indicate occasional use of marijuana as entailing moderate/great risk. In Lublino District (Table 12) young people were generally less inclined in 2003 than in 2001 to report the listed patterns of psychoactive substance use as entailing moderate/great risk. In contrast with the results of the 2001 survey, the results of the 2003 survey showed that males’ preparedness to associate moderate/great risk with the listed patterns of psychoac-

tive substance use generally increased with age in Lublino District (Table 12).

Tables 13-15 show the extent to which the respondents in the 2001 and 2003 Youth KAP Surveys (strongly) disapproved of selected patterns of youth psychoactive substance use. In line with the above response patterns regarding the riskiness of youth psychoactive substance use, the respondents in both the 2001 and 2003 surveys in all three sites generally (strongly) disapproved of the relevant patterns of psychoactive substance use, except “taking 1 or 2 drinks several times a week” and “smoking 10 or more cigarettes a day”. In Irkutsk (Table 13) the proportions of young people who (strongly) disapproved of the listed psychoactive substance use patterns tended to be higher in 2003 than in 2001, with distinct exceptions in some age and gender groups. For example, a marked reduction (Table 13) occurred in the proportions of (1) 10-13 year old males, and 14-16 as well as 17-21 year old females who (strongly) disapproved of “taking 1 or 2 drinks several times a week”, as well as (2) 10-13 year old males and 14-16 year old females who (strongly) disapproved of respectively “smoking 10 or more cigarettes a day” and “taking marijuana/hashish occasionally”. In Ivanovo (Table 14) and especially in Lublino District (Table 15) the proportions of young people who (strongly) disapproved of the listed patterns of psychoactive substance use generally declined over the intervention period.

Table 10. Respondents in the Youth KAP Surveys of 2001 and 2003 in Irkutsk reporting selected patterns of youth psychoactive substance use as entailing moderate or great risk (percentages)

Patterns of psychoactive substance use	All		Boys		Girls		Boys						Girls					
	2001	2003	2001	2003	2001	2003	10-13 years		14-16 years		17-21 years		10-13 years		14-16 years		17-21 years	
							2001	2003	2001	2003	2001	2003	2001	2003	2001	2003	2001	2003
Smoke 10 or more cigarettes a day	61.2	63.4	54.3	63.6	67.3	63.3	58.5	68.0	54.7	60.0	50.0	64.4	65.2	67.7	64.2	61.2	75.7	61.5
Take marijuana/hashish occasionally	70.2	68.3	62.1	65.5	77.4	69.8	63.4	68.0	66.0	67.5	56.5	62.2	72.5	71.0	81.1	71.4	81.1	64.1
Take marijuana/hashish regularly	78.3	80.3	72.9	82.7	83.0	78.9	65.9	92.0	77.4	80.0	73.9	80.0	75.4	72.6	83.0	83.7	97.3	76.9
Take cocaine once/twice	68.9	68.6	65.0	69.1	72.3	68.3	53.7	68.0	71.7	67.5	67.4	71.1	63.8	66.1	77.4	71.4	81.1	64.1
Take cocaine occasionally	71.6	74.1	65.7	75.5	76.7	73.4	61.0	72.0	64.2	77.5	71.7	75.6	72.5	71.0	77.4	74.5	83.8	74.4
Take 1 or 2 drinks several times a week	43.1	45.6	35.0	48.2	50.3	44.2	36.6	72.0	32.1	47.5	37.0	35.6	52.2	45.2	39.6	42.9	62.2	46.2
Take 5 or more drinks once/twice a weekend	61.5	64.1	52.1	64.5	69.8	63.8	53.7	80.0	47.2	62.5	56.5	57.8	66.7	56.5	71.7	70.4	73.0	59.0
Take amphetamine once/twice	64.2	64.4	59.3	69.1	68.6	61.8	53.7	64.0	58.5	77.5	65.2	64.4	60.9	56.5	71.7	66.3	78.4	59.0
Take amphetamine occasionally	64.5	68.0	60.7	70.9	67.9	66.3	61.0	64.0	56.6	75.0	65.2	71.1	65.2	59.7	67.9	69.4	73.0	69.2
Take heroin once/twice	73.2	73.1	69.3	73.6	76.7	72.9	61.0	68.0	67.9	75.0	78.3	75.6	68.1	69.4	83.0	74.5	83.8	74.4
Take heroin occasionally	74.9	77.7	72.1	80.9	77.4	75.9	65.9	76.0	71.7	80.0	78.3	84.4	68.1	66.1	79.2	81.6	91.9	76.9
Take inhalants once/twice	65.9	62.8	63.6	65.5	67.9	61.3	56.1	56.0	64.2	72.5	69.6	64.4	62.3	53.2	64.2	64.3	83.8	66.7
Take inhalants occasionally	66.2	66.3	65.0	68.2	67.3	65.3	58.5	64.0	64.2	70.0	71.7	68.9	63.8	54.8	64.2	70.4	78.4	69.2
Take hallucinogens once/twice	64.5	63.1	62.9	64.5	66.0	62.3	61.0	56.0	58.5	67.5	69.6	66.7	59.4	54.8	69.8	64.3	73.0	69.2
Take hallucinogens occasionally	68.2	66.3	65.7	68.2	70.4	65.3	63.4	64.0	62.3	67.5	71.7	71.1	66.7	56.5	67.9	69.4	81.1	69.2
Total N	299	309	140	110	159	199	41	25	53	40	46	45	69	62	53	98	37	39

Table 11. Respondents in the Youth KAP Surveys of 2001 and 2003 in Ivanovo reporting selected patterns of youth psychoactive substance use as entailing moderate or great risk (percentages)

Patterns of psychoactive substance use	All		Boys		Girls		Boys						Girls					
	2001	2003	2001	2003	2001	2003	10-13 years		14-16 years		17-21 years		10-13 years		14-16 years		17-21 years	
							2001	2003	2001	2003	2001	2003	2001	2003	2001	2003	2001	2003
Smoke 10 or more cigarettes a day	72.3	71.7	70.2	70.7	74.0	72.3	79.7	70.8	60.0	62.8	62.5	84.0	66.7	70.3	81.0	74.3	74.7	72.0
Take marijuana/hashish occasionally	70.3	66.3	65.6	69.0	74.0	64.7	70.3	66.7	62.9	67.4	59.4	76.0	64.6	60.9	76.2	68.6	78.5	64.0
Take marijuana/hashish regularly	83.0	82.0	82.4	84.5	83.4	80.4	85.9	77.1	71.4	86.0	87.5	96.0	66.7	71.9	85.7	80.0	92.4	92.0
Take cocaine once/twice	65.3	64.3	67.2	70.7	63.9	60.3	73.4	72.9	54.3	69.8	68.8	68.0	56.3	59.4	76.2	64.3	62.0	56.0
Take cocaine occasionally	73.0	72.3	74.0	76.7	72.2	69.6	78.1	77.1	68.6	74.4	71.9	80.0	66.7	70.3	73.8	68.6	74.7	70.0
Take 1 or 2 drinks several times a week	48.3	46.3	51.9	50.9	45.6	43.5	68.8	62.5	40.0	46.5	31.3	36.0	50.0	50.0	52.4	44.3	39.2	34.0
Take 5 or more drinks once/twice a weekend	71.0	70.3	70.2	70.7	71.6	70.1	76.6	70.8	65.7	67.4	62.5	76.0	60.4	68.8	76.2	71.4	75.9	70.0
Take amphetamine once/twice	65.0	65.0	68.7	65.5	62.1	64.7	79.7	70.8	57.1	65.1	59.4	56.0	52.1	65.6	71.4	62.9	63.3	66.0
Take amphetamine occasionally	69.7	68.0	71.8	69.8	68.0	66.8	81.3	72.9	62.9	67.4	62.5	68.0	56.3	65.6	69.0	62.9	74.7	74.0
Take heroin once/twice	73.0	73.0	77.9	77.6	69.2	70.1	84.4	72.9	71.4	81.4	71.9	80.0	52.1	64.1	78.6	72.9	74.7	74.0
Take heroin occasionally	79.3	79.0	80.2	81.9	78.7	77.2	84.4	77.1	77.1	86.0	75.0	84.0	60.4	70.3	81.0	77.1	88.6	86.0
Take inhalants once/twice	65.0	65.0	69.5	71.6	61.5	60.9	78.1	72.9	60.0	69.8	62.5	72.0	50.0	60.9	66.7	61.4	65.8	60.0
Take inhalants occasionally	71.0	70.7	76.3	73.3	66.9	69.0	82.8	72.9	68.6	72.1	71.9	76.0	54.2	67.2	73.8	71.4	70.9	68.0
Take hallucinogens once/twice	64.0	65.0	68.7	68.1	60.4	63.0	73.4	68.8	62.9	65.1	65.6	72.0	47.9	62.5	66.7	62.9	64.6	64.0
Take hallucinogens occasionally	73.3	71.3	76.3	73.3	71.0	70.1	81.3	72.9	68.6	72.1	75.0	76.0	58.3	67.2	73.8	70.0	77.2	74.0
Total N	300	300	131	116	169	184	64	48	35	43	32	25	48	64	42	70	79	50

Table 12. Respondents in the Youth KAP Surveys of 2001 and 2003 in Lublino District reporting selected patterns of youth psychoactive substance use as entailing moderate or great risk (percentages)

Patterns of psychoactive substance use	All		Boys		Girls		Boys						Girls					
	2001	2003	2001	2003	2001	2003	10-13 years		14-16 years		17-21 years		10-13 years		14-16 years		17-21 years	
							2001	2003	2001	2003	2001	2003	2001	2003	2001	2003	2001	2003
Smoke 10 or more cigarettes a day	68.8	59.9	62.3	51.8	75.7	67.6	75.0	46.2	64.1	52.2	45.0	57.6	83.3	65.4	71.6	76.8	75.5	48.1
Take marijuana/hashish occasionally	76.4	62.4	74.1	56.1	78.9	68.2	84.1	51.3	78.2	61.2	55.0	51.5	83.3	73.1	80.6	76.8	73.5	37.0
Take marijuana/hashish regularly	90.8	70.4	87.7	64.0	94.1	76.4	86.4	53.8	89.7	62.7	85.0	78.8	88.9	73.1	97.0	84.1	93.9	63.0
Take cocaine once/twice	78.3	61.7	78.4	59.0	78.3	64.2	77.3	43.6	84.6	62.7	67.5	69.7	83.3	57.7	73.1	79.7	81.6	37.0
Take cocaine occasionally	86.0	69.7	84.0	66.9	88.2	72.3	75.0	53.8	84.6	68.7	92.5	78.8	86.1	73.1	89.6	79.7	87.8	51.9
Take 1 or 2 drinks several times a week	44.9	43.6	40.1	41.7	50.0	45.3	56.8	48.7	35.9	43.3	30.0	30.3	61.1	48.1	50.7	55.1	40.8	14.8
Take 5 or more drinks once/twice a weekend	69.7	57.5	66.7	51.8	73.0	62.8	72.7	41.0	67.9	59.7	57.5	48.5	83.3	63.5	79.1	69.6	57.1	44.4
Take amphetamine once/twice	75.8	60.3	72.2	59.7	79.6	60.8	75.0	46.2	75.6	62.7	62.5	69.7	86.1	59.6	76.1	71.0	79.6	37.0
Take amphetamine occasionally	78.0	63.8	74.7	64.0	81.6	63.5	63.6	51.3	79.5	65.7	77.5	75.8	83.3	61.5	80.6	75.4	81.6	37.0
Take heroin once/twice	85.0	67.9	85.2	66.9	84.9	68.9	81.8	48.7	91.0	71.6	77.5	78.8	83.3	63.5	86.6	78.3	83.7	55.6
Take heroin occasionally	90.4	72.8	88.3	69.8	92.8	75.7	81.8	53.8	91.0	73.1	90.0	81.8	91.7	73.1	92.5	82.6	93.9	63.0
Take inhalants once/twice	76.1	62.4	77.8	60.4	74.3	64.2	72.7	43.6	85.9	65.7	67.5	69.7	80.6	63.5	67.2	71.0	79.6	48.1
Take inhalants occasionally	79.0	64.8	77.8	63.3	80.3	66.2	70.5	51.3	87.2	65.7	67.5	72.7	77.8	69.2	80.6	71.0	81.6	48.1
Take hallucinogens once/twice	75.5	62.0	74.7	58.3	76.3	65.5	70.5	43.6	79.5	61.2	70.0	69.7	83.3	65.4	70.1	73.9	79.6	44.4
Take hallucinogens occasionally	80.6	66.2	77.8	63.3	83.6	68.9	72.7	51.3	82.1	64.2	75.0	75.8	83.3	69.2	80.6	76.8	87.8	48.1
Total N	314	287	162	139	152	148	44	39	78	67	40	33	36	52	67	69	49	27

Table 13. Respondents in the Youth KAP Surveys of 2001 and 2003 in Irkutsk (strongly) disapproving of selected patterns of youth psychoactive substance use (percentages)

Patterns of psychoactive substance use	All		Boys		Girls		Boys						Girls					
	2001	2003	2001	2003	2001	2003	10-13 years		14-16 years		17-21 years		10-13 years		14-16 years		17-21 years	
							2001	2003	2001	2003	2001	2003	2001	2003	2001	2003	2001	2003
	2001	2003	2001	2003	2001	2003	2001	2003	2001	2003	2001	2003	2001	2003	2001	2003	2001	2003
Smoke 10 or more cigarettes a day	49.8	56.3	39.3	51.8	59.1	58.8	53.7	40.0	32.1	52.5	34.8	57.8	56.5	67.7	67.9	56.1	51.4	51.3
Take marijuana/hashish occasionally	59.5	66.0	47.9	59.1	69.8	69.8	63.4	56.0	47.2	55.0	34.8	64.4	58.0	72.6	81.1	68.4	75.7	69.2
Take marijuana/hashish regularly	66.9	74.1	58.6	66.4	74.2	78.4	63.4	64.0	62.3	65.0	50.0	68.9	60.9	77.4	84.9	78.6	83.8	79.5
Take cocaine once/twice	64.9	73.8	57.9	66.4	71.1	77.9	63.4	60.0	62.3	60.0	47.8	75.6	62.3	75.8	81.1	79.6	73.0	76.9
Take 1 or 2 drinks several times a week	45.5	46.9	37.9	37.3	52.2	52.3	58.5	36.0	28.3	35.0	30.4	40.0	46.4	64.5	64.2	52.0	45.9	33.3
Take 5 or more drinks once/twice a weekend	55.2	61.2	47.1	52.7	62.3	65.8	61.0	52.0	41.5	47.5	41.3	57.8	55.1	72.6	71.7	66.3	62.2	53.8
Take amphetamine once/twice	56.9	67.6	51.4	65.5	61.6	68.8	58.5	60.0	50.9	60.0	45.7	73.3	47.8	71.0	71.7	70.4	73.0	61.5
Take amphetamine occasionally	57.2	68.0	52.1	66.4	61.6	68.8	56.1	56.0	52.8	62.5	47.8	75.6	49.3	72.6	71.7	69.4	70.3	61.5
Take heroin once/twice	65.9	73.8	59.3	68.2	71.7	76.9	58.5	60.0	64.2	62.5	54.3	77.8	60.9	72.6	84.9	78.6	73.0	79.5
Take heroin occasionally	66.2	77.3	60.0	74.5	71.7	78.9	61.0	64.0	64.2	70.0	54.3	84.4	63.8	77.4	81.1	79.6	73.0	79.5
Take hallucinogens once/twice	60.9	71.2	58.6	67.3	62.9	73.4	61.0	60.0	64.2	60.0	50.0	77.8	52.2	71.0	77.4	73.5	62.2	76.9
Take hallucinogens occasionally	61.9	71.2	60.0	69.1	63.5	72.4	61.0	60.0	66.0	65.0	52.2	77.8	52.2	69.4	77.4	73.5	64.9	74.4
Total N	299	309	140	110	159	199	41	25	53	40	46	45	69	62	53	98	37	39

Table 14. Respondents in the Youth KAP Surveys of 2001 and 2003 in Ivanovo (strongly) disapproving of selected patterns of youth psychoactive substance use (percentages)

Patterns of psychoactive substance use	All		Boys		Girls		Boys						Girls					
	2001	2003	2001	2003	2001	2003	10-13 years		14-16 years		17-21 years		10-13 years		14-16 years		17-21 years	
							2001	2003	2001	2003	2001	2003	2001	2003	2001	2003	2001	2003
	2001	2003	2001	2003	2001	2003	2001	2003	2001	2003	2001	2003	2001	2003	2001	2003	2001	2003
Smoke 10 or more cigarettes a day	68.0	63.3	61.1	66.4	73.4	61.4	75.0	72.9	54.3	67.4	40.6	52.0	79.2	67.2	78.6	64.3	67.1	50.0
Take marijuana/hashish occasionally	75.0	70.7	71.0	74.1	78.1	68.5	76.6	66.7	65.7	76.7	65.6	84.0	75.0	64.1	81.0	71.4	78.5	70.0
Take marijuana/hashish regularly	79.3	75.0	73.3	76.7	84.0	73.9	76.6	66.7	71.4	81.4	68.8	88.0	75.0	64.1	90.5	81.4	86.1	76.0
Take cocaine once/twice	72.0	67.3	68.7	70.7	74.6	65.2	70.3	58.3	68.6	76.7	65.6	84.0	66.7	59.4	78.6	68.6	77.2	68.0
Take cocaine occasionally	79.7	76.7	76.3	80.2	82.2	74.5	81.3	75.0	77.1	86.0	65.6	80.0	83.3	76.6	88.1	75.7	78.5	70.0
Take 1 or 2 drinks several times a week	55.7	54.7	48.9	56.9	60.9	53.3	57.8	56.3	48.6	58.1	31.3	56.0	77.1	62.5	61.9	52.9	50.6	42.0
Take 5 or more drinks once/twice a weekend	73.0	71.0	68.7	71.6	76.3	70.7	76.6	70.8	68.6	74.4	53.1	68.0	83.3	75.0	81.0	70.0	69.6	66.0
Take amphetamine once/twice	70.0	68.7	64.1	71.6	74.6	66.8	65.6	64.6	62.9	76.7	62.5	76.0	75.0	59.4	81.0	70.0	70.9	72.0
Take amphetamine occasionally	75.3	73.3	74.8	74.1	75.7	72.8	75.0	62.5	77.1	83.7	71.9	80.0	75.0	65.6	83.3	75.7	72.2	78.0
Take heroin once/twice	79.3	74.7	76.3	77.6	81.7	72.8	78.1	68.8	77.1	83.7	71.9	84.0	77.1	67.2	85.7	74.3	82.3	78.0
Take heroin occasionally	77.3	72.0	73.3	74.1	80.5	70.7	73.4	64.6	74.3	79.1	71.9	84.0	75.0	60.9	83.3	75.7	82.3	76.0
Take hallucinogens once/twice	69.7	65.7	62.6	69.0	75.1	63.6	64.1	60.4	57.1	69.8	65.6	84.0	72.9	57.8	76.2	65.7	75.9	68.0
Take hallucinogens occasionally	74.3	70.0	71.8	72.4	76.3	68.5	73.4	64.6	68.6	74.4	71.9	84.0	72.9	62.5	81.0	71.4	75.9	72.0
Total N	300	300	131	116	169	184	64	48	35	43	32	25	48	64	42	70	79	50

Table 15. Respondents in the Youth KAP Surveys of 2001 and 2003 in Lublino District (strongly) disapproving of selected patterns of youth psychoactive substance use (percentages)

Patterns of psychoactive substance use	All		Boys		Girls		Boys						Girls					
	2001	2003	2001	2003	2001	2003	10-13 years		14-16 years		17-21 years		10-13 years		14-16 years		17-21 years	
							2001	2003	2001	2003	2001	2003	2001	2003	2001	2003	2001	2003
Smoke 10 or more cigarettes a day	57.6	46.7	54.3	45.3	61.2	48.0	70.5	48.7	52.6	47.8	40.0	36.4	75.0	57.7	56.7	52.2	57.1	18.5
Take marijuana/ hashish occasionally	76.1	57.1	70.4	49.6	82.2	64.2	79.5	51.3	73.1	50.7	55.0	45.5	86.1	67.3	85.1	75.4	75.5	29.6
Take marijuana/ hashish regularly	82.2	63.1	74.1	57.6	90.8	68.2	77.3	53.8	74.4	58.2	70.0	60.6	88.9	67.3	89.6	75.4	93.9	51.9
Take cocaine once/twice	77.1	61.3	72.8	55.4	81.6	66.9	79.5	51.3	71.8	56.7	67.5	57.6	86.1	65.4	80.6	75.4	79.6	48.1
Take cocaine occasionally	79.9	62.7	75.3	56.1	84.9	68.9	75.0	51.3	76.9	56.7	72.5	60.6	86.1	65.4	83.6	76.8	85.7	55.6
Take 1 or 2 drinks several times a week	50.0	44.3	47.5	42.4	52.6	45.9	65.9	51.3	43.6	43.3	35.0	30.3	66.7	55.8	56.7	43.5	36.7	33.3
Take 5 or more drinks once/twice a weekend	70.7	52.3	64.8	50.4	77.0	54.1	72.7	51.3	65.4	56.7	55.0	36.4	83.3	59.6	77.6	58.0	71.4	33.3
Take amphetamine once/twice	69.7	60.3	64.2	57.6	75.7	62.8	68.2	53.8	64.1	58.2	60.0	60.6	75.0	61.5	70.1	69.6	83.7	48.1
Take amphetamine occasionally	72.3	61.3	67.3	58.3	77.6	64.2	68.2	51.3	67.9	61.2	65.0	60.6	75.0	63.5	71.6	72.5	87.8	44.4
Take heroin once/twice	78.0	64.8	73.5	59.0	82.9	70.3	79.5	53.8	75.6	61.2	62.5	60.6	86.1	67.3	79.1	79.7	85.7	51.9
Take heroin occasionally	81.5	65.9	78.4	59.7	84.9	71.6	77.3	53.8	79.5	62.7	77.5	60.6	83.3	67.3	79.1	79.7	93.9	59.3
Take hallucinogens once/twice	75.5	61.0	70.4	55.4	80.9	66.2	72.7	51.3	74.4	56.7	60.0	57.6	80.6	61.5	77.6	78.3	85.7	44.4
Take hallucinogens occasionally	77.4	61.7	71.6	55.4	83.6	67.6	70.5	51.3	74.4	58.2	67.5	54.5	80.6	65.4	80.6	78.3	89.8	44.4
Total N	314	287	162	139	152	148	44	39	78	67	40	33	36	52	67	69	49	27

Tables 16-21b present reported psychoactive substance use in the 2001 and 2003 Youth KAP Surveys in the evaluation sites in the Russian Federation. As shown in Tables 16 and 18, the proportions who reported the use of tobacco and alcohol generally declined over the intervention period in Irkutsk and Lublino District. For example, reported lifetime use of tobacco declined from 47.8% to 35.9% in Irkutsk (Table 16) and from 58.6% to 43.9% in Lublino District (Table 18); and reported lifetime use of alcohol from 56.2% to 47.6% in Irkutsk (Table 16) and from 81.8% to 58.2% in Lublino District (Table 18). In certain age groups, however, tobacco and to a lesser extent alcohol use increased. For example, in Irkutsk lifetime tobacco use increased from 24.4% to 32.0% among the very young males (10-13 years) and from 37.8% to 48.7% among older females (17-21 years); and past 12 months' alcohol use from 24.4% to 32.0% among 10-13 year old males (Table 16). (Interviews with key informants and focus group discussions underlined that the age of onset of psychoactive substance use decreased (e.g. lower than 10 years for alcohol) in Irkutsk; remained more or less constant (9-10 years) for tobacco/alcohol and increased for illicit psychoactive substances (e.g. 17 years or older) in Lublino District; and increased in Ivanovo (e.g. later than 10 years).)

Particularly notable also are the following trends in reported regular use of cigarettes ((almost) daily use) and alcohol (at least 3 times a week) among young people in Irkutsk: regular use of cigarettes decreased from 24.4% to 17.8%, even though it increased among 10-13 year old males from 2.4% to 16.0%; and whereas regular use of alcohol generally decreased from 7.7% to 1.6%, regular use of malt beer increased from 4.4% to 7.5% among females.

In Ivanovo, the reported proportions of users of tobacco and alcohol in general did not change markedly over the intervention period, except in certain age/gender groups (Table 17). For example, regarding tobacco use, (1) lifetime use increased from 32.8% to 47.9% and past 12 months' use from 25.0% to 41.7% among the very young males (10-13 years); (2) lifetime use decreased from 75.0% to 32.0% and past 12 months' use from 56.3% to 32.0% among older males (17-21 years); (3) past 12 months' use decreased among the very young females (10-13 years) from 27.1% to 17.2%; and (4) lifetime use increased among 14-16 year old females from 45.2% to 61.4% (Table 17). Among males lifetime use of alcohol increased from 61.1% to 70.7% and past 12 months' use from 49.6% to 59.5% (Table 17).

Regarding the use of particular alcoholic beverages, Table 16 shows that in Irkutsk and Lublino District reported lifetime, past 12 months' and past 30 days' use of hard liquor, malt beer and champagne generally decreased between 2001 and 2003. Reported lifetime use of malt beer among females in Irkutsk was, however, more or less the same in 2001 and 2003 (57.9% of the females in Irkutsk reported lifetime use of malt beer in 2001 and 58.8% in 2003). Table 17 shows that in Ivanovo the proportions who reported the use of particular alcoholic beverages in 2001 were more or less the same as those in 2003.

Tables 19a and 19b show that in Irkutsk (1) reports of the non-medical use of painkillers in 2001 increased in 2003 (e.g. lifetime use increased from 21.7% to 33.7%, past 12 months' use from 10.4% to 21.4%, and past 30 days' use from 3.3% to 9.4%); (2) the proportions who reported the non-medical use of tranquilizers and sedatives did not change markedly

from 2001 to 2003; and (3) the proportions who reported lifetime use of illicit psychoactive substances tended to be lower in 2003 than in 2001, with some exceptions among females. Table 19b, for example, shows that lifetime use of marijuana/hashish decreased from 16.1% in 2001 to 14.6% in 2003. However, among 17-21 year old females lifetime use of marijuana/hashish increased from 8.1% in 2001 to 23.1% in 2003.

Table 20a shows that in Ivanovo lifetime use of painkillers increased from 28% in 2001 to 30.7% in 2003; lifetime use of tranquillizers remained low over the intervention period (2.7% in 2001 and 1.7% in 2003); and lifetime use of sedatives increased from 14.7% to 16.0%. Reports of illicit psychoactive substance use remained more or less the same and at low levels over the intervention period, except in the case of the use of marijuana (Table 20b). (Lifetime use of marijuana increased from 11.3% to 12.7%; among males in particular lifetime use of marijuana increased from 10.7% to 14.7%, and among 17-21 year old females from 15.2% to 24.0%; reports of past 12 months' use of marijuana increased from 3.8% to 8.0% among 17-21 year old females).

Table 21a shows that in Lublino District reports of the non-medical use of painkillers, tranquillizers and sedatives generally decreased from 2001 to 2003 (e.g. lifetime use of

painkillers declined from 32.8% to 25.1%). Table 21b shows that reports of lifetime use of illicit psychoactive substances generally increased in Lublino District. For example, lifetime use of marijuana/hashish increased from 9.2% to 17.4%, and past 12 months' use from 6.7% to 11.2%. Among 17-21 year olds lifetime use of marijuana/hashish increased markedly, i.e. among females from 12.2% to 51.9%, and among males from 32.5% to 45.5%.

Participants in the focus group discussions and key informant interviews in Irkutsk asserted that the use of psychoactive substances generally increased among young people in the community, especially among females. In Ivanovo, the participants in the informant interviews and focus group discussions were of the view that no marked changes occurred over the intervention period in psychoactive substance use among young people. In Lublino District, participants in the key informant interviews and in the focus group discussions agreed that tobacco use increased among young females; that the use of cocktails of low alcohol content increased among especially young females; that although youth use of illicit psychoactive substances (especially heroin) generally decreased, and that the use of homemade amphetamines ("pervetin") increased.

Table 16. Respondents in the Youth KAP surveys of 2001 and 2003 in Irkutsk reporting the use of alcohol and tobacco during particular periods in time (percentages)

Alcohol and tobacco use	All		Boys		Girls		Boys						Girls						
	2001	2003	2001	2003	2001	2003	10-13 years		14-16 years		17-21 years		10-13 years		14-16 years		17-21 years		
							2001	2003	2001	2003	2001	2003	2001	2003	2001	2003	2001	2003	2001
Tobacco generally																			
Lifetime use	47.8	35.9	65.0	49.1	32.7	28.6	24.4	32.0	75.5	47.5	89.1	60.0	13.0	6.5	54.7	34.7	37.8	48.7	
Past 12 months' use	35.1	21.7	47.1	30.0	24.5	17.1	4.9	28.0	54.7	27.5	76.1	33.3	11.6	3.2	34.0	17.3	35.1	38.5	
Past 30 days' use	27.4	16.2	41.4	24.5	15.1	11.6	2.4	28.0	45.3	22.5	71.7	24.4	8.7	3.2	17.0	12.2	24.3	23.1	
Alcohol generally																			
Lifetime use	56.2	47.6	63.6	55.5	49.7	43.2	29.3	32.0	71.7	60.0	84.8	64.4	20.3	14.5	64.2	53.1	83.8	64.1	
Past 12 months' use	45.5	37.5	55.7	49.1	36.5	31.2	24.4	32.0	60.4	57.5	78.3	51.1	15.9	12.9	47.2	36.7	59.5	46.2	
Past 30 days' use	38.1	24.6	47.9	35.5	29.6	18.6	12.2	12.0	54.7	40.0	71.7	44.4	11.6	6.5	41.5	19.4	45.9	35.9	
Hard liquor/spirits																			
Lifetime use	38.8	29.1	52.1	38.2	27.0	24.1	7.3	16.0	64.2	30.0	78.3	57.8	7.2	1.6	35.8	24.5	51.4	59.0	
Past 12 months' use	31.1	23.0	45.0	33.6	18.9	17.1	4.9	4.0	49.1	30.0	76.1	53.3	8.7	3.2	22.6	14.3	32.4	46.2	
Past 30 days' use	21.4	12.3	32.1	20.0	11.9	8.0	-	4.0	32.1	10.0	60.9	37.8	2.9	1.6	13.2	5.1	27.0	25.6	
Malt beer																			
Lifetime use	67.2	60.2	77.9	62.7	57.9	58.8	53.7	48.0	90.6	62.5	84.8	71.1	36.2	35.5	69.8	68.4	81.1	71.8	
Past 12 months' use	58.5	48.2	67.9	56.4	50.3	43.7	31.7	40.0	79.2	55.0	87.0	66.7	27.5	19.4	67.9	54.1	67.6	56.4	
Past 30 days' use	48.8	36.9	57.9	46.4	40.9	31.7	14.6	24.0	66.0	37.5	87.0	66.7	23.2	17.7	54.7	33.7	54.1	48.7	
Champagne																			
Lifetime use	64.5	60.5	65.7	58.2	63.5	61.8	36.6	44.0	79.2	60.0	76.1	64.4	42.0	51.6	79.2	65.3	81.1	69.2	
Past 12 months' use	47.5	40.8	50.0	40.9	45.3	40.7	26.8	28.0	58.5	35.0	60.9	53.3	26.1	25.8	64.2	41.8	54.1	61.5	
Past 30 days' use	18.1	12.6	17.9	13.6	18.2	12.1	4.9	8.0	15.1	12.5	32.6	17.8	13.0	1.6	28.3	9.2	13.5	35.9	
Wine																			
Lifetime use	51.5	52.8	55.0	53.6	48.4	52.3	19.5	40.0	66.0	52.5	73.9	62.2	20.3	32.3	71.7	59.2	67.6	66.7	
Past 12 months' use	36.1	38.8	38.6	44.6	34.0	35.7	12.2	28.0	41.5	42.5	58.7	55.6	15.9	17.7	43.4	36.7	54.1	61.5	
Past 30 days' use	19.7	19.4	21.4	23.6	18.2	17.1	7.3	16.0	15.1	20.0	41.3	31.1	7.2	4.8	24.5	17.3	29.7	35.9	
Homebrew																			
Lifetime use	19.7	18.4	32.1	26.4	8.8	14.1	2.4	8.0	30.2	22.5	60.9	40.0	2.9	1.6	7.5	10.2	21.6	43.6	
Past 12 months' use	10.4	10.0	17.9	16.4	3.8	6.5	2.4	-	17.0	15.0	32.6	26.7	1.4	-	3.8	6.1	8.1	17.9	
Past 30 days' use	4.7	3.6	8.6	6.4	1.3	2.0	-	-	7.5	2.5	17.4	13.3	-	-	1.9	1.0	2.7	7.7	
Total N	299	309	140	110	159	199	41	25	53	40	46	45	69	62	53	98	37	39	

Table 17. Respondents in the Youth KAP surveys of 2001 and 2003 in Ivanovo reporting the use of alcohol and tobacco during particular periods in time (percentages)

Alcohol and tobacco use	All		Boys		Girls		Boys						Girls						
	2001	2003	2001	2003	2001	2003	10-13 years		14-16 years		17-21 years		10-13 years		14-16 years		17-21 years		
							2001	2003	2001	2003	2001	2003	2001	2003	2001	2003	2001	2003	2001
Tobacco generally																			
Lifetime use	45.3	47.0	55.0	50.0	37.9	45.1	32.8	47.9	77.1	62.8	75.0	32.0	33.3	28.1	45.2	61.4	36.7	44.0	
Past 12 months' use	36.0	39.3	42.0	45.7	31.4	35.3	25.0	41.7	60.0	58.1	56.3	32.0	27.1	17.2	50.0	52.9	24.1	34.0	
Past 30 days' use	29.0	30.3	33.6	36.2	25.4	26.6	18.8	35.4	51.4	44.2	43.8	24.0	25.0	14.1	35.7	42.9	20.3	20.0	
Alcohol generally																			
Lifetime use	65.7	66.3	61.1	70.7	69.2	63.6	45.3	56.3	74.3	74.4	78.1	92.0	52.1	43.8	71.4	77.1	78.5	70.0	
Past 12 months' use	54.0	54.7	49.6	59.5	57.4	51.6	32.8	39.6	60.0	62.8	71.9	92.0	37.5	29.7	64.3	65.7	65.8	60.0	
Past 30 days' use	36.3	38.7	34.4	39.7	37.9	38.0	21.9	22.9	42.9	44.2	50.0	64.0	22.9	23.4	40.5	45.7	45.6	46.0	
Hard liquor/spirits																			
Lifetime use	46.7	44.3	41.2	47.4	50.9	42.4	17.2	16.7	62.9	65.1	65.6	76.0	25.0	17.2	54.8	55.7	64.6	56.0	
Past 12 months' use	39.3	38.0	36.6	39.7	41.4	37.0	12.5	16.7	57.1	51.2	62.5	64.0	25.0	12.5	47.6	52.9	48.1	46.0	
Past 30 days' use	20.0	19.7	20.6	22.4	19.5	17.9	10.9	8.3	37.1	27.9	21.9	40.0	6.3	6.3	19.0	24.3	27.8	24.0	
Malt beer																			
Lifetime use	73.0	74.0	74.0	80.2	72.2	70.1	54.7	68.8	88.6	86.0	96.9	92.0	54.2	42.2	76.2	84.3	81.0	86.0	
Past 12 months' use	63.0	64.7	61.1	70.7	64.5	60.9	37.5	47.9	74.3	81.4	93.8	96.0	47.9	34.4	73.8	74.3	69.6	76.0	
Past 30 days' use	46.3	50.0	44.3	48.3	47.9	51.1	21.9	22.9	60.0	60.5	71.9	76.0	29.2	28.1	54.8	60.0	55.7	68.0	
Champagne																			
Lifetime use	68.0	68.3	62.6	75.0	72.2	64.1	43.8	58.3	74.3	86.0	87.5	88.0	56.3	42.2	71.4	74.3	82.3	78.0	
Past 12 months' use	57.3	53.7	50.4	62.1	62.7	48.4	32.8	41.7	62.9	72.1	71.9	84.0	41.7	28.1	69.0	62.9	72.2	54.0	
Past 30 days' use	16.0	16.3	9.2	17.2	21.3	15.8	3.1	8.3	14.3	23.3	15.6	24.0	20.8	12.5	11.9	14.3	26.6	22.0	
Wine																			
Lifetime use	53.3	52.7	45.8	51.7	59.2	53.3	21.9	25.0	62.9	67.4	75.0	76.0	31.3	21.9	66.7	67.1	72.2	74.0	
Past 12 months' use	47.0	46.3	38.2	46.6	53.8	46.2	20.3	22.9	45.7	53.5	65.6	80.0	31.3	20.3	54.8	52.9	67.1	70.0	
Past 30 days' use	18.0	20.0	15.3	21.6	20.1	19.0	9.4	4.2	22.9	25.6	18.8	48.0	2.1	7.8	19.0	24.3	31.6	26.0	
Homebrew																			
Lifetime use	34.7	35.7	33.6	35.3	35.5	35.9	17.2	18.8	51.4	46.5	46.9	48.0	20.8	18.8	35.7	45.7	44.3	44.0	
Past 12 months' use	25.7	26.7	26.0	26.7	25.4	26.6	10.9	18.8	45.7	34.9	34.4	28.0	20.8	14.1	33.3	40.0	24.1	24.0	
Past 30 days' use	7.3	7.0	9.2	5.2	5.9	8.2	6.3	2.1	11.4	7.0	12.5	8.0	-	4.7	-	10.0	12.7	10.0	
Total N	300	300	131	116	169	184	64	48	35	43	32	25	48	64	42	70	79	50	

Table 18. Respondents in the Youth KAP surveys of 2001 and 2003 in Lublino District reporting the use of alcohol and tobacco during particular periods in time (percentages)

Alcohol and tobacco use	All		Boys		Girls		Boys						Girls					
	2001	2003	2001	2003	2001	2003	10-13 years		14-16 years		17-21 years		10-13 years		14-16 years		17-21 years	
							2001	2003	2001	2003	2001	2003	2001	2003	2001	2003	2001	2003
Tobacco generally																		
Lifetime use	58.6	43.9	59.9	54.7	57.2	33.8	22.7	33.3	66.7	55.2	87.5	78.8	25.0	7.7	68.7	34.8	65.3	81.5
Past 12 months' use	41.7	30.0	44.4	38.1	38.8	22.3	15.9	12.8	47.4	35.8	70.0	72.7	16.7	5.8	47.8	21.7	42.9	55.6
Past 30 days' use	30.6	22.6	33.3	25.2	27.6	20.3	4.5	5.1	38.5	23.9	55.0	51.5	5.6	7.7	31.3	17.4	38.8	51.9
Alcohol generally																		
Lifetime use	81.8	58.2	80.9	63.3	82.9	53.4	54.5	43.6	87.2	58.2	97.5	97.0	50.0	28.8	94.0	59.4	91.8	85.2
Past 12 months' use	72.0	42.2	73.5	42.4	70.4	41.9	45.5	23.1	78.2	35.8	95.0	78.8	33.3	21.2	76.1	49.3	89.8	63.0
Past 30 days' use	46.5	24.7	50.0	26.6	42.8	23.0	20.5	7.7	50.0	19.4	82.5	63.6	8.3	7.7	46.3	27.5	63.3	40.7
Hard liquor/spirits																		
Lifetime use	42.4	31.4	42.0	38.1	42.8	25.0	6.8	15.4	44.9	35.8	75.0	69.7	13.9	7.7	43.3	23.2	63.3	63.0
Past 12 months' use	34.4	20.2	35.8	23.7	32.9	16.9	2.3	7.7	35.9	19.4	72.5	51.5	8.3	3.8	34.3	17.4	49.0	40.7
Past 30 days' use	19.4	11.5	20.4	14.4	18.4	8.8	2.3	-	17.9	13.4	45.0	33.3	2.8	1.9	19.4	8.7	28.6	22.2
Malt beer																		
Lifetime use	71.7	64.1	71.6	66.2	71.7	62.2	40.9	41.0	78.2	67.2	92.5	93.9	44.4	38.5	85.1	75.4	73.5	74.1
Past 12 months' use	62.4	43.6	63.6	42.4	61.2	44.6	29.5	20.5	70.5	35.8	87.5	81.8	27.8	19.2	73.1	56.5	69.4	63.0
Past 30 days' use	42.7	26.8	47.5	29.5	37.5	24.3	13.6	5.1	53.8	26.9	72.5	63.6	13.9	5.8	44.8	33.3	44.9	37.0
Champagne																		
Lifetime use	69.7	61.3	64.8	56.1	75.0	66.2	43.2	41.0	65.4	59.7	87.5	66.7	44.4	46.2	79.1	84.1	91.8	59.3
Past 12 months' use	58.0	37.6	54.9	31.7	61.2	43.2	34.1	20.5	56.4	34.3	75.0	39.4	25.0	26.9	64.2	52.2	83.7	51.9
Past 30 days' use	17.8	7.7	17.9	6.5	17.8	8.8	13.6	2.6	17.9	7.5	22.5	9.1	5.6	5.8	20.9	10.1	22.4	11.1
Wine																		
Lifetime use	54.8	60.3	51.2	58.3	58.6	62.2	22.7	30.8	52.6	67.2	80.0	72.7	16.7	26.9	65.7	82.6	79.6	77.8
Past 12 months' use	46.5	38.3	43.2	37.4	50.0	39.2	18.2	7.7	44.9	46.3	67.5	54.5	5.6	11.5	56.7	50.7	73.5	63.0
Past 30 days' use	22.3	18.1	22.8	16.5	21.7	19.6	11.4	5.1	23.1	19.4	35.0	24.2	-	3.8	22.4	26.1	36.7	33.3
Homebrew																		
Lifetime use	17.5	20.2	21.0	23.0	13.8	17.6	6.8	5.1	15.4	23.9	47.5	42.4	-	1.9	9.0	17.4	30.6	48.1
Past 12 months' use	10.8	10.1	13.6	10.1	7.9	10.1	2.3	-	9.0	9.0	35.0	24.2	-	1.9	6.0	11.6	16.3	22.2
Past 30 days' use	2.5	3.5	3.1	3.6	2.0	3.4	2.3	-	3.8	4.5	2.5	6.1	-	1.9	1.5	4.3	4.1	3.7
Total N	314	287	162	139	152	148	44	39	78	67	40	33	36	52	67	69	49	27

Table 19a. Respondents in the Youth KAP surveys of 2001 and 2003 in Irkutsk reporting the non-medical use of prescription medicine during particular periods in time (percentages)

Non-medical use of prescription medicine	All		Boys		Girls		Boys						Girls						
	2001	2003	2001	2003	2001	2003	10-13 years		14-16 years		17-21 years		10-13 years		14-16 years		17-21 years		
							2001	2003	2001	2003	2001	2003	2001	2003	2001	2003	2001	2003	2001
Painkillers																			
Lifetime use	21.7	33.7	15.0	27.3	27.7	37.2	2.4	24.0	17.0	30.0	23.9	26.7	18.8	25.8	32.1	37.8	37.8	53.8	
Past 12 months' use	10.4	21.4	5.0	15.5	15.1	24.6	0.0	20.0	5.7	17.5	8.7	11.1	7.2	17.7	18.9	21.4	24.3	43.6	
Past 30 days' use	3.3	9.4	2.1	1.8	4.4	13.6	2.4	-	1.9	2.5	2.2	2.2	-	4.8	5.7	11.2	10.8	33.3	
Tranquillizers																			
Lifetime use	3.3	3.2	4.3	2.7	2.5	3.5	-	-	1.9	7.5	10.9	-	1.4	-	-	3.1	8.1	10.3	
Past 12 months' use	0.7	2.3	0.7	2.7	0.6	2.0	-	-	-	-	2.2	6.7	-	-	-	-	2.7	10.3	
Past 30 days' use	0.7	0.3	0.7	-	0.6	0.5	2.4	-	-	-	-	-	-	-	1.9	-	-	2.6	
Sedatives																			
Lifetime use	7.4	8.1	7.1	10.9	7.5	6.5	2.4	12.0	5.7	17.5	13.0	4.4	7.2	6.5	5.7	5.1	10.8	10.3	
Past 12 months' use	2.7	4.2	2.1	5.5	3.1	3.5	-	8.0	1.9	7.5	4.3	2.2	5.8	4.8	1.9	-	-	10.3	
Past 30 days' use	2.0	1.0	1.4	1.8	2.5	0.5	2.4	4.0	-	2.5	2.2	-	4.3	1.6	1.9	-	-	-	
Total N	299	309	140	110	159	199	41	25	53	40	46	45	69	62	53	98	37	39	

Table 19b. Respondents in the Youth KAP surveys of 2001 and 2003 in Irkutsk reporting lifetime use of illicit psychoactive substances and inhalants as well as the use of marijuana/hashish in the 12 months before the respective surveys (percentages)

Use of illicit psychoactive substances and inhalants	All		Boys		Girls		Boys						Girls					
	2001	2003	2001	2003	2001	2003	10-13 years		14-16 years		17-21 years		10-13 years		14-16 years		17-21 years	
							2001	2003	2001	2003	2001	2003	2001	2003	2001	2003	2001	2003
Marijuana/hashish (lifetime use)	16.1	14.6	26.4	20.0	6.9	11.6	-	8.0	26.4	15.0	5.0	31.1	-	1.6	15.1	13.3	8.1	23.1
Heroin and other opiates (lifetime use)	2.3	0.6	4.3	0.9	0.6	0.5	-	-	3.8	-	8.7	2.2	-	-	-	-	2.7	2.6
Hallucinogens (lifetime use)	1.0	0.6	2.1	0.9	-	0.5	-	-	1.9	-	4.3	2.2	-	-	-	1.0	-	-
Amphetamines (lifetime use)	-	0.3	-	0.9	-	-	-	-	-	-	-	2.2	-	-	-	-	-	-
Cocaine (lifetime use)	1.3	0.3	2.9	0.9	-	-	-	-	3.8	-	4.3	2.2	-	-	-	-	-	-
Ecstasy (lifetime use)	0.7	1.0	1.4	0.9	-	1.0	-	-	-	-	4.3	2.2	-	-	-	2.0	-	-
Mixtures (lifetime use)	1.3	0.3	2.9	0.9	-	-	-	-	-	-	8.7	2.2	-	-	-	-	-	-
Injection use (lifetime use)	0.7	1.3	1.4	3.6	-	-	-	8.0	-	2.5	4.3	2.2	-	-	-	-	-	-
Inhalants (lifetime use)	1.3	-	2.9	-	-	-	-	-	1.9	-	6.5	-	-	-	-	-	-	-
Past 12 months' marijuana/hashish use	11.4	7.8	20.0	12.7	3.8	5.0	-	4.0	20.8	10.0	37.0	20.0	-	-	9.4	5.1	2.7	12.8
Total N	299	309	140	110	159	199	41	25	53	40	46	45	69	62	53	98	37	39

Table 20a. Respondents in the Youth KAP surveys of 2001 and 2003 in Ivanovo reporting the non-medical use of prescription medicine during particular periods in time (percentages)

Non-medical use of prescription medicine	All		Boys		Girls		Boys						Girls					
	2001	2003	2001	2003	2001	2003	10-13 years		14-16 years		17-21 years		10-13 years		14-16 years		17-21 years	
							2001	2003	2001	2003	2001	2003	2001	2003	2001	2003	2001	2003
Painkillers																		
Lifetime use	28.0	30.7	24.4	27.6	30.8	32.6	20.3	18.8	34.3	37.2	21.9	28.0	8.3	15.6	35.7	40.0	41.8	44.0
Past 12 months' use	21.3	24.0	18.3	21.6	23.7	25.5	20.3	18.8	25.7	27.9	6.3	16.0	8.3	15.6	23.8	28.6	32.9	34.0
Past 30 days' use	13.7	16.3	14.5	16.4	13.0	16.3	18.8	16.7	20.0	23.3	-	4.0	6.3	10.9	16.7	24.3	15.2	12.0
Tranquillizers																		
Lifetime use	2.7	1.7	2.3	0.9	3.0	2.2	-	-	-	-	9.4	4.0	-	-	-	-	6.3	8.0
Past 12 months' use	0.3	0.7	-	0.9	0.6	0.5	-	-	-	-	-	4.0	-	-	-	-	1.3	2.0
Past 30 days' use	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Sedatives																		
Lifetime use	14.7	16.0	16.0	19.8	13.6	13.6	15.6	12.5	14.3	27.9	18.8	20.0	8.3	10.9	16.7	20.0	15.2	8.0
Past 12 months' use	3.0	3.0	0.8	4.3	4.7	2.2	-	-	2.9	7.0	-	8.0	-	-	2.4	4.3	8.9	2.0
Past 30 days' use	1.3	1.7	-	1.7	2.4	1.6	-	-	-	4.7	-	-	-	-	2.4	2.9	3.8	2.0
Total N	300	300	131	116	169	184	64	48	35	43	32	25	48	64	42	70	79	50

Table 20b. Respondents in the Youth KAP surveys of 2001 and 2003 in Ivanovo reporting lifetime use of illicit psychoactive substances and inhalants as well as the use of marijuana/hashish in the 12 months before the respective surveys (percentages)

Use of illicit psychoactive substances and inhalants	All		Boys		Girls		Boys						Girls							
	2001	2003	2001	2003	2001	2003	10-13 years		14-16 years		17-21 years		10-13 years		14-16 years		17-21 years			
							2001	2003	2001	2003	2001	2003	2001	2003	2001	2003	2001	2003	2001	2003
Marijuana/hashish (lifetime use)	11.3	12.7	10.7	14.7	11.8	11.4	4.7	8.3	11.4	16.3	21.9	24.0	4.2	1.6	14.3	11.4	15.2	24.0		
Heroin and other opiates (lifetime use)	0.3	0.7	0.8	1.7	-	-	1.6	4.2	-	-	-	-	-	-	-	-	-	-		
Hallucinogens (lifetime use)	1.0	1.3	1.5	1.7	0.6	1.1	1.6	4.2	-	-	3.1	-	-	-	-	-	1.3	4.0		
Amphetamines (lifetime use)	0.3	0.7	0.8	1.7	-	-	1.6	4.2	-	-	-	-	-	-	-	-	-	-		
Cocaine (lifetime use)	0.7	1.0	0.8	1.7	0.6	0.5	1.6	4.2	-	-	-	-	-	-	-	-	1.3	2.0		
Ecstasy (lifetime use)	1.3	1.7	1.5	2.6	1.2	1.1	1.6	4.2	-	2.3	3.1	-	-	-	2.4	-	1.3	4.0		
Mixtures (lifetime use)	0.3	0.7	0.8	1.7	-	-	1.6	4.2	-	-	-	-	-	-	-	-	-	-		
Injection use (lifetime use)	0.3	0.7	0.8	1.7	-	-	1.6	4.2	-	-	-	-	-	-	-	-	-	-		
Inhalants (lifetime use)	1.0	1.0	1.5	1.7	0.6	0.5	1.6	4.2	-	-	-	-	-	-	-	-	1.3	2.0		
Past 12 months' marijuana/hashish use	5.7	6.3	6.1	6.9	5.3	6.0	3.1	4.2	8.6	11.6	9.4	4.0	4.2	1.6	9.5	8.6	3.8	8.0		
Total N	300	300	131	116	169	184	64	48	35	43	32	25	48	64	42	70	79	50		

Table 21a. Respondents in the Youth KAP surveys of 2001 and 2003 in Lublino District reporting the non-medical use of prescription medicine during particular periods in time (percentages)

Non-medical use of prescription medicine	All		Boys		Girls		Boys						Girls							
	2001	2003	2001	2003	2001	2003	10-13 years		14-16 years		17-21 years		10-13 years		14-16 years		17-21 years			
							2001	2003	2001	2003	2001	2003	2001	2003	2001	2003	2001	2003	2001	2003
Painkillers																				
Lifetime use	32.8	25.1	25.3	18.7	40.8	31.1	20.5	17.9	20.5	19.4	20.5	18.2	20.5	17.3	20.5	36.2	20.5	44.4		
Past 12 months' use	20.7	10.8	16.0	5.8	25.7	15.5	20.5	10.3	20.5	6.0	20.5	-	20.5	5.8	20.5	14.5	20.5	37.0		
Past 30 days' use	6.4	4.9	5.6	1.4	7.2	8.1	6.8	-	6.8	3.0	6.8	-	6.8	1.9	6.8	7.2	6.8	22.2		
Tranquillizers																				
Lifetime use	5.7	4.9	3.7	2.9	7.9	6.8	-	5.1	1.3	1.5	12.5	3.0	2.8	1.9	13.4	4.3	4.1	22.2		
Past 12 months' use	2.2	2.4	1.2	-	3.3	4.7	-	-	1.3	-	2.5	-	-	1.9	7.5	2.9	-	14.8		
Past 30 days' use	1.3	0.7	1.2	-	1.3	1.4	-	-	1.3	-	2.5	-	-	1.9	3.0	-	-	3.7		
Sedatives																				
Lifetime use	12.4	7.0	9.3	4.3	15.8	9.5	6.8	-	6.4	6.0	17.5	6.1	8.3	3.8	16.4	8.7	20.4	22.2		
Past 12 months' use	6.1	3.8	4.3	2.2	7.9	5.4	4.5	-	2.6	3.0	7.5	3.0	8.3	3.8	7.5	2.9	8.2	14.8		
Past 30 days' use	1.6	1.4	1.9	-	1.3	2.7	-	-	1.3	-	5.0	-	-	3.8	1.5	1.4	2.0	3.7		
Total N	314	287	162	139	152	148	44	39	78	67	40	33	36	52	67	69	49	27		

Table 21b. Respondents in the Youth KAP surveys of 2001 and 2003 in Lublino District reporting lifetime use of illicit psychoactive substances and inhalants as well as the use of marijuana/hashish in the 12 months before the respective surveys (percentages)

Use of illicit psychoactive substances and inhalants	All		Boys		Girls		Boys						Girls							
	2001	2003	2001	2003	2001	2003	10-13 years		14-16 years		17-21 years		10-13 years		14-16 years		17-21 years			
							2001	2003	2001	2003	2001	2003	2001	2003	2001	2003	2001	2003	2001	2003
Marijuana/hashish (lifetime use)	9.2	17.4	11.7	22.3	6.6	12.2	-	7.7	7.7	19.4	32.5	45.5	-	-	6.0	5.8	12.2	51.9		
Heroin and other opiates (lifetime use)	1.3	1.0	1.9	1.4	0.7	0.7	-	2.6	-	1.5	7.5	-	-	1.9	1.5	-	-	-		
Hallucinogens (lifetime use)	1.6	1.0	3.1	2.2	-	-	-	-	1.3	3.0	10.0	3.0	-	-	-	-	-	-		
Amphetamines (lifetime use)	-	1.4	-	0.7	-	1.4	-	-	-	1.5	-	-	-	-	-	-	-	7.4		
Cocaine (lifetime use)	0.3	0.3	0.6	0.7	-	-	-	-	-	1.5	2.5	-	-	-	-	-	-	-		
Ecstasy (lifetime use)	0.3	1.4	0.6	0.7	-	2.0	-	-	-	1.5	2.5	-	-	-	-	2.9	-	3.7		
Mixtures (lifetime use)	1.3	1.0	1.9	1.4	0.7	-	-	-	-	1.5	7.5	3.0	-	-	-	-	2.0	-		
Injection use (lifetime use)	1.3	1.0	1.2	1.4	1.3	0.7	-	-	-	3.0	5.0	-	-	-	1.5	-	2.0	3.7		
Inhalants (lifetime use)	1.6	2.1	2.5	3.6	0.7	0.7	-	-	1.3	4.5	7.5	6.1	-	-	1.5	1.4	-	-		
Past 12 months' marijuana/hashish use	6.7	11.2	9.3	15.1	4.0	7.4	-	2.6	7.7	19.4	22.5	24.2	-	-	4.5	4.4	6.1	29.6		
Total N	314	287	162	139	152	148	44	39	78	67	40	33	36	52	67	69	49	27		

2.4 CONCLUSION

The Global Initiative activities in the evaluation sites in the Russian Federation took place amidst various **broad socio-economic pressures** towards as well as against psychoactive substance use. For example, notwithstanding deteriorating economic conditions in Irkutsk and Ivanovo, the availability of illicit psychoactive substances decreased in Irkutsk, and in Ivanovo active interest in the prevention of psychoactive substance use grew among community agents.

A comparison of the results of the pre- and post-project situation assessments in the evaluation sites—as summarized in Table 22—showed that conditions changed as anticipated, although unevenly across the issues concerned (e.g. psychoactive substance use, related attitudes and prevention action), demographic groups and sites. This was illustrated by the following **behavioural and attitudinal findings** of the 2001 and 2003 KAP Surveys among young people in **Irkutsk**:

- Overall rates of reported tobacco and alcohol use decreased generally, notwithstanding increases in certain age and gender groups (e.g. 10-13 year old males);
- Although the overall rate of reported non-medical use of painkillers increased, the related use rates for tranquillizers and sedatives remained largely constant;
- The overall rates of reported illicit psychoactive substance use decreased generally, with some exceptions (e.g. an increase among females);
- The pre-project tendency among young people to view youth psychoactive substance use as risky remained largely intact, except that males became even more inclined to associate such use with risks;
- The pre-project tendency to disapprove of youth psychoactive substance use increased (especially among 14-21 year old males and 10-13 year old females).

The above developments among young people in Irkutsk were supported by the following developments among the adults: (1) The pre-project tendency among adults to (strongly) disapprove of youth psychoactive substance use and to view such use as risky remained intact during the intervention period; and (2) reported use of the most commonly used psychoactive substances, tobacco and alcohol, decreased, although illicit psychoactive substance use increased somewhat.

The situation with psychoactive substance use and related attitudes did not improve in **Ivanovo** to the extent they did in Irkutsk. This is illustrated by the following findings of the 2001 and 2003 KAP Surveys in respect of young people:

- Overall user rates for the psychoactive substances remained largely constant, with exceptions within certain age and

gender groups (e.g. tobacco use decreased among 17-21 year old males and 10-13 year old females, and increased among 10-13 year old males and 14-16 year old females; lifetime use of marijuana increased among males and especially among 17-21 year old females).

- Although young people generally accepted youth psychoactive substance use as risky and (strongly) disapproved of youth psychoactive substance use, the overall (strong) disapproval rate decreased somewhat, as did female views that youth psychoactive substance use entailed risks.

Pertinent findings (as recorded in the 2001 and 2003 Adult KAP Surveys) for young people's seniors in Ivanovo were the following: (1) The pre-project tendency among adults to (strongly) disapprove of psychoactive substance use (especially youth use) remained largely unchanged; (2) males became somewhat more inclined to view youth psychoactive substance use as risky; (3) (almost) daily use of tobacco decreased markedly among males; and (4) the use of hard liquor as well as the non-medical use of painkillers, tranquillizers and sedatives generally decreased.

In **Lublino District**, and as noted in the Youth KAP Surveys, (1) the use of various psychoactive substances declined among young people, including the commonly used psychoactive substances, tobacco and alcohol, as well as painkillers, tranquillizers and sedatives. However, (2) reported use of illicit psychoactive substances increased, and young people became less inclined to view youth psychoactive substance use as risky and to express (strong) disapproval of such use. Similar developments emerged among the young people's seniors (as noted in the Adult KAP Surveys): (1) Use of one of the most commonly used psychoactive substances, alcoholic beverages, declined; (2) so did the non-medical use of painkillers, tranquillizers and sedatives. (3) Reported use of tobacco and illicit psychoactive substances, however, increased. (4) The pre-project tendency among adults to regard psychoactive substance use as risky and to (strongly) disapprove of such use weakened to some extent.

The local partners' evaluations of their **preventive activities** confirmed that local resources in the primary prevention effort had been widely mobilized, that awareness of the risks of psychoactive substance use had grown and that the preventive activities had been well received by the target groups and the wider communities. The projects were considered successful, given that in all three sites a number of new initiatives evolved; that future financial support had been secured in Ivanovo; that the mass media in Ivanovo showed interest in covering the dynamics of psychoactive substance use-related problems in greater depth; and that the project in Lublino District served as a model for related new projects.

Table 22. Summary of key changes over the intervention period in the evaluation sites in the Russian Federation

Data collection method	Irkutsk		Ivanovo		Lublino District	
	Psychoactive substance use-related attitudes	Psychoactive substance use	Psychoactive substance use-related attitudes	Psychoactive substance use	Psychoactive substance use-related attitudes	Psychoactive substance use
Youth KAP Survey	<ul style="list-style-type: none"> • Sustained tendency to regard youth psychoactive substance use as risky (43%-78% in 2001 and 46%-80% in 2003 indicated youth use as risky (Table 10)) • Increased disapproval of youth psychoactive substance use (46%-67% in 2001 and 47%-77% in 2003 disapproved of youth psychoactive substance use (Table 13)) 	<ul style="list-style-type: none"> • Decrease in tobacco use (27%-48% in 2001 and 16%-36% in 2003 admitted use (Table 16)) • Decrease in alcohol use (38%-56% in 2001 and 25%-48% in 2003 admitted use (Table 16)) • Increase in non-medical use of painkillers (3%-22% in 2001 and 9%-34% in 2003 admitted use (Table 19a)) • No marked changes (Table 19a) in level of non-medical use of tranquillizers (1%-3% in 2001 and 0.3%-3% in 2003 admitted use) and sedatives (2%-7% in 2001 and 1%-8% in 2003 admitted use) • Decrease in illicit psychoactive substance use, with some exceptions among females (e.g. 7% of the sampled females in 2001 and 12% in 2003 admitted lifetime use of marijuana (Table 19b)) 	<ul style="list-style-type: none"> • Sustained tendency to regard youth psychoactive substance use as risky (48%-83% in 2001 and 46%-82% in 2003 indicated youth use as risky (Table 11)) • Sustained tendency to disapprove of youth psychoactive substance use (56%-79% in 2001 and 55%-75% in 2003 disapproved of youth psychoactive substance use (Table 14)) 	<ul style="list-style-type: none"> • No marked changes in level of tobacco use (29%-45% in 2001 and 30%-47% in 2003 admitted use (Table 17)) • No marked changes in level of alcohol use (36%-66% in 2001 and 39%-66% in 2003 admitted use (Table 17)) • No marked change in non-medical use of painkillers (28% in 2001 and 31% in 2003 admitted lifetime use (Table 20a)) • No marked changes in non-medical use of tranquillizers and sedatives (3% in 2001 and 2% in 2003 admitted lifetime use of tranquillizers; 15% in 2001 and 16% in 2003 admitted lifetime use of sedatives (Table 20a)) • No marked change in illicit psychoactive substance use, with some exceptions (e.g. 11% in 2001 and 13% in 2003 admitted lifetime use of marijuana; 11% males in 2001 and 15% in 2003 admitted lifetime use of marijuana; 15% of 17-21 year old females in 2001 and 24% in 2003 admitted lifetime use of marijuana (Table 20b)) 	<ul style="list-style-type: none"> • Decreased sense of the riskiness of youth psychoactive substance use, but sustained general tendency to ascribe risk to such use (45%-91% in 2001 and 44%-73% in 2003 indicated youth use as risky (Table 12)) • Decrease in disapproval of youth psychoactive substance use (50%-82% in 2001 and 44%-66% in 2003 disapproved of youth psychoactive substance use (Table 15)) 	<ul style="list-style-type: none"> • Decrease in tobacco use (31%-59% in 2001 and 23%-44% in 2003 admitted use (Table 18)) • Decrease in alcohol use (47%-82% in 2001 and 25%-58% in 2003 admitted use (Table 18)) • Decrease in non-medical use of painkillers, tranquillizers and sedatives (e.g. 33% in 2001 and 25% in 2003 admitted lifetime use of painkillers (Table 21a)) • Increase in illicit psychoactive substance use (e.g. 9% in 2001 and 17% in 2003 admitted lifetime use of marijuana (Table 21b))
Adult KAP Survey	<ul style="list-style-type: none"> • Increased sense of the riskiness of psychoactive substance use, especially youth use (e.g. 74%-87% in 2001 and 80%-93% in 2003 indicated youth use as risky (Table 5)) • Sustained tendency to disapprove of psychoactive substance use (e.g. 58%-87% in 2001 and 60%-87% in 2003 disapproved of youth use (Table 6)) 	<ul style="list-style-type: none"> • Decrease in tobacco use (21%-44% in 2001 and 14%-37% in 2003 admitted use (Table 7)) • Decrease in alcohol use (69%-93% in 2001 and 54%-76% in 2003 admitted use (Table 7)) • Increase in illicit psychoactive substance use (2% in 2001 and 4% in 2003 admitted lifetime use (Table 9)) • Decrease in non-medical use of painkillers, tranquillizers and sedatives (46% in 2001 and 41% in 2003 admitted lifetime use (Table 9)) 	<ul style="list-style-type: none"> • Sustained tendency to regard psychoactive substance use as risky (88%-95% in 2001 and 88%-93% in 2003 regarded youth use as risky (Table 5)) • Sustained tendency to disapprove of youth psychoactive substance use (62%-95% in 2001 and 66%-96% in 2003 disapproved of youth use (Table 6)) 	<ul style="list-style-type: none"> • Largely sustained level of tobacco use (17%-44% in 2001 and 17%-38% in 2003 admitted use (Table 7)) • Largely sustained level of alcohol use (83%-86% in 2001 and 81%-86% in 2003 admitted use (Table 7)) • Increase in illicit psychoactive substance use (1% in 2001 and 2% in 2003 admitted lifetime use (Table 9)) • Decrease in non-medical use of painkillers, tranquillizers and sedatives (49% in 2001 and 41% in 2003 admitted lifetime use (Table 9)) 	<ul style="list-style-type: none"> • Decreased sense of the riskiness of psychoactive substance use, but by far the majority remained inclined to regard use as risky (e.g. 86%-99% in 2001 and 73%-84% in 2003 indicated youth use as risky (Table 5)) • Decrease in disapproval of youth psychoactive substance use (58%-92% in 2001 and 44%-66% in 2003 disapproved of youth use (Table 6)) 	<ul style="list-style-type: none"> • Increase in tobacco use (23%-50% in 2001 and 30%-60% in 2003 admitted use (Table 7)) • Decrease in alcohol use (76%-97% in 2001 and 65%-93% in 2003 admitted use (Table 7)) • Increase in illicit psychoactive substance use (4% in 2001 and 9% in 2003 admitted lifetime use (Table 9)) • Decrease in non-medical use of painkillers, tranquillizers and sedatives (53% in 2001 and 43% in 2003 admitted lifetime use (Table 9))
Focus groups, in-depth interviews and key informant interviews	No information available	<ul style="list-style-type: none"> • Decrease in age of onset of psychoactive substance use, e.g. to lower than 10 years in the case of alcohol use • General increase in psychoactive substance use among young people, especially females 	No information available	<ul style="list-style-type: none"> • Increase in age of onset of psychoactive substance use, e.g. to later than 10 years • No marked changes in psychoactive substance use among young people 	No information available	<ul style="list-style-type: none"> • More or less sustained age of onset of alcohol/tobacco use (9-10 years), but increase (e.g. to 17 years or older) for illicit psychoactive substances • Increase in youth tobacco use, especially among females • Increase in youth use of low-alcohol cocktails, especially among females • Decrease in youth use of illicit psychoactive substances (especially heroin), but increase in use of homemade amphetamines ("pervetin")

Project outcome in the evaluation sites in the Republic of Belarus

3.1 INTRODUCTION

This chapter provides an overview of the key findings of the overall evaluation of the outcome of the implementation of the Global Initiative in the Republic of Belarus. The evaluation was restricted to two urban districts—Central District in the City of Gomel and Partizansky District in the City of Minsk. Minsk—the capital—is more or less in the centre of the country and connected by primary roads to strategic locations, e.g. Moscow in the Russian Federation to the east, Brest and Grodno to the west on the border between Belarus and Poland, and coastal cities such as Kaliningrad (formerly Königsberg) and Klaipėda (formerly Memel) on the Baltic Sea.

The chapter first profiles the main demographic characteristics of the evaluation sites, including key changes that occurred during the intervention period. It then describes the main characteristics of the agencies who were selected as the local Global Initiative partners in the evaluation sites as well as the main preventive activities that they initiated as part of the project. The chapter continues with a comparison of the key results of the pre- and post-project situation assessments in the respective sites. It concludes with an integrated summary, e.g. in tabulated format. It is also important to note that practical difficulties (e.g. limited material and professional resources) inhibited the relevant researchers in reporting in detail the results of the pre- and post-project situation assessments (e.g. the results of the Adult KAP Survey) as well as the demographic characteristics of the participants in the focus group discussions and key informant interviews.

3.2 EVALUATION SITES, LOCAL PARTNERS, PREVENTIVE ACTIVITIES AND BROAD SOCIOECONOMIC DEVELOPMENTS

Table 23 shows that, except for a somewhat larger population in Partizanski District, the two sites had a largely similar gender and age structure, i.e. mostly women and persons in the age group 30 years and older.

The evaluation sites in Belarus faced various debilitating **socioeconomic and health conditions**. For example, most of the households in both sites did not have any (stable) income and comprised nuclear families of about 3–4 members (parents and children). Partizanski District was one of the poorest districts in Minsk. The sites had comparatively high crime rates, including psychoactive substance use-related law offences. Criminal activity related to psychoactive substance use was rising among adolescents. Positive conditions for trading in alcohol and tobacco products prevailed. For example, in Central District there were about 2 alcohol/tobacco outlets per 1 000 people. In Partizanski District there were about 3 alcohol/tobacco outlets per 1 000 people. The local breweries and the sparkling wine factory in Minsk also facilitated access to alcoholic beverages. Moreover, psychoactive substance use was facilitated by various national developments. Traditional social values were declining; the education system was deteriorating; psychoactive substance use-related preventive services were limited; few constructive leisure activities for young people existed; state regulations for the control of psychoactive substance use were lax; and access to illicit psychoactive substances was becoming easier due to increased trafficking in these substances through organized crime networks

Table 23. Demographic features of the participating sites (1999 census) (percentages)

Variable	Central District	Partizanski District
Gender		
Males	45.8	46.7
Females	54.2	53.3
Age		
14 years or younger	17.8	17.4
15-19 years	9.7	9.7
20-23 years	8.3	9.1
24-29 years	7.4	7.4
30 years or older	56.8	56.4
Mean age of the population (years)	43.6	43.5
Total population (N)	70 800	94 501

Table 24. Description of local partners and the nature and outcome of their preventive activities

Central District	Partizanski District
<p>Local partner</p> <p>The Gomel Health Centre was the local Global Initiative partner in Central District in Gomel. This governmental medical institution provided various services to the local population to promote and facilitate healthy lifestyles in the community. It organized psychoactive substance use prevention programmes, and provided medical and psychological consultation. The centre also conducted training seminars for medical specialists and school teachers on psychoactive substance use prevention methods. Although it is located in Gomel, its sphere of influence extended to the surrounding villages.</p> <p>Problem</p> <p>The local situation assessment targeted young people of 11-16 years in school, as well as their parents and teachers. Along with tobacco and alcohol, the psychoactive substances most commonly used by young people were marijuana, ecstasy, heroin and amphetamines. The age of initiation into alcohol and tobacco was reported as 10-12 years, while regular use of these began between 13 and 16 years. The key risk factors were family conflict and a lack of constructive recreational facilities and interests.</p> <p>Aim</p> <p>The project aimed to provide information and create awareness concerning the risks of psychoactive substance use in mainly the school/educational community, apart from enhancing life skills and developing peer support among young learners.</p> <p>Preventive activities</p> <p>The project was implemented in three schools among 11-16 year olds. In addition, 3-day training sessions for 145 teachers (grades 5-7 and 8-10) and a meeting with about 270 parents were organized. Four 3-day training sessions on psychoactive substance use, prevention work, life and social skills were arranged for young people. The 300 pupils in the three schools were divided into 11-12 year olds (grades 5-6), 13-14 year olds (grades 7-8) and 15-16 year olds (grades 9-10). To stimulate active youth involvement in psychoactive substance use prevention programmes, the centre organized a theme-design competition; the best designs were exhibited. A group of seventeen 14-16 year olds established a youth club to promote anti-substance ideas among their peers. The club organized 12 health days and two one-week health festivals in cooperation with the centre, and theatre performances together with psychology students for 600 young people.</p> <p>Project leader's evaluation of project delivery and outcomes</p> <p>The results of the monitoring and evaluation of the activities through questionnaires and unstructured interviews with participants showed that the project was successful in increasing awareness and information concerning psychoactive substance use issues. The participants found the project very useful in increasing involvement in community issues and helped to develop coping and communication skills.</p>	<p>Local partner</p> <p>The Regional Health Centre was the local partner in Partizanski District. This governmental agency provided various services to facilitate healthier lifestyles. The centre implemented programmes on psychoactive substance use prevention and conducted training/seminars for medical specialists and teachers on psychoactive substance use prevention methods. It also produced information on different medical issues, and provided medical and psychological consultation. Furthermore, it coordinated the work of health centres in other regions of Belarus.</p> <p>Problem</p> <p>The local situation assessment was conducted in one of the poorest and most underprivileged districts of the capital. It concluded that 53% of 12-16 year olds in the community smoked tobacco, 65% regularly consumed alcohol, and 40% used illegal psychoactive substances (inhalants, ecstasy, LSD, marijuana and heroin).</p> <p>Aim</p> <p>The main aim of the project was to increase awareness of the psychoactive substance use problem in largely the school community and to stimulate social action to solve this problem.</p> <p>Preventive activities</p> <p>This project was implemented in three schools and targeted young people aged 13-16 years, as well as their parents and teachers. Two-day seminars were conducted in each school for 42 teachers of students in grades 8-10, followed by a meeting with 390 parents of students in grades 5-10. For students themselves, the centre conducted meetings with 73 students aged 15-16 years who were motivated and interested in working as peer educators. This resulted in the selection of 32 students (25 girls, 7 boys) to carry out prevention activities. These volunteers were split into 2 groups and took part in 3 days of life and social skills training, as well as information sessions on the risks of psychoactive substance use and prevention. Weekly meetings were held with centre officials, which helped the volunteers to practise their skills and prepare a series of activities.</p> <p>The activities organized by the volunteers included psychoactive substance use prevention training sessions with 12-13 year old children, participation in a youth radio programme, and the coordination of meetings for students and their parents/teachers. Two health weeks were conducted in the schools, including role plays and mini training for younger children, as well as sports activities and discos for the older students. Over 600 young people participated.</p> <p>Project leader's evaluation of project delivery and outcomes</p> <p>The activities of the project were monitored and evaluated through questionnaires and interviews with participants of the activities. Both adults and children found the project interesting and helpful. Participants noted that the project improved their understanding of psychoactive substance use issues, raised awareness of the threat within the general community, and enhanced the coping and communication skills of learners.</p>

Apart from the Global Initiative projects, which were largely school-based (Table 24), no new agencies/programmes focusing on the prevention of psychoactive substance use among young people evolved over the intervention period in the evaluation sites. However, the project leaders' evaluation of the Global Initiative preventive activities found that the targeted young and adult (parents and teachers) groups experienced the project activities as useful and interesting, noting that the activities enhanced what they knew about the risks of psychoactive substance use, increased their personal involvement in prevention, and improved their coping/problem-solving and communication skills (Table 24).

3.3 COMPARISON OF THE PRE- AND POST-PROJECT SITUATION ASSESSMENT RESULTS

This section compares key results of the pre- and post-project situation assessments and in particular key results of the

Adult and Youth KAP Surveys as well as the focus group discussions and key informant interviews.

3.3.1 DEMOGRAPHIC PROFILE OF RESPONDENTS

As shown in Table 25, males and females were more or less evenly distributed in both the pre-project (2000) and post-project (2003) Adult KAP Surveys in Central District. Female respondents were overrepresented in the Adult KAP Surveys in Partizanski District, especially in 2000. In both sites most of the respondents were employed—to a lesser extent in Partizanski District in 2003—and of Christian faith. Table 26 shows that male and female respondents were evenly distributed in the Youth KAP Surveys in both sites in 2003, and in Partizanski District in the 2000 survey. Females were in the majority in the the 2000 Youth KAP Survey in Central District.

Table 25. Demographic features of the respondents in the Adult KAP Surveys of 2000 and 2003 (percentages)

Variable	Central District		Partizanski District	
	2000	2003	2000	2003
Gender				
Males	46.0	46.9	33.3	
Females	54.0	53.1	76.7	
			44.1	
			55.9	
Employment status				
Employed	90.8	77.7	89.5	61.9
Unemployed/other categories	9.2	22.3	10.5	38.1
Religion				
Christians	93.1	80.8	81.7	76.1
Other religions	2.0	2.1	1.8	8.1
None	4.9	17.1	16.3	15.4
Mean age (years)	42.8	38.0	41.5	33.7
Total N	87	98	105	84

Table 26. Demographic features of the respondents in the Youth KAP Surveys of 2000 and 2003 (percentages)

Variable	Central District		Partizanski District	
	2000	2003	2000	2003
Gender				
Males	41.0	50.0	51.8	
Females	59.0	50.0	48.2	
			51.0	
			49.0	
Median age (years)	15.4	16.0	17.4	17.0
Total N	307	298	309	284

3.3.2 PSYCHOACTIVE SUBSTANCE USE-RELATED ATTITUDES AND PRACTICES AMONG ADULTS

A comparison of the responses of adults in the pre-project (2000) and post-project (2003) Adult KAP Surveys in Central District as to whether various patterns of psychoactive substance use by people in general and young people in particular entailed **risk** showed the following general trends: Respondents were generally less inclined in 2003 than in 2000 to indicate the listed patterns of psychoactive substance use as entailing no or a slight risk, especially if used by young people. For example, the proportion who indicated the use of 1 or 2 drinks several times a week by people in general as entailing no or a slight risk decreased from 28.6% in 2000 to 23.4% in 2003. Between 3.4% and 16.9% of the adults in 2000 and between 2.1% and 11.6% in 2003 indicated various patterns of illicit psychoactive substance use by people in general as entailing no or a slight risk. The proportion of surveyed adults who regarded the use of 10 or more cigarettes a day by people in general as entailing no or a slight risk, however, increased from 16.1% in 2000 to 25.5% in 2003. In contrast, the proportions who indicated the use of 10 or more cigarettes a day by young people as no or a slight risk decreased, i.e. from 11.5% to 6.3%. In addition, in 2000 11.5% of the surveyed adults and in 2003 10.2% reported the use of 1 or 2 drinks several times a week by young people as entailing no or a slight risk. Between 2.3% and 6.9% of the surveyed adults in 2000 and between 1.1% and 4.3% in 2003 indicated the use of various forms of illicit psychoactive substances by young people as entailing no or a slight risk.

The surveyed adults in Partizanski District were markedly more inclined in 2003 than in 2000 to indicate licit psychoactive substance use among people in general as risky. For example, in 2000 14.2% and in 2003 none of the surveyed adults viewed the use of 10 or more cigarettes a day by people in general as entailing no or a slight risk, with 78.0% in 2000 and 93.8% in 2003 indicating this pattern of use as entailing great risk. Whereas in 2000 28.1% of the surveyed adults reported the use of 1 or 2 drinks several times a week by people in general as entailing no or slight risk, only 3.0% in 2003 did so, with 57.2% in 2000 and 83.3% in 2003 assessing this pattern of use as entailing great risk. Furthermore, by far the majority of the surveyed adults remained over the intervention period inclined to regard the use of illicit psychoactive substance use as entailing risk. In fact, 80.0% and more of the surveyed adults in both 2000 and 2003 indicated various patterns of illicit psychoactive substance use by people in general as entailing great risk. Regarding the use of psychoactive substances among young people in particular, more than 90.0% of the surveyed adults in both 2000 and 2003 reported such use as entailing great risk.

In Central District rates of (strong) disapproval of psychoactive substance use by people in general and young people in particular generally remained more or the less the same over the intervention period. In fact, the majority of the surveyed adults in both 2000 and 2003 (**strongly disapproved**) of various patterns of psychoactive substance use. For example, in 2000 the use of 10 or more cigarettes a day by people in general was (strongly) disapproved by 63.1% of the surveyed adults and in 2003 60.5%. In both 2000 and 2003 80.0% or more of the surveyed adults (strongly) disapproved of various patterns of illicit psychoactive substance use by people in general. More than 80.0% of the surveyed adults in 2000 and 2003 (strongly) disapproved of various patterns of psychoactive substance use by young people. For example, in 2000 89.5% and in 2003 84.8% (strongly) disapproved of young people taking 10 cigarettes or more a day.

In both 2000 and 2003 most of the surveyed adults in Partizanski District (strongly) disapproved of various patterns of psychoactive substance use, especially youth use and illicit psychoactive substance use. Moreover, reports of (strong) disapproval increased distinctly over the intervention period. For example, the use of 10 or more cigarettes a day by people in general was (strongly) disapproved by 59.5% in 2000 and 85.7% in 2003. The use of 1 or 2 drinks several times a week by people in general was (strongly) disapproved by 51.9% in 2000 and 82.1% in 2003. In both 2000 and 2003 more than 85.0% of the surveyed adults (strongly) disapproved of the use of various patterns of illicit psychoactive substance use by people in general. More than 90.0% in both 2000 and 2003 (strongly) disapproved of youth psychoactive substance use.

Regarding reported psychoactive substance use among the surveyed adults in the evaluation sites in Belarus, comparisons of the pre- and post-project Adult KAP Surveys showed the following key trends: In Central District **tobacco** use among the surveyed adults declined, e.g. in 2000 64.3% reported lifetime tobacco use and in 2003 56.5%. A decrease in reported use of a range of **alcoholic beverages** took place. For example, reported lifetime use of hard liquor decreased from 91.1% to 80.0% and past 12 months' use from 80.4% to 61.9%; reported lifetime use of wine from 95.4% to 93.8% and past 12 months' use from 82.7% to 72.3%; reported lifetime use of malt beer from 94.2% to 84.9% and past 12 months' use from 80.4% to 55.4%. Although reports of the non-medical lifetime use of **painkillers** increased from 9.2% in 2000 to 13.0% in 2003, the non-medical lifetime use of **tranquillizers** declined from 20.6% to 10.0%, and that of **sedatives** from 36.7% to 21.0%. Reports of the use of **illicit psychoactive substances** increased somewhat over the intervention period in Central District. For example, reported lifetime use of hashish/marijuana increased from

5.7% to 8.0%, lifetime use of heroin from zero to 8.0%, and amphetamines from 1.2% to 5.1%.

Reported lifetime **cigarette use** among the surveyed adults in Partizanski District decreased drastically over the intervention period, i.e. from 97.3% to 53.0%. A decline in reported use of some **alcoholic beverages** also occurred. For example, reported lifetime use of hard liquor decreased from 85.1% to 73.4%; and reported lifetime use of wine from 91.2% to 84.5%. Reported lifetime use of malt beer, however, remained practically the same, i.e. 84.5% in 2000 and 83.5% in 2003. It is also important to note that comparatively regular use (several times a month) of alcoholic beverages increased considerably over the intervention period among adults in Partizanski District. For example, in 2000 35.0% of the surveyed adults reported regular use of malt beer and in 2003 the corresponding figure was 76.4%; reports of regular use of hard liquor increased from 30.6% to 50.7%; and reports of regular use of wine from 30.4% to 63.1%. Reports of the non-medical use of psychoactive substances such as **painkillers**, tranquilizers and sedatives also increased in Partizanski District. For example, lifetime non-medical use of **painkillers** (Tramal and Tramadol) increased from 9.5% to 27.3%, lifetime non-medical use of **tranquillizers** from 17.1% to 34.9%, and lifetime non-medical use of **sedatives** from 23.8% to 36.9%. In addition, reported lifetime use of **illicit psychoactive substances** and especially **inhalants** increased in Partizanski District, e.g. hashish/marijuana from 5.7% to 8.4%, amphetamines from 0.9% to 9.2%, and inhalants from 1.8% to 28.5%. Moreover, in 2003 the surveyed adults reported the lifetime use of various illicit psychoactive substances that they did not report in 2000, i.e. cocaine (5.9%), heroin (9.5%), hallucinogens (11.9%), mixtures of psychoactive substances (17.9%) and injections (11.9%).

3.3.3 PSYCHOACTIVE SUBSTANCE USE-RELATED ATTITUDES AND PRACTICES AMONG YOUNG PEOPLE

Tables 27 and 28 show the responses of the young people included in the pre-project (2000) and post-project (2003) Youth KAP Surveys in the evaluation sites in Belarus—Central District and Partizanski District—to the questions as to whether they regarded various patterns of youth psychoactive substance use (1) as entailing risk, and whether they (2) approved/disapproved of these patterns of use. Table 27 shows that not only was there in Central District a marked decrease in reports that the relevant patterns of youth psychoactive substance use entailed moderate/great **risk**, but markedly more respondents indicated that they “did not know” whether the relevant patterns of use entailed risk. In Partizanski District, on the other hand, the surveyed

young people’s views on whether the relevant patterns of youth psychoactive substance use entailed risk remained largely the same over the intervention period. As in the case of the question as to whether youth psychoactive substance use entailed risks, Table 28 shows that the proportions in Central District that indicated **disapproval** of the relevant patterns of youth psychoactive substance use decreased markedly. At the same time the proportions that stated that they “did not know” whether to approve or disapprove of the relevant patterns of use increased. In Partizanski District, the responses of the surveyed young people generally did not change markedly over the intervention period, except that the proportion that approved of using 10 or more cigarettes a day almost doubled, i.e. from 7.4% in 2000 to 13.4% in 2003.

Table 29 shows that in Central District reports of **tobacco use** among the surveyed young people were lower in 2003 than in 2000. On the other hand, the proportion in Central District who reported that they used tobacco (almost) every day increased from 11.2% in 2000 to 22.8% in 2003. In both the 2000 and 2003 Youth KAP Surveys in Central District most of the respondents indicated that they first tried tobacco at the age 13-14 years. In Partizanski District the proportions of reported tobacco users among the surveyed young people increased over the intervention period: In 2000 50.0% of the respondents reported lifetime use of tobacco, 41.0% past 12 months’ use and 32.0% past 30 days’ use; in 2003 the corresponding proportions were 68.5%, 54.6% and 47.6%. Both in 2000 and in 2003 the majority of the surveyed young people in Partizanski District first tried tobacco at the age 13-14 years.

As shown in Table 29 the proportions of surveyed young people in Central District who reported **use of alcohol** generally diminished over the intervention period, e.g. lifetime use from 86.3% to 75.4%. In both 2000 and 2003 the surveyed young people in Central District tended to state that they were in the age group 13-14 years when they first used alcohol. In contrast, in Partizanski District the proportion of reports of use of alcohol generally increased over the intervention period, e.g. lifetime use from 79.0% to 90.0%. Indeed, the increase manifested across a range of alcoholic beverages. For example, whereas 55.0% of the respondents admitted lifetime use of hard liquor in 2000, 74.3% reported such use in 2003; lifetime use of malt beer increased from 79.0% to 90.0% and lifetime use of wine from 70.0% to 86.5%. However, the average reported starting age for the use of alcoholic beverages in Partizanski District rose from 11.5 years in 2000 to 13.5 years in 2003.

In Central District the proportions of reported lifetime non-medical use of **painkillers, tranquilizers and sedatives** were generally lower in 2003 than in 2000. In fact, in Central District 1.6% and less reported lifetime use in 2003 and 4.6%

and less reported such use in 2000. In contrast, reports of the non-medical lifetime use of these substances increased somewhat in Partizanski District over the intervention period, i.e. from 5.5% and less in 2000 to 7.0% and less in 2003.

Table 30 shows that Central District generally experienced an increase among young people in the **use of illicit psychoactive substances**. In both 2000 and in 2003 young people in Central District generally started using illicit psychoactive substances in their mid-teens, namely at the age 15-18 years. Partizanski District also experienced an increase in the use of illicit psychoactive substances among young people over the intervention period, especially in the case of hashish/marijuana (Table 30). Both in 2000 and in 2003 the surveyed young people in Partizanski District generally reported starting the use of illicit psychoactive substances during their mid-teen years (age 15-18 years).

Table 31 shows that in both evaluation sites in Belarus reports among the surveyed young people of experiences of negative **consequences** of psychoactive substance use increased over the intervention period, especially in Partizanski District. For example, reports of an inability to cope with everyday chores after alcohol use increased from 4.5% in 2000 to 9.3 % in 2003 in Central District; and reports of absence from work due to the use of illicit psychoactive substances increased from 6.7% to 16.8% in Partizanski District.

Focus group discussions and key informant interviews with adults as well as young people in Central District underlined that over the past years psychoactive substance use among young people had increased progressively, with smoking tobacco and drinking alcoholic beverages (especially malt beer) especially common and with hashish/marijuana as the most commonly used illicit psychoactive substance. Interviewees in Central District especially mentioned family problems, curiosity, idleness/boredom and a lack of constructive leisure activities as contributors to youth psychoactive substance use. In Partizanski District, interviewees also noted a general increase in psychoactive substance use among young people over the past years. They pointed to the following issues as the main contributors to youth psychoactive substance use: curiosity, a lot of spare time, a desire to pass for an adult, parents' example, inability to fill spare time with interesting pursuits, a desire to brag among one's peers and to be "in" and/or "fashionable", a desire to relax/cope with stress/difficulties, a poor family environment (e.g. parents indulging in psychoactive substance use, and family conflict), low cultural/moral standards, a flood of commercial advertising of alcoholic beverages and tobacco goods, ineffective anti-alcohol and anti-nicotine campaigns, social settings conducive to youth psychoactive substance use, and the easy availability of psychoactive substances.

Table 27. Respondents in the Youth KAP Surveys of 2000 and 2003 reporting selected patterns of youth psychoactive substance use as entailing moderate or great risk (percentages)

Patterns of psychoactive substance use	Central District						Partizanski District					
	No/slight risk		Moderate/great risk		Don't know		No/slight risk		Moderate/great risk		Don't know	
	2000	2003	2000	2003	2000	2003	2000	2003	2000	2003	2000	2003
Smoke 10 or more cigarettes a day	19.1	9.0	80.0	18.1	0.9	72.9	25.0	24.3	70.0	70.8	5.0	4.9
Take marijuana/hashish occasionally	8.7	5.7	83.3	21.8	8.0	72.5	20.0	21.1	76.0	71.5	4.0	7.4
Take marijuana/hashish regularly	2.1	1.9	90.7	25.6	7.2	72.5	5.0	3.9	90.0	88.0	5.0	8.1
Take cocaine once/twice	10.5	5.4	80.4	21.4	9.1	73.2	17.0	11.6	77.0	82.4	6.0	6.0
Take cocaine occasionally	4.3	2.9	86.2	23.6	9.5	73.5	5.0	3.9	90.0	89.8	5.0	6.3
Take 1 or 2 drinks several times a week	36.5	11.4	53.2	16.1	16.1	72.5	48.0	42.7	47.0	52.3	5.0	5.0
Take 5 or more drinks once/twice a weekend	13.3	6.3	76.4	20.9	20.9	72.8	23.0	21.1	72.0	73.9	5.0	5.0
Take amphetamine once/twice	5.1	3.6	82.4	21.2	21.2	75.2	16.0	14.5	70.0	71.5	14.0	14.0
Take amphetamine occasionally	4.4	2.2	83.5	21.9	21.9	75.9	10.0	6.3	78.0	81.7	12.0	12.0
Take heroin once/twice	3.6	2.9	84.2	22.2	22.2	74.9	7.0	6.1	85.0	85.9	8.0	8.0
Take heroin occasionally	4.3	1.7	83.9	23.4	23.4	74.9	7.0	4.0	85.0	88.0	8.0	8.0
Take hallucinogens once/twice	5.8	3.3	80.5	19.8	13.7	76.9	12.0	11.2	77.0	77.5	11.0	11.3
Take hallucinogens occasionally	4.7	2.6	82.1	21.5	13.2	75.9	8.0	7.8	81.0	80.6	11.0	11.6
Total N	307	298	307	298	307	298	309	284	309	284	309	284

Table 28. Respondents in the Youth KAP Surveys of 2000 and 2003 (dis)approving of selected patterns of youth psychoactive substance use (percentages)

Patterns of psychoactive substance use	Central District						Partizanski District					
	Approval		(Strong) disapproval		Don't know		Approval		(Strong) disapproval		Don't know	
	2000	2003	2000	2003	2000	2003	2000	2003	2000	2003	2000	2003
Smoke 10 or more cigarettes a day	8.5	2.6	67.8	17.4	23.7	80.0	7.4	13.4	61.7	61.5	30.9	25.1
Take marijuana/hashish occasionally	4.4	1.6	80.7	23.1	14.9	75.3	6.4	9.9	75.8	72.8	17.8	17.3
Take marijuana/hashish regularly	2.4	1.2	83.4	24.2	14.2	74.6	2.6	4.9	85.7	82.4	11.7	12.7
Take cocaine once/twice	2.4	1.9	80.0	22.5	17.6	75.6	4.0	4.6	78.0	78.4	18.0	17.0
Take cocaine occasionally	2.4	1.3	82.6	24.4	15.0	74.3	3.0	3.5	84.0	81.3	13.0	15.2
Take 1 or 2 drinks several times a week	15.7	2.6	57.9	26.4	26.4	77.7	17.0	19.4	56.0	59.4	27.0	21.2
Take 5 or more drinks once/twice a weekend	7.4	1.6	73.1	19.5	19.5	76.2	6.0	11.3	72.0	73.5	22.0	15.2
Take amphetamine once/twice	1.7	2.2	79.7	18.6	18.6	74.6	3.0	5.0	75.0	76.9	22.0	18.1
Take amphetamine occasionally	3.1	1.6	81.2	15.7	15.7	74.3	2.0	3.5	79.0	80.6	19.0	15.9
Take heroin once/twice	3.5	1.9	81.5	23.5	15.0	74.6	2.0	3.5	85.0	82.0	13.0	14.5
Take heroin occasionally	2.4	1.6	83.2	24.1	14.4	74.3	1.0	2.8	87.0	84.5	12.0	12.7
Take hallucinogens once/twice	2.1	1.9	83.2	21.5	14.7	76.6	4.3	5.7	76.9	78.8	18.8	15.5
Take hallucinogens occasionally	2.0	2.2	82.3	22.5	15.7	75.3	2.0	5.3	82.0	80.5	16.0	14.2
Total N	307	298	307	298	307	298	309	284	309	284	309	284

Table 29. Respondents in the Youth KAP Surveys of 2000 and 2003 in Central District and Partizanski District reporting the use of alcohol and tobacco during particular periods in time (percentages)

Alcohol and tobacco use	Central District		Partizanski District	
	2000	2003	2000	2003
Tobacco generally				
Lifetime use	64.9	48.7	50.0	68.5
Past 12 months' use	45.2	34.8	41.0	54.6
Past 30 days' use	32.0	27.4	32.0	47.6
Alcohol generally				
Lifetime use	86.3	75.4	79.0	90.0
Past 12 months' use	74.4	67.4	73.0	82.8
Past 30 days' use	48.6	45.7	54.0	74.3
Hard liquor/spirits				
Lifetime use	56.6	52.4	55.0	74.3
Past 12 months' use	45.8	46.8	51.0	59.2
Past 30 days' use	25.8	31.4	38.0	42.6
Malt beer				
Lifetime use	84.3	71.2	79.0	90.0
Past 12 months' use	69.2	64.8	73.0	82.8
Past 30 days' use	47.1	45.7	53.0	74.3
Wine				
Lifetime use	76.0	61.5	70.0	86.5
Past 12 months' use	61.4	52.1	61.0	77.5
Past 30 days' use	33.6	27.8	38.0	54.8
Homebrew				
Lifetime use	46.0	37.2	50.0	50.5
Past 12 months' use	33.6	22.9	33.0	35.2
Past 30 days' use	19.9	13.3	14.0	17.9
Total N	307	298	309	284

Table 30. Respondents in the Youth KAP Surveys of 2000 and 2003 in Central District and Partizanski District reporting the use of illicit psychoactive substances during particular periods in time (percentages)

Illicit psychoactive substance use	Central District		Partizanski District	
	2000	2003	2000	2003
Marijuana/hashish				
Lifetime use	6.2	9.2	9.9	17.3
Past 12 months' use	2.2	6.9	5.8	10.7
Past 30 days' use	1.6	5.2	2.7	5.0
Heroin				
Lifetime use	0.6	1.3	0.9	3.5
Past 12 months' use	0.6	0.6	0.6	1.7
Past 30 days' use	-	0.6	0.3	1.7
Hallucinogens				
Lifetime use	0.6	2.7	3.2	6.6
Past 12 months' use	-	1.3	0.6	3.2
Past 30 days' use	-	0.6	-	1.4
Cocaine				
Lifetime use	0.9	1.3	1.3	2.4
Past 12 months' use	0.9	1.0	0.6	1.7
Past 30 days' use	0.9	0.3	-	1.0
Ecstasy				
Lifetime use	0.9	2.0	2.9	6.6
Past 12 months' use	0.6	0.3	1.0	3.5
Past 30 days' use	0.6	-	0.3	1.4
Total N	307	298	309	284

Table 31. Respondents in the Youth KAP Surveys of 2000 and 2003 in Central District and Partizanski District reporting consequences experienced with regard to past 12 months' use of psychoactive substances (percentages)

Consequences of psychoactive substance use	Central District		Partizanski District	
	2000	2003	2000	2003
Could not stop after having started drinking	4.4	3.8	6.0	8.2
Could not cope with everyday chores	4.5	9.3	10.0	15.2
Felt an urge to freshen the nip	5.2	3.5	10.0	11.0
Experienced a feeling of guilt or pangs of conscience after drinking	12.6	14.4	21.0	23.2
Could not remember what had been going on overnight after drinking	16	17.7	16.0	17.7
Got injured due to alcohol abuse	8.2	11.4	14.0	18.8
Kinsmen or medical professionals expressed their concern with the person's use of alcohol	7.4	8.3	10.0	12.2
Absence from work due to the use of illicit psychoactive substances	3.9	0.6	6.7	16.8
Driving a car in a state of alcohol or illicit psychoactive substance intoxication	1.0	0.3	1.7	5.0
Operating complicated mechanisms in a state of alcohol or illicit psychoactive substance intoxication	0.6	-	4.2	5.0
Arrest for antisocial behaviour in a state of alcohol or illicit psychoactive substance intoxication	2.0	0.3	2.8	7.9
Family quarrels or fights in a state of alcohol or illicit psychoactive substance intoxication	4.3	1.2	9.4	11.8
Total N	307	298	309	284

3.4 CONCLUSION

Various broad socioeconomic conditions impacted negatively on beliefs and practices regarding psychoactive substances within the country and the evaluation sites, complicating Global Initiative activities. This notwithstanding, a comparison of the results of the pre- and post-project situation assessments (as summarized in Table 32) showed that behaviour and attitude generally changed as expected, although unevenly across the issues concerned.

Among young people in Central District reported user rates of various psychoactive substances declined over the intervention period. Experiences of negative illicit psychoactive substance use-related consequences also decreased (negative consequences related to alcohol increased). Attitudinal developments among young people in Central District were, however, not generally supportive of the positive behaviour developments. For example, acceptance of youth psychoactive substance use as risky and (strong) disapproval of such use declined noticeably among young people in Central District amidst a marked increase in undecided (“did not know”) responses. In contrast, various positive developments occurred among the young people’s seniors.

Among adults in Central District reported rates of (1) tobacco use remained largely constant over the intervention period; (2) the use of hard liquor, wine and malt beer dropped; (3) the non-medical use of tranquillizers and sedatives declined (use of painkillers increased); and (4) although the use of illicit psychoactive substances increased, user rates remained comparatively low (below 3.0%), except for marijuana/hashish (lifetime use was 6.2% in 2000 and 9.2% in 2003). In addition, (5) the tendency among adults to view psychoactive substance use as risky remained intact. (6) Adults also became generally less inclined to indicate psychoactive substance use and especially youth use as entailing no or a slight risk (except in the case of people in general using 10 or more cigarettes a day). (7) Expressions of (strong) disapproval of psychoactive substance use among adults generally remained the same.

Somewhat in contrast with developments in Central District, psychoactive substance use-related behaviour and attitudes among young people in Partizanski District generally deteriorated. (The weaker results in Partizanski District in comparison with those in Central District might be attributed to (1) the greater ease of countering psychoactive substance use in a community (Central District) within the smaller City of Gomel than in a community (Partizanski District) in the larger City of Minsk; and to (2) organized crime being known to be more active in Partizanski District

than in Central District.) For example, reported psychoactive substance use increased across a range of substances, namely tobacco, alcohol, medicine such as painkillers, tranquillizers and sedatives, as well as illicit psychoactive substances (especially marijuana/hashish). Reported experiences of negative consequences of psychoactive substance use also increased. Conditions, however, did not deteriorate throughout. Positive changes also manifested among young people in Partizanski District: (1) The age of first use either remained constant or increased for various psychoactive substances (first use of tobacco (13-14 years) and illicit psychoactive substances (15-18 years) remained constant; the average starting age for the use of alcohol rose (from 11.5 years to 13.5 years); (2) reported rates of acceptance of youth psychoactive substance use as risky remained largely the same; and (3) reported rates of expressions of (strong) approval of youth psychoactive substance use also did not change markedly (except that approval of using 10 or more cigarettes a day was markedly higher in 2003 than in 2000).

The mentioned positive developments among young people were supported by various developments among adults in Partizanski District. For example, (1) cigarette users decreased noticeably; and (2) reported use of hard liquor and wine declined and reported use of malt beer remained practically the same. (Reported regular (several times a month) alcohol use, however, increased among adults. Similarly, the non-medical use of psychoactive substances such as painkillers, tranquillizers and sedatives as well as the use of illicit psychoactive substances increased.) (3) Adults became more inclined to indicate psychoactive substance use as risky, and to (strongly) disapprove of such use.

In both evaluation communities in Belarus the project leaders concentrated on increasing awareness and providing information about the risks of psychoactive substance use, and stimulating wide involvement in preventive activities, at least within the school community. The local partners’ evaluations of their preventive activities showed that the project activities were well received by the targeted youth and adults (parents and teachers). The target groups’ knowledge about psychoactive substance use, their personal involvement in prevention, and their coping and communication skills improved. Apart from the Global Initiative project, which was largely school-based, no new agencies/programmes focusing on the prevention of psychoactive substance use among young people evolved in the evaluation sites. However, the project reached widely into the school environment in the evaluation sites.

Table 32. Summary of key changes in the evaluation sites in Belarus

Data collection method	Central District		Partizanski District	
	Psychoactive substance use-related attitudes	Psychoactive substance use	Psychoactive substance use-related attitudes	Psychoactive substance use
Youth KAP Survey	<ul style="list-style-type: none"> Decreased sense of the riskiness of psychoactive substance use (e.g. between 53% and 91% in 2000 and between 16% and 26% in 2003 indicated youth psychoactive substance use as entailing a moderate/great risk (Table 27)) Decrease in (strong) disapproval of youth psychoactive substance use (e.g. between 58% and 83% in 2000 and between 17% and 26% in 2003 (strongly) disapproved of youth psychoactive substance use (Table 28)) 	<ul style="list-style-type: none"> Generally decreased tobacco use (e.g. between 32% and 65% in 2000 and between 27% and 49% in 2003 admitted tobacco use (Table 29)) Sustained age of onset of tobacco use, i.e. 13-14 years General decline in alcohol use (e.g. between 49% and 86% in 2000 and between 46% and 75% in 2003 admitted alcohol use (Table 29)) Sustained age of onset of alcohol use, i.e. 13-14 years General decrease in non-medical use of painkillers, tranquilizers and sedatives, e.g. lifetime use decreased from 5% and less to 2% and less Some increase in the level of illicit psychoactive substance use (e.g. between 2% and 6% in 2000 and between 5% and 9% in 2003 admitted use of marijuana (Table 30)) Sustained age of onset of illicit psychoactive substance use, i.e. 15-18 years 	<ul style="list-style-type: none"> Generally sustained belief in the riskiness of psychoactive substance use (e.g. between 47% and 90% in 2000 and between 52% and 90% in 2003 indicated youth psychoactive substance use as entailing a moderate/great risk (Table 27)) Generally sustained tendency to (strongly) disapprove of youth psychoactive substance use (e.g. between 56% and 87% in 2000 and between 59% and 85% in 2003 (strongly) disapproved of youth psychoactive substance use (Table 28)), but marked increase in approval of taking 10 or more cigarettes per day (i.e. from 7% to 13% (Table 29)) 	<ul style="list-style-type: none"> Generally increased tobacco use (e.g. between 32% and 50% in 2000 and between 48% and 69% in 2003 admitted tobacco use (Table 29)) Sustained age of onset of tobacco use, i.e. 13-14 years Generally increased alcohol use (e.g. between 38% and 55% in 2000 and between 43% and 74% in 2003 admitted alcohol use (Table 29)) Increase in average starting age for alcohol use from 11.5 years to 13.5 years Some increase in non-medical use of painkillers, tranquilizers and sedatives, e.g. lifetime use from 6% and less to 7% and less Increase in illicit psychoactive substance use (e.g. between 3% and 10% in 2000 and between 5% and 17% in 2003 admitted marijuana use (Table 30)) Sustained age of onset of illicit psychoactive substance use, i.e. 15-18 years
Adult KAP Survey	<ul style="list-style-type: none"> Increased sense of the riskiness of psychoactive substance use (e.g. view that the taking of 10 or more cigarettes a day by young people entailed no/a slight risk decreased from 12% to 6%; view that 1 or 2 drinks a week by young people entailed a slight/no risk decreased from 12% to 10%; between 2% and 7% in 2000 and between 1% and 4% in 2003 viewed youth use of various illicit psychoactive substances as entailing no/a slight risk) Sustained general tendency to (strongly) disapprove of psychoactive substance use (e.g. 80% or more in 2000/2003 (strongly) disapproved of illicit psychoactive substance use by people in general; more than 80% in 2000/2003 (strongly) disapproved of youth psychoactive substance use) 	<ul style="list-style-type: none"> Decline in tobacco use (e.g. lifetime use declined from 64% to 57%) Decline in the use of a range of alcoholic beverages (e.g. lifetime use decreased from between 80% and 95% in 2000 to between 55% and 93% in 2003) Increase in the non-medical use of painkillers (e.g. lifetime use increased from 9% to 13%) Decrease in the non-medical use of tranquilizers and sedatives (e.g. lifetime use of tranquilizers declined from 21% to 10% and lifetime use of sedatives from 37% to 21%) Some increase in the use of illicit psychoactive substances (e.g. lifetime use of marijuana increased from 6% to 8%; lifetime heroin use from zero to 8% and lifetime use of amphetamines from 1% to 5%) 	<ul style="list-style-type: none"> Increased sense of the riskiness of psychoactive substance use (e.g. 78% in 2000 and 94% in 2003 indicated the use of 10 or more cigarettes a day by people in general as entailing a great risk; 57% in 2000 and 83% in 2003 indicated the use of 1 or 2 drinks a week by people in general as entailing a great risk; 80% or more in 2001/2003 indicated illicit psychoactive substance use by people in general as entailing a great risk; more than 90% in 2000/2003 viewed illicit psychoactive substance use by young people as entailing a great risk) Increased tendency to (strongly) disapprove of psychoactive substance use (e.g. (strong) disapproval of the taking of 10 or more cigarettes a day by people in general increased from 60% to 86%; (strong) disapproval of people in general taking 1 or 2 drinks a week increased from 52% to 82%; more than 85% in 2000/2003 (strongly) disapproved of illicit psychoactive substance use by people in general; more than 90% in 2000/2003 disapproved of youth psychoactive substance use) 	<ul style="list-style-type: none"> Marked decrease in cigarette use (e.g. lifetime use decreased from 97% to 53%) Marked decrease in the use of hard liquor and wine (e.g. lifetime use of hard liquor decreased from 85% to 73%; lifetime use of wine decreased from 91% to 85%), and limited change in the use of malt beer (e.g. lifetime use was 85% in 2000 and 84% in 2003) Marked increase in the non-medical use of painkillers, tranquilizers and sedatives (e.g. lifetime use of painkillers increased from 10% to 27%, tranquilizers from 17% to 35%, and sedatives from 24% to 37%) Marked increase in illicit psychoactive substance use and especially the use of inhalants (e.g. lifetime use of marijuana increased from 6% to 8%, amphetamines from 1% to 9%, and inhalants from 2% to 29%)
Focus groups, in-depth interviews and key informant interviews	No information available	<ul style="list-style-type: none"> Progressive increase in psychoactive substance use among young people Tobacco and alcohol were the most commonly used psychoactive substances Marijuana was the most commonly used illicit psychoactive substance 	No information available	<ul style="list-style-type: none"> Progressive increase in psychoactive substance use

Project outcome in the evaluation sites in the Kingdom of Thailand

4.1 INTRODUCTION

This chapter discusses key findings of the overall evaluation of the outcome of the Global Initiative in two urban communities—Wat Chaiyaprukmalā in the Talingchan District and Sulaw Jorakaekob in the Prawes District of Bangkok—in Thailand. (“Wat” means “Buddhist temple” and “Sulaw” means “Muslim temple”.) The Bangkok Metropolitan Administration is responsible for the general administration of the communities and accountable to the Ministry of Interior. Wat Chaiyaprukmalā is a fairly newly established (± 15 years) community of mostly working-class people. It is situated on land that is partly owned by and leased from the Chaiyaprukmalā Temple. Sulaw Jorakaekob is a more established (± 55 years) community spread along a largely flat area on both sides of the Klong Jorakaekob canal.

The chapter first describes the main sociodemographic characteristics of the evaluation sites; the broad socioeconomic conditions impacting on these sites; as well as the main characteristics and preventive activities of the local Global Initiative partners in these sites. It then compares the key results of the pre- and post-project situation assessments in the sites, and concludes with an integrated summary (e.g. in tabulated format) of these results.

4.2 EVALUATION SITES, LOCAL PARTNERS, PREVENTIVE ACTIVITIES AND BROAD SOCIOECONOMIC DEVELOPMENTS

Table 33 shows that the evaluation sites were about similar in population size and in gender composition. Wat

Chaiyaprukmalā had a somewhat older population with higher proportions of persons with secondary and tertiary education than Sulaw Jorakaekob. The former community was mostly of Buddhist background and Sulaw Jorakaekob of Muslim background.

The Global Initiative project in the evaluation sites took place against the background of various broad socioeconomic developments within these sites and the broader region/country, including psychoactive substance use-related preventive activities in progress. For example, both sites faced a variety of socioeconomic pressures. Adults tended to be unskilled casual workers. In Wat Chaiyaprukmalā about 10.0% of the households had a regular monthly income and in Sulaw Jorakaekob about 8.0%. Households in Wat Chaiyaprukmalā lived in cluster houses of which some were temporary structures; in contrast, households in Sulaw Jorakaekob lived in permanent houses on separate stands. All households in Wat Chaiyaprukmalā and most in Sulaw Jorakaekob had access to piped water and electricity—some households in Sulaw Jorakaekob used the water in the canal running through the village.

Notwithstanding generally debilitating economic circumstances, Wat Chaiyaprukmalā was well provided with public amenities (e.g. educational, health and recreational facilities) in comparison with other communities in the Bangkok Metropolis. These amenities were also within easy reach of households and free of charge. The youth centre, for example, opened every day and had a library, offered classes in skills training (e.g. Thai dancing, cooking and creative thinking) and provided sports grounds.

Table 33. Demographic features of the project sites (2001 figures) (percentages)

Variable	Wat Chaiyaprukmalā	Sulaw Jorakaekob
Gender		
Males	48.1	48.2
Females	52.0	51.8
Age		
14 years or younger	17.8	26.7
15-25 years	13.0	22.1
26-59 years	63.3	46.7
60 years or older	5.8	4.5
Educational attainment		
None	6.9	18.2
Primary school	31.2	54.4
Secondary school	20.0	9.8
Tertiary education	21.9	1.2
Studying	19.9	16.4
Mean age of the population (years)	35.8	30.0
Total population (N)	1 560	1 700

Table 34. Recent national government psychoactive substance use-related prevention projects

Government organizations	National projects	Targets
Ministry of Interior	“Strong Community”	General public, communities
Ministry of Public Health	“To Be Number One” Urine screening	Youth Schools, factories
Ministry of Education	“White School”	Youth in school, school safety
National Police Bureau	“Strong/White Community”	Community, school, factories

The use of licit psychoactive substances—and alcohol in particular—was widely accepted in Thai society, with adults generally being more accepting of alcohol use among males than among females, especially in terms of the age of onset of use and the amount imbibed. Alcohol use tended to be associated with having a good time and with celebrations in Thailand. In contrast, the use of illicit psychoactive substances was generally frowned upon, indeed associated with crime and viewed as destroying individuals, families and communities. Notwithstanding this general intolerance, illicit psychoactive substance use/trafficking occurred within Thai communities (e.g. to earn a living), although to a considerably lesser extent than use/trade in licit psychoactive substances.

Non-governmental non-profit organizations (NGOs) were rare in Thailand. The few within the field of psychoactive substance use-related **prevention** mostly operated in urban slum and rural communities and under the auspices of religious leaders. In contrast, and as shown in Table 34, various government ministries engaged in psychoactive substance use-related prevention, and were about to implement government policy to coordinate/integrate action at especially local level.

The psychoactive substance use-related initiatives of the **Thai government** were part of attempts to (1) facilitate the social integration of families/communities, (2) increase

young people’s participation in constructive recreation activities, (3) strengthen community members’ voluntary participation in the administration of their communities, and (4) facilitate collaboration between government and civil society. An example was the government’s strategy of declaring a community that demonstrated success in preventing/reducing illicit psychoactive substance use/trafficking a “strong community” (Table 34). The Strong Community initiative raised awareness of the risks of illicit psychoactive substance use/trafficking and motivated community members towards concerted prevention action in cooperation with government agencies. Wat Chaiyaprukmalā and Sulaw Jorakaekob were both declared “strong communities”.

In the **Bangkok Metropolis**—of which the evaluation sites were part—various government agencies were engaged in preventing psychoactive substance use and related problems since more or less the beginning of 2000, e.g. schools, health centres and especially the police. School curriculums, for example, generally included discussions on psychoactive substance use and related problems. The police, for example, raised awareness of the risks of psychoactive substance use in schools (e.g. through their community relations units), apart from strictly enforcing the law against illicit psychoactive substance use and trafficking. For example, in Sulaw Jorakaekob the police facilitated an agreement between the community administration and neighbouring community

Table 35. Description of local partners and the nature and outcome of their preventive activities

Wat Chaiyaprukmalā	Sulaw Jorakaekob
<p>Local partner</p> <p>The Wat Chaiyaprukmalā Community Committee is a non-governmental organization that works in Talingchan District in the Bangkok Metropolis. It promotes Thai culture, public health services, disaster prevention training and sports activities. It also runs a revolving savings fund and a small retail store.</p> <p>Problem</p> <p>The local situation assessment identified tobacco, alcohol, marijuana and amphetamine-type stimulants as the most commonly used psychoactive substances. Alcohol and tobacco were widely used. Psychoactive substance use particularly occurred among men, and marijuana and amphetamine use mostly among men 17 to 18 years.</p> <p>Aim</p> <p>The main objectives of the project were to improve family communication skills, provide information on the risks of especially illicit psychoactive substance use to especially young people, educate young people in prevention work, and encourage cooperation on these issues between government agencies and NGOs.</p> <p>Preventive activities</p> <p>The project mobilized a number of groups in support of the project and with the help of local government agencies (e.g. the health clinic, elementary/community school, youth centre and police) and established a community forum to facilitate cooperation. After some adjustments and minor coordination difficulties because of different approaches and methods regarding the prevention of psychoactive substance use, a formal cooperation agreement was closed between the participating agencies. Participating agencies contributed available time, facilities, advice and skills rather than direct financial support. The project trained 120 people from age 4 years and up (including family groups) in the prevention of psychoactive substance use and about constructive family relations/communication. In coordination with local police and other agencies, it held information trips and interactive lectures on the risks of psychoactive substance use.</p> <p>To promote Thai culture and raise self-esteem, training in Thai dancing and acting was provided to 48 children aged 1 to 20 years. Training in Thai drumming was given to 50 males aged 10 to 30 years, and vocational skills training to 110 people aged 1 to 50 years. The project also organized facilities for 70 people aged 10 to 55 years to do batik work and sell it to strengthen their families' incomes. Several sports competitions for young people, ranging from soccer to sack racing, were held and about 600 people between 5 and 60 years participated. To promote environmental awareness and the community's dedication to the project, the participants conducted monthly clean-up activities. The project also involved 330 people 5 years and older in the research for and the production and distribution of an information magazine on the risks of psychoactive substance use.</p> <p>Project leaders' evaluation of project delivery/outcome</p> <p>Evaluation of the project's activities through questionnaires/interviews, attendance records, photographic/video documentation and cooperation agreements with other organizations showed that planned activities were executed and well received. Participation in activities was high, especially sports. Participants met new people and enjoyed themselves without the use of psychoactive substances. The distributed information contributed to constructive attitudes towards self, family and community. Batik production allowed for skills development and extra income. Cooperation among stakeholders was central to the success of the project, facilitating stronger, cost-effective and sustained action.</p>	<p>Local partner</p> <p>Chorakhe Khob Community Committee is an NGO that works in the Prawes District in the Bangkok Metropolis.</p> <p>Problem</p> <p>The local situation assessment identified tobacco, alcohol, marijuana and amphetamines as the most commonly used psychoactive substances.</p> <p>Aim</p> <p>The main objectives of the project were to improve relations between young people and their families, prevent/reduce the use of especially illicit psychoactive substances among young people, provide information on the risks of psychoactive substance use, train young people in campaigning against/preventing the use of psychoactive substances, and encourage cooperation on these issues between government agencies and NGOs.</p> <p>Preventive activities</p> <p>A core group of youth leaders were recruited and trained to prevent psychoactive substance use, support their peers constructively and facilitate constructive relations between young people and adults as well as cooperation between various preventive agencies (e.g. police, religious leaders, the educational committee, housewives, public health workers, farmer groups, local businesses and youth/parent groups).</p> <p>The trained young people were supported by preventive agencies in planning and implementing activities such as youth seminars/training sessions, skills training (e.g. in Muslim music making and singing), products for distribution through the media, public relations activities, study trips and charity fairs.</p> <p>Project leaders' evaluation of project delivery/outcome</p> <p>Evaluation through questionnaires/interviews showed that the project strengthened relationships between preventive agencies and that activities were well-received.</p>

Table 36. Agencies involved in the planning and/or implementation of the Global Initiative activities in the evaluation sites

Wat Chaiyaprukmalala		Sulaw Jorakaekob	
Prevention activity	Organization	Prevention activity	Organization
	1. Government agency		1. Government
Facilitate youth and community outreach Disseminate psychoactive substance use-related information at youth centre (e.g. through showing movies) Participate in community activities, e.g. providing activity facilitators and trainers	Police (community relations unit)	Cooperate in suppression and prevention of psychoactive substance use (e.g. through youth and community outreach)	Police
Vocational training Fund management	School (school headmaster)	Cooperate when requested	School
Provide facilities Assist in the organization of sport/dance performances Music and dance training	Youth centre		2. Non-government/community agency
Provide trainers in family relations	Health centre	Provide leadership training Contribute to planning, facilities Provide spiritual training Arrange annual youth academic awards Patrol the community and care for needy	Community mosque: mosque committee
	2. Non-government/community agency	Participate in the activities Provide spiritual training and facilities	Mosque religious school
Plan and coordinate	Community committee	Participate in activity planning Disseminate information	Housewives group
Provide start-up funding	Savings group	Participate in the activities and fund raising	Two religious schools in community
Participate in planning and activities	Sports group	Part of the work team—making posters, disseminating information, etc.	Informal youth group
Participate in planning and activities	Informal youth group	Plan and oversee project activities	Global Initiative project work team (adults)
Participate in planning and activities	Senior group		
Participate in activities	Housewives group		3. Others
	3. Others	Donating funds or prizes as requested	Local private businesses
Request/mobilize donors/supporters	Local politicians	Donating funds or prizes as requested	Local politicians

administrations to work together towards raising awareness of the risks of psychoactive substance use (e.g. through mobilizing anti-psychoactive substance use marches in the communities). The fact that at the time of the Global Initiative post-project situation assessment all known traffickers in illicit psychoactive substances were imprisoned in Sulaw Jorakaekob also demonstrated the local police's commitment towards and effectiveness in curbing such activities. Indeed, the Sulaw Jorakaekob community had the advantage that the police and the religious leaders jointly led preventive activities. Moreover, licit as well as illicit psychoactive substance use was discouraged on religious grounds in Sulaw Jorakaekob. The sale of alcohol, the open display of tobacco in shops and past practices such as workers or football players using amphetamine to increase stamina were prohibited. Voluntary workers in the community supervised and supported past psychoactive substance users towards maintaining sobriety, and assisted the police in identifying and reporting trafficking in illicit psychoactive substances.

Table 35 describes the **Global Initiative** partners and their preventive activities in the evaluation sites in some detail. Community committees administered the Global Initiative project in the respective sites. (These committees were elected by community members every second year to liaise between them and government administrators/sectors.) In both sites the Global Initiative activities focused on illicit psychoactive substance use, on young people, and on strengthening cooperation between community sectors with regard to the prevention of psychoactive substance use and related problems. In fact, the Global Initiative project was the first active attempt to systematically and widely mobilize integrated psychoactive substance use-related preventive activities in the respective sites, although the government underscored the need for such integration in, for example, its mentioned Strong Community initiative.

Table 35 also shows that the Global Initiative activities proceeded as planned and achieved the expected outcomes, e.g. information distribution, prevention education/training, involvement of young people in constructive recreation/skills development activities, and strengthening collaboration among community members to prevent psychoactive substance use and related problems. Table 36 shows that in Wat Chaiyaprukmal a wider range of agencies participated in the Global Initiative than in Sulaw Jorakaekob. In Wat Chaiyaprukmal collaboration between prevention initiatives tightened during the intervention period, especially as a consequence of the cooperation that was solicited from the local community/elementary school and youth centre. A key advantage in the execution of the Global Initiative

project was the fact that both communities had good relationships with the local government agencies and a number of established civil society groups. Key informants in the pre- and post-project situation assessments also mentioned that community members in Sulaw Jorakaekob were generally actively engaged in religious activities, accepted a faith that expected abstinence from psychoactive substance use, and had leaders who worked closely together and were committed to securing the well-being of community members. Particular mention was also made of the fact that the local civic leader in Sulaw Jorakaekob was most capable, and was committed to the Muslim faith and abstinence from psychoactive substance use.

4.3 COMPARISON OF THE PRE- AND POST-PROJECT SITUATION ASSESSMENT RESULTS

This section compares key results of the pre- and post-project situation assessments and in particular the key results of the Adult and Youth KAP Surveys as well as the focus group discussions and key informant interviews.

4.3.1 DEMOGRAPHIC PROFILE OF RESPONDENTS

The pre- and post-project KAP Survey samples in the evaluation sites as a whole were demographically largely similar, especially the Adult KAP Survey samples. In both sites most respondents stated that religion was very/pretty important in their lives. In Wat Chaiyaprukmal 107 adults were included in the pre-project Adult KAP Survey and 101 in the related post-project survey; the comparative figures for Sulaw Jorakaekob were 115 and 113. The respondents in the pre- and post-project Adult KAP Survey samples were mostly female, in the age group 22–39 years, and employed. About similar proportions of males and females were included in the pre- and post-project Youth KAP Survey samples. Table 37 presents the age distribution of the respondents in the pre- (2001) and post-project (2003) Youth KAP Surveys in the respective sites. Young people in the Wat Chaiyaprukmal survey sample were more evenly distributed in terms of age (51.0% were 16 years and older) in the 2001 Youth KAP Survey sample than in the 2003 sample—the younger age group was overrepresented (62.3% were 15 years and younger) in the latter case. In Sulaw Jorakaekob the younger group (65.7%) was in the majority in the 2001 sample and the older group (56.9%) in 2003.

Table 37. Age distribution of the respondents in the Youth KAP Surveys of 2001 and 2003 (percentages)

Variable	Wat Chaiyaprukmal		Sulaw Jorakaekob	
	2001	2003	2001	2003
10-12	27.3	29.1	42.4	16.4
13-15	21.8	33.2	23.3	26.6
16-18	21.8	16.8	16.8	25.3
19-21	29.2	20.8	17.5	31.6
Total N	308	298	309	316

4.3.2 PSYCHOACTIVE SUBSTANCE USE-RELATED ATTITUDES AND PRACTICES AMONG ADULTS

Data on the attitudinal results of the pre- (2001) and post-project (2003) Adult KAP Surveys in the evaluation sites in Thailand were only available for the evaluation sites as a whole. As a result the discussion in this section only distinguishes between the two sites when presenting the results on reported psychoactive substance use.

Table 38 shows that in both 2001 and 2003 most of the surveyed adults indicated psychoactive substance use by people in general and by young people in particular as entailing a **moderate/great risk**. The proportions of respondents who stated that the use of psychoactive substances by people in general entailed a moderate/great risk were generally higher in 2003 than in 2001, especially for the use of alcohol, cocaine and mandrax, but the opposite applied in the case of the use of marijuana/hashish (regular use), amphetamines and heroin. Similarly, the proportions of respondents who stated that the use of psychoactive substances by young people entailed a moderate/great risk were higher in 2003 than in 2001 in a number of cases but declined for tobacco, marijuana/hashish, amphetamines and heroin (Table 38).

Table 39 shows that the respondents tended to be less inclined in 2003 (46.3%–79.9%) than in 2001 (49.1%–86.1%) to **(strongly) disapprove** of psychoactive substance use among people in general, and more inclined in 2003 (72.9%–89.7%) than in 2001 (6.8%–84.2%) to **(strongly) disapprove** of psychoactive substance use among young people. Particularly noticeable was the general increase in

the proportions of respondents who did not know whether to approve or disapprove of the patterns of psychoactive substance use of concern. The increase in “don’t know” responses over the intervention period might mean that the respondents had become more accepting of the use of psychoactive substances.

Table 40 points to the following trends among adults in the evaluation sites with regard to **psychoactive substance use**: (1) The proportions of adults who reported psychoactive substance use in 2003 were generally more or less the same as those in 2001. (2) Reports of the non-medical use of painkillers were an exception—markedly lower proportions reported the non-medical use of painkillers in 2003 than in 2001, especially in Wat Chaiyaprukmal—a notable exception was past 30 days’ use in Sulaw Jorakaekob (increased from 33.9% to 55.7%). (3) Moreover, in Wat Chaiyaprukmal reports of the lifetime use of alcohol were substantially lower in 2003 than in 2001, whereas reports of past 12 months’ and past 30 days’ use increased. (4) Overall, the proportions of respondents who reported the use of psychoactive substances were to some extent lower in Sulaw Jorakaekob than in Wat Chaiyaprukmal, especially in the case of alcohol and marijuana/hashish use and excluding the non-medical use of painkillers. Reported non-medical use of painkillers was higher in Sulaw Jorakaekob than in Wat Chaiyaprukmal. (5) Overall, the proportions of respondents who admitted illicit psychoactive substance use were comparatively small (4.0% or lower for lifetime use), except reported lifetime use of marijuana/hashish (14.9% in 2001 and 11.9%) in Wat Chaiyaprukmal.

Table 38. Respondents in the Adult KAP Surveys of 2001 and 2003 in the evaluation sites as a whole reporting selected patterns of psychoactive substance use by people in general and young people as entailing no/a slight or moderate/great risk (percentages)

Patterns of psychoactive substance use	People in general						Young people					
	No/slight risk		Moderate/great risk		Don't know		No/slight risk		Moderate/great risk		Don't know	
	2001	2003	2001	2003	2001	2003	2001	2003	2001	2003	2001	2003
Smoke 10 or more cigarettes a day	10.8	6.1	85.6	88.3	3.6	5.6	5.9	5.2	91.4	86.9	2.7	7.9
Take marijuana/hashish occasionally	7.6	5.1	83.4	85.1	9.0	9.8	5.8	4.7	87.9	85.5	6.3	9.8
Take marijuana/hashish regularly	2.7	2.9	88.3	86.4	9.0	10.7	2.3	2.4	91.4	87.8	6.3	9.8
Take cocaine once/twice	3.1	5.1	74.4	83.7	22.5	11.2	1.8	3.8	79.3	84.1	18.9	12.1
Take cocaine occasionally	1.8	5.6	76.1	83.2	22.1	11.2	0.8	3.3	80.7	85.5	18.5	11.2
Take 1 or 2 drinks several times a week	30.2	9.3	63.5	83.2	6.3	7.5	22.9	6.1	73.0	84.6	4.1	9.3
Take 5 or more drinks once/twice a weekend	18.4	9.3	76.6	83.7	5.0	7.0	14.8	4.6	81.1	85.1	4.1	10.3
Take amphetamines once/twice	4.9	5.6	86.5	84.1	8.6	10.3	4.9	4.8	89.2	84.5	6.8	10.7
Take amphetamines occasionally	2.2	3.2	90.1	86.5	7.7	10.3	0.9	2.0	91.9	85.9	7.2	12.1
Take heroin once/twice	2.2	4.7	86.1	85.0	11.7	10.3	0.9	3.3	88.3	84.1	10.8	12.6
Take heroin occasionally	0.9	3.8	87.8	85.0	11.3	11.2	0.9	2.8	87.8	84.1	11.3	13.1
Take mandrax once/twice	1.8	4.7	64.0	79.9	34.2	15.4	0.9	3.2	65.3	82.3	33.8	14.5
Take mandrax occasionally	0.9	3.2	65.8	82.3	33.3	14.5	-	3.2	66.2	82.3	33.8	14.5
Take hallucinogens once/twice	4.9	3.7	80.2	84.6	14.9	11.7	3.6	3.8	82.0	85.9	14.4	10.3
Total N	222	214	222	214	222	214	222	214	222	214	222	214

Table 39. Respondents in the Adult KAP Surveys of 2001 and 2003 in the evaluation sites as a whole (dis)approving of selected patterns of psychoactive substance use by people in general and young people (percentages)

Patterns of psychoactive substance use	People in general						Young people in particular					
	Approval		(Strong) disapproval		Don't know		Approval		(Strong) disapproval		Don't know	
	2001	2003	2001	2003	2001	2003	2001	2003	2001	2003	2001	2003
Smoke 10 or more cigarettes a day	43.2	30.3	49.1	46.3	7.7	23.4	26.1	10.7	68.9	72.9	5.0	16.4
Take marijuana/hashish occasionally	11.3	9.3	76.5	70.6	12.2	20.1	6.8	2.8	83.7	82.7	9.5	14.5
Take marijuana/hashish regularly	8.6	3.7	79.2	77.6	12.2	18.7	5.9	2.3	84.2	84.6	9.9	13.1
Take cocaine once/twice	5.0	3.7	77.9	75.7	17.1	20.6	3.6	2.8	83.3	84.1	13.1	13.1
Take cocaine occasionally	5.9	3.2	77.0	76.2	17.1	20.6	5.4	3.3	81.5	82.7	13.1	14.0
Take 1 or 2 drinks several times a week	46.8	23.4	47.3	55.6	5.9	21.0	32.8	10.8	61.3	73.3	5.9	15.9
Take 5 or more drinks once/twice a weekend	38.7	19.7	55.9	62.1	5.4	18.2	25.7	9.3	68.0	76.2	6.3	14.5
Take amphetamine once/twice	9.5	7.0	81.9	72.4	8.6	20.6	6.7	3.7	6.8	82.7	6.8	13.6
Take amphetamine occasionally	6.8	7.0	84.6	74.3	8.6	18.7	5.8	3.2	6.8	83.2	6.8	13.6
Take heroin once/twice	4.0	2.8	85.6	79.9	10.4	17.3	3.5	9.2	9.5	89.7	9.5	12.1
Take heroin occasionally	3.5	2.8	86.1	79.9	10.4	17.3	2.6	1.9	9.5	85.5	9.5	12.6
Take mandrax once/twice	2.7	4.7	74.3	76.6	23.0	18.7	2.3	2.8	21.6	83.6	21.6	13.6
Take mandrax occasionally	3.1	3.3	73.0	77.5	23.9	19.2	2.3	2.3	22.1	84.1	22.1	13.6
Take hallucinogens once/twice	5.4	6.5	80.2	74.8	14.4	18.7	5.8	5.1	12.2	81.3	12.2	13.6
Take hallucinogens occasionally	6.3	7.4	79.7	73.4	14.0	19.2	5.0	3.7	11.7	82.7	11.7	13.6
Total N	222	214	222	214	222	214	222	214	222	214	222	214

Table 41 shows that in 2001 and especially in 2003 reasonable proportions of respondents in Wat Chaiyaprukmalā admitted experiencing unfavourable consequences related to their use of alcohol and/or other psychoactive substances (in 2001 2.8%–16.8% reported unfavourable drinking-related experiences and in 2003 5.9%–15.8%; the comparative figures for consequences related to other psychoactive substances were 1.9%–9.3% for 2001 and 3.0%–6.9% for 2003). In 2001 none of the respondents in Sulaw Jorakaekob and comparatively few in 2003 admitted having experienced unfavourable consequences related to their use of psychoactive substances (in 2003 2.6% experienced feelings of guilt related to their drinking and 3.5% admitted that some people had suggested that they cut down on their drinking).

4.3.3 PSYCHOACTIVE SUBSTANCE USE-RELATED ATTITUDES AND PRACTICES AMONG YOUNG PEOPLE

Comparison of the responses to the question of whether youth psychoactive substance use entailed a **moderate/great risk** in the 2001 and 2003 Youth KAP Surveys in the evaluation sites as a whole shows (Table 42) that the surveyed young people were generally less inclined in 2003 than in 2001 to attach a moderate/great risk to youth use of psycho-

active substances. (Site-specific responses to the question of whether youth use of psychoactive substances entailed a risk were not available for 2001.) For example, in 2001 between 62.5% and 90.5% of the respondents stated that youth use of various psychoactive substances entailed a moderate/great risk, and in 2003 between 59.0% and 71.5%.

Notwithstanding the decline in perceptions that youth psychoactive substance use entailed a moderate/great risk, most of the young people in the evaluation sites—but especially those in Sulaw Jorakaekob—still stated in 2003 that youth psychoactive substance use entailed a moderate/great risk, especially illicit psychoactive substance use (Table 43); alcohol use was to some extent an exception in Wat Chaiyaprukmalā. For example, between 47.7% (“taking one or two drinks several times a week”) and 59.1% (“smoke 10 or more cigarettes a day”) of the respondents in Wat Chaiyaprukmalā, and between 69.6% (“taking one or two drinks several times a week”) and 77.6% (“smoke 10 or more cigarettes a day”) in Sulaw Jorakaekob stated that youth use of alcohol and tobacco entailed a moderate/great risk. Between 54.7% (use of mandrax and occasional use of amphetamines) and 61.7% (regular use of marijuana/hashish) in Wat Chaiyaprukmalā, and between 72.5% (occasional use of hallucinogens) and 80.7% (regular use of marijuana/hashish) in Sulaw Jorakaekob stated that youth use of illicit psychoactive substances entailed a moderate/great risk.

Table 40. Respondents in the Adult KAP Surveys of 2001 and 2003 in Wat Chaiyaprukmalā and Sulaw Jorakaekob reporting the use of psychoactive substances during particular periods in time (percentages)

Psychoactive substance use	Wat Chaiyaprukmalā		Sulaw Jorakaekob	
	2001	2003	2001	2003
Alcohol				
Lifetime use	68.2	58.4	13.0	10.6
Past 12 months' use	49.5	55.4	3.5	5.3
Past 30 days' use	29.9	37.6	0.9	2.6
Tobacco				
Lifetime use	35.5	37.6	39.1	41.6
Past 12 months' use	23.4	23.7	26.1	23.9
Past 30 days' use	22.4	21.8	24.3	19.5
Marijuana/hashish				
Lifetime use	14.9	11.9	3.5	3.5
Past 12 months' use	0.9	2.0	0.9	0.9
Past 30 days' use	-	-	-	-
Heroin				
Lifetime use	1.9	4.0	3.5	3.5
Past 12 months' use	-	1.0	0.9	0.9
Past 30 days' use	-	-	-	-
Inhalants				
Lifetime use	2.8	2.0	0.9	1.8
Past 12 months' use	-	1.0	-	0.9
Past 30 days' use	-	1.0	-	-
Hallucinogens				
Lifetime use	2.8	2.0	0.9	0.9
Past 12 months' use	0.9	1.0	-	-
Past 30 days' use	-	-	-	-
Amphetamines				
Lifetime use	2.8	4.0	3.5	1.8
Past 12 months' use	0.9	3.0	1.7	0.9
Past 30 days' use	-	2.0	1.7	-
Painkillers				
Lifetime use	74.8	44.5	83.5	74.3
Past 12 months' use	62.6	40.6	74.8	69.9
Past 30 days' use	35.5	30.7	33.9	55.7
Tranquillizers				
Lifetime use	1.9	3.0	6.1	3.5
Past 12 months' use	0.9	2.0	4.3	0.9
Past 30 days' use	-	2.0	1.7	-
Hypnotics and sedatives				
Lifetime use	7.5	6.0	12.2	13.3
Past 12 months' use	1.9	4.0	7.8	9.7
Past 30 days' use	-	2.0	4.3	7.1
Total N	107	101	115	113

Table 41. Respondents in the Adult KAP Surveys of 2001 and 2003 in Wat Chaiyaprukmal and Sulaw Jorakaekob reporting consequences experienced with regard to past 12 months' use of psychoactive substances (percentages)

Consequences of psychoactive substance use	Wat Chaiyaprukmal		Sulaw Jorakaekob	
	2001	2003	2001	2003
Unable to stop drinking after having started drinking	6.5	15.8	-	-
Failed to do what was normally expected	9.3	14.8	-	-
Need a drink first thing in the morning	2.8	6.9	-	2.6
Experience feelings of guilt related to drinking	2.8	7.9	-	-
Unable to remember what happened when drinking the night before	4.7	10.9	-	-
Injured as a result of drinking	10.3	5.9	-	-
Many people have suggested cutting down on drinking	16.8	15.8	-	3.5
Being absent from work or having poor work performance because of psychoactive substance use	9.3	6.9	-	-
Being absent, suspended or expelled from school or performing poorly at school because of psychoactive substance use	2.8	3.0	-	-
Driving a motor vehicle under the influence of alcohol or other psychoactive substances	6.5	7.9	-	-
Operating a machine under the influence of alcohol or other psychoactive substances	6.5	5.9	-	-
Being arrested for disorderly conduct because of psychoactive substance use	1.9	4.9	-	-
Having physical fights or arguments with family/relatives/friends as a consequence of psychoactive substance use	2.8	3.0	-	-
Total N	107	101	115	113

As in the case of the question of whether youth psychoactive substance use entailed risks, the surveyed respondents in the evaluation sites as a whole were less inclined in 2003 than in 2001 to **(strongly) disapprove** of youth psychoactive substance use—in 2001 between 52.9% and 91.0% (strongly) disapproved of youth psychoactive substance use; the comparative figures for 2003 were 50.3% and 70.9% (Table 44). (Site-specific responses to the question of whether selected patterns of youth psychoactive substance use entailed a risk were not available for the related 2001 Youth KAP Survey.) Substantially larger proportions in the 2003 Youth KAP Survey than in the related 2001 survey also indicated that they did not know whether to approve or disapprove of the selected patterns of youth psychoactive substance use (Table 44). Notwithstanding the overall decline over the intervention period in reports of (strong) disapproval of psychoactive substance use among surveyed young people in the evaluation sites, Table 45 shows that most of the respondents in the 2003 Youth KAP Surveys in the evaluation sites still (strongly) disapproved of the patterns of youth psychoactive substance use listed in the survey questionnaire, especially in Sulaw Jorakaekob (57.3%–79.4%); alcohol/tobacco use (36.9%–43.0%) in Wat Chaiyaprukmal was a notable exception. Between 52.6% and 64.7% (strongly) disapproved of youth use of psychoactive substances other than alcohol/tobacco in Wat Chaiyaprukmal.

Table 46 shows with regard to licit psychoactive substances that whereas reported use of both **tobacco and alcohol** increased over the intervention period in Sulaw

Jorakaekob, only reported alcohol use increased in Wat Chaiyaprukmal. For example, in both sites reported lifetime use of alcohol increased from 5.5% in 2001 to 11.7% in 2003. Reported lifetime use of tobacco increased from 8.7% in 2001 to 17.4% in 2003 in Sulaw Jorakaekob, and decreased in Wat Chaiyaprukmal from 22.4% in 2001 to 15.4% in 2003. (The different changes in reported lifetime tobacco use in the two sites could be related to the differences in the age distribution of the pre- (2001) and post-project (2003) survey samples in the two sites—in Wat Chaiyaprukmal the younger age group was overrepresented in the 2003 survey sample and in Sulaw Jorakaekob in the 2001 survey sample (Table 37).) Reports of the non-medical use of **painkillers** declined markedly in both sites except in respect of past 30 days' use in Sulaw Jorakaekob. For example, lifetime use decreased from 69.5% in 2001 to 42.6% in 2003 in Wat Chaiyaprukmal, and from 86.4% to 59.5% in Sulaw Jorakaekob, whereas past 30 days' use increased from 32.7% in 2001 to 34.5% in 2003 in Sulaw Jorakaekob. In both sites reported use of **illicit psychoactive substances** increased somewhat over the intervention period (Table 46). However, the level of reported use remained low over the intervention period—figures were below 3.0% in 2001 as well as in 2003. The range of illicit psychoactive substances respondents admitted using was somewhat smaller in Sulaw Jorakaekob (none reported use of heroin, designer psychoactive substances and mandrax in 2001 and 2003) than in Wat Chaiyaprukmal (in 2003 young people reported use of all the psychoactive substances listed in the Youth KAP Survey questionnaire).

Table 42. Respondents in the Youth KAP Surveys of 2001 and 2003 in the evaluation sites as a whole reporting selected patterns of youth psychoactive substance use as entailing no/a slight or moderate/great risk (percentages)

Patterns of psychoactive substance use	No/slight risk		Moderate/great risk		Don't know	
	2001	2003	2001	2003	2001	2003
Smoke 10 or more cigarettes a day	8.2	12.9	89.6	68.6	2.1	18.6
Take marijuana/hashish occasionally	7.5	11.9	85.9	66.9	6.6	21.2
Take marijuana/hashish regularly	3.9	8.6	88.8	71.5	7.3	19.9
Take cocaine once/twice	4.1	11.1	77.4	67.4	18.6	21.7
Take cocaine occasionally	3.9	10.8	78.1	66.8	18.0	21.7
Take 1 or 2 drinks several times a week	27.7	21.7	68.4	59.0	3.9	19.4
Take 5 or more drinks once/twice a weekend	14.5	15.3	81.0	63.7	4.4	21.0
Take amphetamines once/twice	4.7	11.6	89.5	66.0	5.8	21.5
Take amphetamines occasionally	3.2	12.2	90.5	66.1	6.3	21.7
Take heroin once/twice	1.2	9.8	88.9	68.7	9.7	21.5
Take heroin occasionally	1.2	9.3	89.3	68.6	9.4	22.2
Take mandrax once/twice	2.1	10.1	62.5	66.9	35.3	23.0
Take mandrax occasionally	1.3	10.4	63.7	66.5	35.0	23.1
Take hallucinogens once/twice	2.6	10.4	79.4	65.2	18.0	24.4
Take hallucinogens occasionally	2.5	10.8	79.4	65.5	18.0	23.8
Total N	617	617	617	617	617	617

Table 43. Respondents in the Youth KAP Surveys of 2003 in Wat Chaiyaprukmal and Sulaw Jorakaekob reporting selected patterns of youth psychoactive substance use as entailing a moderate/great risk (percentages)

Patterns of psychoactive substance use	Wat Chaiyaprukmal			Sulaw Jorakaekob		
	No/slight risk	Moderate/great risk	Don't know	No/slight risk	Moderate/great risk	Don't know
Smoke 10 or more cigarettes a day	18.8	59.1	22.1	7.2	77.6	15.2
Take marijuana/hashish occasionally	17.5	58.0	24.5	6.7	75.3	18.0
Take marijuana/hashish regularly	14.8	61.7	23.5	2.8	80.7	16.5
Take cocaine once/twice	16.2	58.0	25.8	6.3	76.0	17.7
Take cocaine occasionally	14.8	58.4	26.8	6.9	74.7	18.4
Take 1 or 2 drinks several times a week	28.8	47.7	23.5	14.9	69.6	15.5
Take 5 or more drinks once/twice a weekend	24.2	50.3	25.5	7.0	76.2	16.8
Take amphetamines once/twice	19.4	55.1	25.5	4.1	78.2	17.7
Take amphetamines occasionally	19.5	54.7	25.8	5.4	76.9	17.7
Take heroin once/twice	15.7	58.1	26.2	4.1	78.8	17.1
Take heroin occasionally	14.4	59.1	26.5	4.5	77.5	18.0
Take mandrax once/twice	15.4	54.7	29.9	5.0	78.5	16.5
Take mandrax occasionally	15.8	54.7	29.5	5.4	77.5	17.1
Take hallucinogens once/twice	16.4	57.1	26.5	4.7	72.8	22.5
Take hallucinogens occasionally	17.1	58.1	24.8	4.7	72.5	22.8
Total N	298	298	298	316	316	316

Table 44. Respondents in the Youth KAP Surveys of 2001 and 2003 in the evaluation sites as a whole (dis)approving of selected patterns of youth psychoactive substance use (percentages)

Patterns of psychoactive substance use	Approval		(Strong) disapproval		Don't know	
	2001	2003	2001	2003	2001	2003
Smoke 10 or more cigarettes a day	33.3	22.6	61.1	50.3	5.5	27.0
Take marijuana/hashish occasionally	8.4	11.2	84.4	62.1	7.1	26.7
Take marijuana/hashish regularly	4.8	6.7	87.7	68.4	7.5	24.9
Take cocaine once/twice	2.1	6.5	83.2	66.9	14.7	26.6
Take cocaine occasionally	5.0	2.8	80.7	70.9	14.3	26.4
Take 1 or 2 drinks several times a week	42.6	24.3	52.9	52.6	4.5	23.1
Take 5 or more drinks once/twice a weekend	33.2	19.1	62.1	57.7	4.7	23.3
Take amphetamines once/twice	6.5	8.6	89.1	66.6	4.4	24.8
Take amphetamines occasionally	5.4	9.3	90.3	66.5	4.4	24.3
Take heroin once/twice	2.0	5.9	91.0	70.0	7.1	24.1
Take heroin occasionally	1.8	6.4	90.4	69.2	7.8	24.4
Take mandrax once/twice	2.5	5.2	73.6	68.7	24.0	26.1
Take mandrax occasionally	2.2	5.5	73.2	68.4	24.5	26.1
Take hallucinogens once/twice	4.4	7.8	81.2	67.4	14.4	24.8
Take hallucinogens occasionally	3.8	6.8	81.5	68.2	14.7	24.9
Total N	617	614	617	614	617	614

Table 45. Respondents in the Youth KAP Surveys of 2003 in Wat Chaiyaprukmal and Sulaw Jorakaekob (dis)approving of selected patterns of youth psychoactive substance use (percentages)

Patterns of psychoactive substance use	Wat Chaiyaprukmal			Sulaw Jorakaekob		
	Approval	(Strong) disapproval	Don't know	Approval	(Strong) disapproval	Don't know
Smoke 10 or more cigarettes a day	23.4	43.0	33.6	21.8	57.3	20.9
Take marijuana/hashish occasionally	14.2	52.6	33.2	8.5	70.9	20.6
Take marijuana/hashish regularly	9.8	58.0	32.2	3.9	78.1	18.0
Take cocaine once/twice	9.4	56.0	34.6	3.8	77.2	19.0
Take cocaine occasionally	1.4	64.7	33.9	4.1	76.6	19.3
Take 1 or 2 drinks several times a week	34.9	36.9	28.2	14.2	67.4	18.4
Take 5 or more drinks once/twice a weekend	28.2	41.3	30.5	10.4	73.1	16.5
Take amphetamines once/twice	12.4	55.0	32.6	5.0	77.6	17.4
Take amphetamines occasionally	13.1	55.4	31.5	5.7	76.9	17.4
Take heroin once/twice	8.4	60.1	31.5	3.5	79.4	17.1
Take heroin occasionally	9.1	59.0	31.9	3.8	78.8	17.4
Take mandrax once/twice	7.7	58.7	33.6	2.8	78.2	19.0
Take mandrax occasionally	8.3	58.1	33.6	2.9	78.1	19.0
Take hallucinogens once/twice	10.0	57.4	32.6	5.7	76.9	17.4
Take hallucinogens occasionally	9.0	58.4	32.6	4.8	77.5	17.7
Total N	298	298	298	316	316	316

Table 46. Respondents in the Youth KAP Surveys of 2001 and 2003 in Wat Chaiyaprukmalā and Sulaw Jorakaekob reporting the use of illicit psychoactive substances during particular periods in time (percentages)

Illicit psychoactive substance use	Wat Chaiyaprukmalā		Sulaw Jorakaekob	
	2001	2003	2001	2003
Alcohol				
Lifetime use	5.5	11.7	5.5	11.7
Past 12 months' use	2.9	9.8	2.9	9.8
Past 30 days' use	1.3	6.0	1.3	6.0
Tobacco				
Lifetime use	22.4	15.4	8.7	17.4
Past 12 months' use	18.5	12.4	7.1	15.2
Past 30 days' use	14.3	7.4	6.5	12.3
Marijuana/hashish				
Lifetime use	2.3	2.3	1.0	2.2
Past 12 months' use	1.0	2.0	-	0.9
Past 30 days' use	-	0.7	-	-
Heroin				
Lifetime use	-	1.0	-	-
Past 12 months' use	-	1.0	-	-
Past 30 days' use	-	0.3	-	-
Designer psychoactive substances (e.g. Ecstasy)				
Lifetime use	-	1.0	-	-
Past 12 months' use	-	1.0	-	-
Past 30 days' use	-	0.3	-	-
Mandrax				
Lifetime use	-	1.0	-	-
Past 12 months' use	-	1.0	-	-
Past 30 days' use	-	1.0	-	-
Inhalants				
Lifetime use	-	1.7	1.6	3.5
Past 12 months' use	-	1.0	-	2.2
Past 30 days' use	-	0.7	-	1.3
Hallucinogens				
Lifetime use	0.1	1.0	-	0.3
Past 12 months' use	-	1.0	-	-
Past 30 days' use	-	0.3	-	-
Amphetamines				
Lifetime use	1.6	1.3	2.6	2.2
Past 12 months' use	1.0	1.3	1.0	1.3
Past 30 days' use	0.3	1.0	0.6	0.3
Painkillers				
Lifetime use	69.5	42.6	86.4	59.5
Past 12 months' use	53.6	39.9	67.6	54.1
Past 30 days' use	28.9	19.1	32.7	34.5
Tranquillizers				
Lifetime use	0.6	2.7	-	0.3
Past 12 months' use	0.6	2.7	-	0.3
Past 30 days' use	0.6	1.7	-	0.3
Hypnotics and sedatives				
Lifetime use	4.5	3.7	7.1	1.6
Past 12 months' use	3.9	3.0	4.2	0.9
Past 30 days' use	1.6	2.0	2.3	1.6
Total N	308	298	309	316

Table 47. Respondents in the Youth KAP Surveys of 2001 and 2003 in Wat Chaiyaprukmalā and Sulaw Jorakaekob reporting consequences experienced with regard to past 12 months' use of psychoactive substances (percentages)

Consequences of psychoactive substance use	Wat Chaiyaprukmalā		Sulaw Jorakaekob	
	2001	2003	2001	2003
Unable to stop drinking after having started drinking	4.2	6.4	-	2.5
Failed to do what was normally expected	4.2	6.4	-	0.9
Need a drink first thing in the morning	2.6	3.0	-	0.6
Experience feelings of guilt related to drinking	5.5	5.0	0.6	2.8
Unable to remember what happened when drinking the night before	2.6	4.4	-	0.9
Injured as a result of drinking	4.2	5.4	0.6	1.6
Many people have suggested cutting down on drinking	7.5	8.4	0.3	5.4
Being absent from work or having poor work performance because of psychoactive substance use	3.6	3.7	-	2.2
Being absent, suspended or expelled from school or performing poorly at school because of psychoactive substance use	2.6	3.7	-	1.6
Driving a motor vehicle under the influence of alcohol or other psychoactive substances	1.0	3.0	-	0.6
Operating a machine under the influence of alcohol or other psychoactive substances	1.0	2.3	-	0.6
Being arrested for disorderly conduct because of psychoactive substance use	0.6	2.0	0.3	1.3
Having physical fights or arguments with family/relatives/friends as a consequence of psychoactive substance use	1.3	2.3	0.3	2.2
Total N	308	298	309	316

Table 47 shows that reported experiences of negative psychoactive substance use-related consequences increased somewhat in both sites. In Wat Chaiyaprukmalā 2.6%–7.5% reported drinking-related consequences in 2001 and 3.0%–8.4% in 2003; and 0.6%–3.6% in 2001 and 2.0%–3.7% in 2003 admitted experiencing negative consequences related to other psychoactive substances. In Sulaw Jorakaekob 0.3%–0.6% reported drinking-related consequences in 2001 and 0.9%–5.4% in 2003; and 0.3% in 2001 and 0.6%–2.2% in 2003 admitted experiencing negative consequences related to other psychoactive substances.

Key informants in the Global Initiative pre- and post-project situation assessments also mentioned that young people who used licit psychoactive substances such as alcohol, who engaged in early sexual activity, who had limited supervision and lived in communities/groups where members were socially poorly integrated and who had limited access to social services, were particularly at risk of psychoactive substance use. These risks applied to Wat Chaiyaprukmalā rather than to Sulaw Jorakaekob.

4.4 CONCLUSION

The Global Initiative project in the evaluation sites in Thailand should be seen against the backdrop of the **broad socioeconomic situation**—“pressures” towards as well as against psychoactive substance use. For example, although poverty was widespread in both sites, most households had access to essential amenities, especially in Wat

Chaiyaprukmalā. Whereas the use of licit psychoactive substances was traditionally widely accepted in Thai society, the use of illicit psychoactive substances was frowned upon. In contrast, in the Sulaw Jorakaekob community the use of licit as well as illicit psychoactive substances was prohibited on religious grounds. Moreover, during the intervention period, the Thai Government engaged in curbing psychoactive substance use/trafficking and soliciting support from civil society in this respect.

Comparison of the pre- and post-project situation assessments (as summarized in Table 48) revealed that **behaviour and attitude** generally changed as anticipated, although unevenly across the sites and issues concerned. For example, the pre- and post-project Youth KAP Surveys showed that over the intervention period most of the **young people** in the evaluation sites—especially in Sulaw Jorakaekob—remained inclined (1) to state that youth psychoactive substance use entailed a moderate/great risk (especially illicit psychoactive substance use but excluding alcohol use); and (2) to (strongly) disapprove of such use (except youth use of alcohol/tobacco in Wat Chaiyaprukmalā). Reports of the non-medical use of painkillers declined markedly among young people in both sites, except for past 30 days' use in Sulaw Jorakaekob. Although reported use of tobacco and alcohol increased in Sulaw Jorakaekob, and alcohol use in Wat Chaiyaprukmalā, these increases could (partly) have been manifestations of the differences between the age composition of the pre-project and post-project survey samples in each site. In both sites the level of reported use of illicit psychoactive substances remained low over the intervention

Table 48. Summary of key attitudinal and behavioural changes over the intervention period in the evaluation sites in Thailand

Data collection method	Wat Chaiyaprukmalā		Sulaw Jorakakob	
	Psychoactive substance use-related attitudes	Psychoactive substance use	Psychoactive substance use-related attitudes	Psychoactive substance use
Youth KAP Survey	<ul style="list-style-type: none"> • Decreased sense of the riskiness of youth psychoactive substance use (63%-91% in 2001 and 59%-72% in 2003 indicated youth psychoactive substance use as entailing a moderate/great risk (Table 42))* • Decrease in (strong) disapproval of youth psychoactive substance use (53%-91% in 2001 and 50%-71% in 2003 (strongly) disapproved of youth psychoactive substance use (Table 44))* 	<ul style="list-style-type: none"> • Increase in alcohol use (lifetime use of alcohol rose from 6% to 12% (Table 46)) • Decrease in tobacco use (lifetime use decreased from 22% to 15% (Table 46)) • Decrease in non-medical use of painkillers (lifetime use decreased from 70% to 43% (Table 46)) • No marked changes in illicit psychoactive substance use, with the level of use remaining low, i.e. below 3% (Table 46) 	<ul style="list-style-type: none"> • Decreased sense of the riskiness of youth psychoactive substance use (63%-91% in 2001 and 59%-72% in 2003 indicated youth psychoactive substance use as entailing a moderate/great risk (Table 42))* • Decrease in (strong) disapproval of youth psychoactive substance use (53%-91% in 2001 and 50%-71% in 2003 (strongly) disapproved of youth psychoactive substance use (Table 44))* 	<ul style="list-style-type: none"> • Increase in the use of alcohol (lifetime use increased from 6% to 12%) and tobacco (lifetime use increased from 9% to 17%) • Decrease in the non-medical use of painkillers (lifetime use decreased from 86% to 60% (Table 46)) • No marked changes in illicit psychoactive substance use; marijuana use increased somewhat (e.g. lifetime use from 1% to 2%); and the overall level of use remained low (i.e. below 3% (Table 46))
Adult KAP Survey	<ul style="list-style-type: none"> • Increased sense of the riskiness of psychoactive substance use (e.g. 65%-92% in 2001 and 82%-88% in 2003 indicated youth psychoactive substance use as entailing a moderate or great risk (Table 38))* • Increase in (strong) disapproval of psychoactive substance use among young people (e.g. 7%-84% in 2001 and 73%-90% in 2003 (strongly) disapproved of youth psychoactive substance use (Table 39))* 	<ul style="list-style-type: none"> • No marked change in the level of psychoactive substance use, except a decrease in alcohol use (lifetime use decreased from 68% to 58%) and in non-medical use of painkillers (lifetime use decreased from 75% to 45%) (Table 40) 	<ul style="list-style-type: none"> • Increased sense of the riskiness of psychoactive substance use (e.g. between 65% and 92% in 2001 and between 82% and 88% in 2003 indicated youth psychoactive substance use as entailing a moderate/great risk (Table 38))* • Increase in (strong) disapproval of psychoactive substance use among young people (e.g. 7%-84% in 2001 and 73%-90% in 2003 (strongly) disapproved of youth psychoactive substance use (Table 39))* 	<ul style="list-style-type: none"> • No marked change in the level of psychoactive substance use, except a decrease in alcohol use (lifetime use decreased from 13% to 11%), amphetamine use (lifetime use decreased from 4% to 2%), and non-medical use of painkillers (from 84% to 74%) (Table 40)
Focus groups, in-depth interviews and key informant interviews	No information available	No information available	No information available	No information available

period, i.e. below 3.0%. The range of illicit psychoactive substances young people admitted using remained smaller in Sulaw Jorakaekob than in Wat Chaiyaprukmal, and reported experiences of negative psychoactive substance use-related consequences among young people remained reasonably low (i.e. below 8.5% in Wat Chaiyaprukmal and below 5.5% in Sulaw Jorakaekob).

The pre- and post-project Adult KAP Surveys also pointed to positive developments among **adults** in the evaluation sites. For example, most of the surveyed adults remained inclined to indicate psychoactive substance use as entailing a moderate/great risk and to (strongly) disapprove of such use. In some respects, adults became more willing to state that psychoactive substance use entailed a moderate/great risk, e.g. in the case of people in general using alcohol, cocaine and mandrax. In general, larger proportions of adults (strongly) disapproved of young people using psychoactive substances in the post-project than in the pre-project Adult KAP Survey. The level of psychoactive substance use among adults remained also more or less the same in the two sites, except for the non-medical use of painkillers, which declined markedly in especially Wat Chaiyaprukmal.

Another positive development was that reported lifetime use of alcohol lowered substantially (from 68.2% to 58.4%) among adults in Wat Chaiyaprukmal. The overall level of illicit psychoactive substance use reported by adults in the two sites remained small (4.0% and lower for lifetime use), except for reported lifetime use of marijuana/hashish in Wat Chaiyaprukmal, which declined somewhat (from 14.9% to 11.9%). Reports of experiences of unfavourable consequences related to psychoactive substance use remained reasonably low in especially Sulaw Jorakaekob (i.e. below 4.0%).

The local Global Initiative partners' evaluations of their **prevention activities** showed that they widely mobilized local prevention resources/initiatives towards greater collaboration and stronger action, especially in Wat Chaiyaprukmal. In fact, the partners' evaluations showed that their Global Initiative activities proceeded as planned and achieved the expected outcomes, e.g. information distribution, prevention education/training, involvement of young people in constructive recreational/skills development activities, and the strengthening of collaboration among community members on the prevention of psychoactive substance use and related problems.

Project outcome in the evaluation sites in the Republic of South Africa

5.1 INTRODUCTION

This chapter discusses key findings of the overall evaluation of the outcome of the Global Initiative in respectively an urban community, Greater Pretoria, which is part of what is currently known as Tshwane, and a neighbourhood within the rural town of Warmbaths, which is currently known as Bela-Bela. (For practical purposes, the rural site will henceforth be referred to as Bela-Bela.) Greater Pretoria is situated about 60 km north of Johannesburg, the capital of the Gauteng province. This province is in the northern part of South Africa, surrounded by various other provinces, and has the second largest population (7 348 423 according to 1996 census figures) although it is the smallest province (17 010 km²). Bela-Bela is situated about 100 km north of Greater Pretoria in the most northern province in South Africa, the Limpopo province, which has a population of about half that of Gauteng (4 929 368). Bela-Bela is close to a key national road running from Cape Town in the south to the northern border town of Musina.

The chapter describes the main sociodemographic characteristics, broad socioeconomic developments as well as the main characteristics and preventive activities of the agencies selected as the local Global Initiative partners in the evaluation sites. It then compares the key results of the pre- and post-project situation assessments in these sites, and concludes with an integrated summary (e.g. in tabulated format) of the key findings of the overall evaluation of the outcome of the Global Initiative in South Africa.

5.2 EVALUATION SITES, LOCAL PARTNERS, PREVENTIVE ACTIVITIES AND BROAD SOCIOECONOMIC DEVELOPMENTS

Table 49 shows that the evaluation sites were demographically largely similar, except for the much larger population in the urban site (Greater Pretoria) and the larger percentage of persons below 15 years of age in the rural site (Bela-Bela).

Table 49. Demographic features of the project sites (2001 figures) (percentages)

Variable	Bela-Bela	Greater Pretoria
Gender		
Males	48.0	50.0
Females	52.0	50.0
Age		
9 years or younger	24.8	18.0
10-14 years	12.2	8.0
15-64 years	59.0	69.0
64 years or older	4.0	5.0
Mean age of the population (years)	29.2	33.1
Total population (N)	23 537	1 243 590

Table 50. Description of local partners and the nature and outcome of their preventive activities

Bela-Bela	Greater Pretoria
<p>Local partner The local partner was the Youth For Christ (YFC).</p> <p>Problem Psychoactive substances use was largely characterized by the use of licit psychoactive substances such as alcohol, tobacco and particularly the non-medical use of painkillers, and to a lesser extent by the use of inhalants and marijuana. Young people tended to be (in)directly encouraged to use psychoactive substances by significant others such as parents or guardians, teachers, friends, employers/traders. Parents, for example, sent their children to traders to buy alcohol/tobacco. Psychological and social needs such as coping with unpleasantness, having fun/getting “high”, sociability and fashionableness contributed towards initiation into and maintenance of psychoactive substance use. The risks of psychoactive substance use and the need for prevention action were widely recognized among community leaders. Although community leaders were willing to mobilize prevention action, they faced various constraints. For example, the issue of psychoactive substance use and related problems was not openly discussed among community members (e.g. for cultural reasons); and health issues such as the prevention of HIV/AIDS and economic empowerment initiatives received priority from funding agencies and existing service providers. Interaction between community programmes/ service providers was largely absent, including concerted community action, though to a lesser extent on international awareness days. The community lacked psychoactive substance use-related prevention/treatment services and service providers with the required knowledge/skills.</p> <p>Aim The project’s main aim was to recruit/train core peer support groups in the local high school in Bela-Bela. The trained groups were then to recruit/train similar groups. Support groups were to receive training in raising awareness among learners and the wider school community as well as the general public on the risks of psychoactive substance use (e.g. regarding the contraction of HIV/AIDS). They were also to support learners towards developing constructive life skills and preventing psychoactive substance use.</p> <p>Preventive activities After officially gaining access to authorities and consequently to learners in a local high school and explaining the project, volunteer trainees were recruited. This group was trained over a weekend at an outdoor camp in conducting workshops for learners/young people on life skills development, giving special attention to psychoactive substance use and related problems such as HIV/AIDS, sexuality, peer pressure, and ways in which traders lure young people into trading/using psychoactive substances. Workshop participants were also trained in supporting peers experiencing psychoactive substance use-related difficulties; in raising awareness in the school and wider community about the risks of psychoactive substance use; and in prevention action. The core group of trained young people then recruited and trained the Active Youth Committee in their school. A YFC worker supported the committee, e.g. through periodically and interactively assessing progress and writing progress reports. The committee members took responsibility for training more trainers in life skills development, and for increasing support in the community.</p> <p>Project leaders’ evaluation of project delivery/outcome Evaluation of the project activities through the administration of questionnaires to participants and related agents as well as unstructured interviews with selected participants/informants revealed that the project proceeded as planned and yielded the expected fruit. In fact, awareness about the risks of psychoactive substance use and about the need for prevention action spread to not only young people but also key community agencies such as local educational authorities (e.g. school principals and teachers, and the provincial Department of Education’s local representative) and the municipal authorities (e.g. local mayor). Various agencies formally committed themselves to support psychoactive substance use-related preventive activities, e.g. local businesses offered financial support/equipment. The training was well received by the recruits. In fact, they expressed a better understanding of the effects of psychoactive substance use. Some recruits decided to abstain from substance use on account of what they had learnt. The trained young people also indicated that they felt capable of encouraging their peers towards a life free of psychoactive substance use, but somewhat less confident of their ability to act as counsellors because of, for example, the few referral resources in the community and the fact that some young people perceived them as a potential threat because of their association with agents such as teachers and police officers. The recruits also indicated that they found it difficult to solicit support among families/young people who made a living through trading psychoactive substances. A number of prevention initiatives emerged during the intervention period. For example, the group “Light of Africa” started with life skills development programmes and training in peer support to young people/families experiencing psychoactive substance use-related problems. A church called “Power House” introduced faith-based counselling and referral. The local radio station introduced weekly professional programmes on psychoactive substance use-related prevention.</p>	<p>Local partner The Psychology Department of the University of Pretoria (UP) and Youth For Christ (YFC) jointly acted as local Global Initiative partner.</p> <p>Problem The use of licit psychoactive substances was part of the day-to-day activities in the community. The range of illicit psychoactive substances available and used in the community was increasing. Marijuana was the most commonly used illicit psychoactive substance. The use of mandrax, cocaine and heroin was also fairly common, especially in the more affluent neighbourhoods. Various individual and group factors (e.g. a need to have fun, to feel “high”, to feel confident, to be sociable; and (in)direct pressure from peers and/or other significant others to use psychoactive substances) as well as environmental conditions such as poverty, unemployment and organized crime networks contributed to the onset and maintenance of psychoactive substance use.</p> <p>The risks of psychoactive substance use were well recognized and discussed among community leaders, especially in the formal sectors. Potential for sustained and effective psychoactive substance use-related prevention/treatment was facilitated by the numerous existing and well-established (non-) specialized services in this respect. Existing psychoactive substance use-related service providers were actively improving service outreach. Although psychoactive substance use-related service providers interacted routinely, strong competition for turf complicated concerted action.</p> <p>Aim The project had three main objectives. The first objective was to identify and train young peer supporters in at least eight schools to raise awareness about the risks of psychoactive substance use; and assist young people towards abstaining from psychoactive substance use. The second objective was to solicit wide support within the school community (e.g. principals, teachers, learners) and active participation in project planning/execution, thus creating a generally supportive climate for the project. The third objective was to negotiate networking between the school authorities and other service providers in the community, e.g. provincial educational authorities and youth groups.</p> <p>Preventive activities A core group of youth leaders were recruited and trained to prevent psychoactive substance use, support their peers constructively and facilitate constructive life skills development. The agreed responsibilities of the peer supporters were to (1) identify and constructively support young people/learners who experienced psychosocial problems; (2) refer young people/learners in need to relevant service providers; (3) effectively communicate the risks of psychoactive substance use to young people and significant others in the community; and (4) act as a communication channel between young people/learners, school authorities and other service providers. Various information seminars on the nature and risks of psychoactive substance use were conducted by the core project team members, including trained peer support groups, for learners, parents and teachers in the schools targeted. Progress was assessed on a weekly basis to facilitate timely adjustments.</p> <p>Project leaders’ evaluation of project delivery/outcome Evaluation of the project activities through the administration of questionnaires to participants and related agents as well as in-depth and focus group interviews with selected participants/informants revealed that the project proceeded as planned and rendered the expected results. For example, the project activities assisted in the personal growth, development of self-esteem and communication skills of the peer supporters. The trained peer support workers also indicated that they had acquired more detailed information about psychoactive substance use-related issues, and had become more acutely aware of the need for prevention action. Teachers were positive about the programme, but reticent to be involved to a greater extent, e.g. because of limited free time. However, a generally positive attitude towards the peer support system emerged among the relevant school authorities. Project leaders, for example, reported that teachers developed an appreciation of, and indeed trust in, the trained peer supporters’ abilities to contribute towards the prevention of psychoactive substance use-related problems among young people/learners. The strong and positive relationship forged between the project leaders, the trained peer supporters and the relevant school authorities was also expected to contribute towards the continuation and expansion of the relevant projects. Indeed, authorities at all the participating schools pledged support towards the continuation and expansion of the peer support system. The peer supporters, however, faced various challenges. For example, some peer supporters found the work too burdensome at times. Reluctance on the part of some parents to admit their children experienced problems also complicated matters. Some teachers were skeptical about the peer supporters’ ability to offer anything meaningful and/or expected the peer supporters to divulge the personal information they had obtained from the learners.</p>

Various geographical conditions and **broad socio-economic developments** in **South Africa** generally, and in the evaluation sites in particular, impinged on and complicated the prevention of psychoactive substance use and related problems in these sites. For example, South Africa's geographical position made it an ideal route for psychoactive substances originating from Asia, the Middle East and Western Europe. As a consequence, almost all psychoactive substances were available in South Africa and their use was spreading (United Nations Office on Drugs and Crime 2002; Rocha-Silva 1998). Moreover, the use of psychoactive substances among young people, which used to be largely an urban phenomenon occurring among mostly historically advantaged young people, was progressively spreading to rural areas and disadvantaged young people. A large youth component and limited employment opportunities facilitated the recruitment of young people into trading in illicit psychoactive substances in urban as well as rural areas. In fact, the age group 10-24 years comprised 32.0% of the total population, and the unemployment rate among 15-56 year olds was estimated to be at least 24.0% (Statistics South Africa 2003). Technical and financial resources for preventing psychoactive substance use and related problems were limited because of the considerable health, safety and security, and economic challenges facing South Africa (Da Rocha Silva 2004; United Nations Office on Drugs and Crime 2002; Bradshaw, Matsiteng & Nannan 2001). Although South Africa's gross domestic product (GDP) positioned it as a middle-income country, it masked the large difference between rich and poor. In fact, South Africa had a higher (0.5) income inequality measure (using the Gini Coefficient and 1996 figures) than middle-income countries such as Poland (0.27), Thailand (0.46) and Malaysia (0.48) (Poverty and inequality in South Africa 1998). The level of crime, especially violent crime (murder, rape, assault), has been increasing over the past two decades, including the operation of organized crime syndicates (United Nations Office on Drugs and Crime 2002; Department for Safety and Security 1998).

The **evaluation sites** experienced various broad socio-economic burdens (World Health Organization 2003a). In the rural site, poverty was widespread and intense; basic services such as medical and police facilities were lacking; and dwellings were mostly informal structures. In contrast, the urban site, Greater Pretoria, was well-serviced in terms of basic services, but to a lesser extent in a few historically disadvantaged districts. Greater Pretoria, however, tended to have higher rates of overall crime, driving under the influence of psychoactive substances, and arrests for possession of and trading in illicit psychoactive substances than Bela-Bela. There were more liquor trade outlets per square kilometer in Bela-Bela (2.75 outlets per km²) than in Greater Pretoria (0.7 outlets per km²). Trafficking in illicit psychoactive substances was increasing in Bela-Bela through cross-border truck drivers and holidaymakers. Although key community leaders in both sites expressed willingness

to mobilize/strengthen psychoactive substance use-related prevention action, institutional constraints—e.g. strong competition between service providers in the urban site and a lack of service providers/programmes in the rural site—complicated matters (Table 50).

Table 50 identifies the local partners in the **Global Initiative** in the evaluation sites, and provides an overview of their **preventive activities**. The table shows that the local partners focused on mobilizing peer support prevention programmes among young people, using schools as a starting point. A special attempt was also made to increase/strengthen networking between stakeholder agencies and increase awareness about the risks of psychoactive substance use within the wider community. The projects generally proceeded as planned and yielded the expected outcomes. For example, in the rural community, key agents such as local businesses and the town's mayor pledged support for psychoactive substance use-related prevention action, and various new initiatives in this respect emerged within civil society. In the urban community, the project managed to strengthen existing interaction/relationships between prevention agents and solicit strong support for the maintenance and expansion of the peer support group initiative among school authorities, even though peer supporters faced various challenges. For example, some peer supporters found the work too burdensome at times; reluctance on the part of some parents to admit their children experienced problems complicated the rendering of support; and some teachers were skeptical about the programme.

5.3 COMPARISON OF THE PRE- AND POST-PROJECT KAP SURVEY RESULTS

This section compares key results of the pre- (2001) and post-project (2003) KAP Surveys in the evaluation sites. It is important to note that the relatively small samples—especially in the Adult KAP Surveys—complicated the interpretation of the survey results, indeed comparison of the questionnaire responses in the pre- and post-project KAP Surveys.

5.3.1 DEMOGRAPHIC PROFILE OF RESPONDENTS

Table 51 shows that in Bela-Bela (rural site) the pre- and post-project KAP Survey samples were demographically largely similar. That is, females were in the majority (especially in the Adult KAP Surveys); the single largest proportions of the respondents in the Adult KAP Surveys were unemployed at the time of the surveys; by far the majority of the respondents in the Youth KAP Surveys were attending school at the time of the surveys; and most of the young people in the Youth KAP Survey samples were in the 10-19 years age group, with more or less equal proportions (especially in the 2003 survey) in the 10-14 years and 15-19 years

age groups. In Greater Pretoria (urban site), females were in the majority in the Adult KAP Survey samples, whereas males and females were more or less evenly distributed in the 2001 Youth KAP Survey sample and males were in the majority in the 2003 sample.

5.3.2 PSYCHOACTIVE SUBSTANCE USE-RELATED ATTITUDES AND PRACTICES AMONG ADULTS AND YOUNG PEOPLE

Table 52 presents the views of the respondents in the 2001 and 2003 **Adult KAP Surveys** as to whether selected patterns of psychoactive substance use among respectively people in general and young people in particular entailed a **great risk**. The table shows that in **Bela-Bela** the respondents in the post-project survey were more inclined than their counterparts in the pre-project survey to assign a great risk to the patterns of psychoactive substance use listed in the survey questionnaire, especially in the case of licit psychoactive substance use. For example, 24.0% of the respondents in 2001 indicated that people in general who “smoked 10 or more cigarettes a day” exposed themselves to a great risk, and 73.0% did so in 2003; the related percentages for “taking 1 or 2 drinks several times a week” were 24.0% in 2001 and 62.0% in 2003. Furthermore, 18.0% of the respondents in 2001 and 65.0% in 2003 stated that people in general who “took 5 or more drinks once or twice over a weekend” were exposed to a great risk. Between 46.0% and 85.0% of the respondents in 2001 and between 89.0% and 96.0% in 2003 assigned a great risk to illicit psychoactive substance use among people in general. Regarding licit psychoactive substance use among young people, between 43.0% and 49.0% of the respondents in the Adult KAP Survey in 2001, and between 74.0% and 86.0% in 2003 indicated such use as entailing a great risk. With regard to illicit psychoactive substance use among young people, between 67.0% and 91.0% of the respondents in 2001, and between 94.0% and 100.0% in 2003 assigned a great risk to “tak[ing] marijuana occasionally”.

With regard to **Greater Pretoria**, Table 52 shows that in 2001 as well as in 2003 the majority of the respondents in the Adult KAP Surveys generally indicated the listed patterns of psychoactive substance use as entailing a great risk, and in some instances became even more inclined to attach a great risk to psychoactive substance use. For example, 75.0% (taking 1 or 2 drinks several times a week) and more of the respondents in 2001 stated that youth use of psychoactive substances entailed a great risk; and in 2003 74.0% (taking 5 or more drinks once or twice over a weekend) and higher did the same. With regard to psychoactive substance use among people in general, 36.0% (taking 1 or 2 drinks several times a week) and more indicated in 2001 psychoactive substance use as entailing a great risk; and in 2003 62.0% (taking 1 or 2 drinks several times a week) and more did so.

Table 53 presents the extent to which respondents in the 2001 and 2003 Adult KAP Surveys **strongly disapproved**

of selected patterns of psychoactive substance use among respectively people in general and young people in particular. The table shows that in **Bela-Bela** the respondents were more inclined in 2003 than in 2001 to disapprove strongly of licit psychoactive substance use; and more or less similar proportions (the majority) in 2001 and 2003 expressed strong disapproval of illicit psychoactive substance use, except that larger proportions strongly disapproved of the use of marijuana in 2003 than in 2001. In **Greater Pretoria**, a less encouraging picture emerged over the intervention period. That is, the respondents tended to be less inclined in 2003 than in 2001 to express strong disapproval of psychoactive substance use, especially when people in general were the users, except in the case of “taking one or two drinks several times a week”. By far the majority of the respondents in the 2001 and 2003 Adult KAP Surveys strongly disapproved of psychoactive substance use among young people, though to a lesser extent in the case of the relevant patterns of alcohol use.

With regard to reports of **psychoactive substance use**, Table 54 shows that in **Bela-Bela** reports of psychoactive substance use were generally more common in the 2003 Adult KAP Surveys than in the related 2001 surveys, especially in respect of cider and at least with regard to usage in the 12 months before the respective surveys. In contrast, the prevalence of reported psychoactive substance use (past 12 months’ use) generally declined over the intervention period in **Greater Pretoria**, except that the level of reported use of tranquillizers remained constant (12.0%) and reported use of sedatives increased from 12.0% in 2001 to 18.0% in 2003.

Table 55 presents the extent to which the respondents in the **Youth KAP Surveys** reported **psychoactive substance use** at some time in their life (lifetime use) and in the 12 months before the respective surveys (past 12 months’ use). The table focuses on those substances that were most commonly reported. In Greater Pretoria, reported psychoactive substance use generally decreased. In Bela-Bela, a more complex pattern emerged. For example, (1) reported lifetime use of cigarettes and marijuana declined (from 19.0% to 9.2% for cigarettes and from 10.1% to zero for marijuana); so did past 12 months’ use; (2) reported lifetime use of wine (6.0% in 2001 and 9.2% in 2003) and painkillers (70.0% in 2001 and 74.3% in 2003) as well as past 12 months’ use of cider (16% in 2001 and 13.8% in 2003) remained more or less constant; (3) reported past 12 months’ use of wine decreased (from 6.0% to zero); and (4) reported past 12 months’ non-medical use of painkillers increased from 42.0% to 67.0% and lifetime use of cider from 17.0% to 25.7%.

Focus group and in-depth interviews with selected adults and young people in both sites pointed out that community members experienced various negative psychoactive substance use-related conditions, e.g. poor health and poor concentration on school/work, and crime. Interviewees, however, found it difficult to tell whether the level of occurrence of these conditions in their communities had changed over the intervention period.

Table 51. Demographic features of the respondents in the Youth and Adult KAP Surveys of 2001 and 2003 (percentages)

Variable	Bela-Bela				Greater Pretoria			
	Adults		Youth		Adults		Youth	
	2001	2003	2001	2003	2001	2003	2001	2003
Gender								
Males	30.0	25.0	41.0	42.0	45.00	45.0	51.0	54.0
Females	70.0	75.0	59.0	58.0	55.00	55.0	49.0	46.0
Employment/school attendance								
Full time	42.0	40.0	86.0	89.0	45.0	63.0	89.0	90.0
Part time	12.0	14.0	6.0	11.0	19.0	*	2.0	*
Unemployed/not a student	46.0	46.0	8.0	-	36.0	*	9.0	*
Age								
10-14 years	*	*	49.0	45.0	*	*	40.0	48.0
15-19 years	*	*	41.0	44.0	*	*	44.0	*
20-21 years	*	*	10.0	11.0	*	*	16.0	*
Mean age (years)	29.5	*	14.9	15.1	36.2	*	15.6	*
Total N	33	36	109	109	67	66	193	189

Table 52. Respondents in the Adult KAP Surveys of 2001 and 2003 reporting selected patterns of psychoactive substance use by people in general and young people as entailing a great risk (percentages)

Patterns of psychoactive substance use	Bela-Bela				Greater Pretoria			
	People in general		Young people		People in general		Young people	
	2001	2003	2001	2003	2001	2003	2001	2003
Smoke 10 or more cigarettes a day	24.0	73.0	47.0	86.0	66.0	73.0	90.0	86.0
Take marijuana/hashish occasionally	46.0	92.0	67.0	94.0	73.0	92.0	91.0	94.0
Take marijuana/hashish regularly	61.0	96.0	79.0	99.0	73.0	96.0	97.0	99.0
Take cocaine once/twice	79.0	89.0	91.0	96.0	98.0	89.0	97.0	96.0
Take cocaine occasionally	79.0	94.0	91.0	97.0	97.0	94.0	100.0	97.0
Take 1 or 2 drinks several times a week	24.0	62.0	43.0	76.0	36.0	62.0	75.0	76.0
Take 5 or more drinks once/twice a weekend	18.0	65.0	49.0	74.0	47.0	65.0	78.0	74.0
Take amphetamines once/twice	64.0	92.0	85.0	97.0	84.0	92.0	90.0	97.0
Take amphetamines occasionally	70.0	92.0	85.0	100.0	93.0	92.0	93.0	100.0
Take heroin once/twice	82.0	94.0	91.0	97.0	94.0	94.0	100.0	97.0
Take heroin occasionally	82.0	96.0	91.0	100.0	94.0	96.0	100.0	100.0
Take mandrax once/twice	82.0	94.0	88.0	100.0	97.0	94.0	100.0	99.0
Take mandrax occasionally	85.0	94.0	91.0	100.0	97.0	96.0	100.0	99.0
Total N	33	36	33	36	67	66	67	66

Table 53. Respondents in the Adult KAP Surveys of 2001 and 2003 strongly disapproving of selected patterns of psychoactive substance use by people in general and young people (percentages)

Patterns of psychoactive substance use	Bela-Bela				Greater Pretoria			
	People in general		Young people		People in general		Young people	
	2001	2003	2001	2003	2001	2003	2001	2003
Smoke 10 or more cigarettes a day	21.0	60.0	49.0	63.0	60.0	51.0	88.0	82.0
Take marijuana/hashish occasionally	30.0	80.0	64.0	80.0	75.0	72.0	88.0	89.0
Take marijuana/hashish regularly	70.0	83.0	70.0	80.0	88.0	71.0	96.0	91.0
Take cocaine once/twice	82.0	83.0	79.0	80.0	98.0	70.0	98.0	88.0
Take cocaine occasionally	82.0	82.0	76.0	80.0	98.0	73.0	100.0	89.0
Take 1 or 2 drinks several times a week	21.0	47.0	53.0	57.0	27.0	47.0	66.0	71.0
Take 5 or more drinks once/twice a weekend	18.0	47.0	46.0	61.0	43.0	42.0	76.0	70.0
Take amphetamines once/twice	64.0	69.0	79.0	78.0	79.0	65.0	91.0	86.0
Take amphetamines occasionally	73.0	69.0	79.0	78.0	82.0	68.0	90.0	88.0
Take heroin once/twice	73.0	75.0	79.0	78.0	95.0	70.0	97.0	88.0
Take heroin occasionally	73.0	78.0	79.0	78.0	97.0	71.0	100.0	89.0
Take mandrax once/twice	72.0	78.0	76.0	78.0	95.0	70.0	100.0	91.0
Take mandrax occasionally	72.0	78.0	76.0	78.0	95.0	71.0	98.0	92.0
Total N	33	36	33	36	67	66	67	66

Table 54. Respondents in the Adult KAP Surveys of 2001 and 2003 reporting the use of selected psychoactive substances in the 12 months before the respective surveys (percentages)*

Psychoactive substance use	Bela-Bela		Greater Pretoria	
	2001	2003	2001	2003
Tobacco generally	27.0	38.0	39.0	26.0
Cigarettes	15.0	26.0	25.0	22.0
Alcohol generally	33.0	46.0	67.0	55.0
Wine	15.0	28.0	50.0	45.0
Cider	9.0	46.0	43.0	40.0
Painkillers	45.0	79.0	72.0	68.0
Tranquillizers	3.0	10.0	12.0	12.0
Sedatives	3.0	9.0	12.0	18.0
Total N	33	36	67	66

* The table reflects only the most commonly reported psychoactive substances.

Table 55. Respondents in the Youth KAP Surveys of 2001 and 2003 reporting the use of selected psychoactive substances at particular periods in time (percentages)*

Psychoactive substance use	Bela-Bela										Greater Pretoria										
	All		Male		Female		10-14 years		15-21 years		All		Male		Female		10-14 years		15-21 years		
	2001	2003	2001	2003	2001	2003	2001	2003	2001	2003	2001	2003	2001	2003	2001	2003	2001	2003	2001	2003	
Cigarettes																					
Lifetime use	19.0	9.2	9.2	6.4	3.7	2.8	3.7	1.8	9.2	7.3	32.0	19.6	20.0	12.2	11.9	7.4	5.7	6.4	26.4	14.3	
Past 12 months' use	8.0	-	6.4	-	1.8	-	1.8	-	6.4	-	23.0	15.3	14.0	10.6	7.8	4.8	3.1	4.8	18.7	11.6	
Wine																					
Lifetime use	6.0	9.2	2.8	5.5	3.7	3.7	1.8	0.9	4.6	8.3	51.0	35.5	24.9	13.8	25.9	12.7	14.5	6.9	36.3	20.6	
Past 12 months' use	6.0	-	2.8	-	3.7	-	1.8	-	4.6	-	39.0	19.6	18.1	10.1	19.7	9.5	10.4	4.2	27.5	15.9	
Cider																					
Lifetime use	17.0	25.7	6.4	11.9	11.0	13.8	3.7	9.1	13.8	16.5	54.0	26.5	27.5	19.1	25.9	16.4	14.5	10.1	38.8	25.9	
Past 12 months' use	16.0	13.8	4.6	10.1	11.0	3.7	3.7	4.6	11.9	10.1	44.0	28.0	21.8	16.4	21.8	11.6	9.9	8.5	33.7	20.6	
Painkillers																					
Lifetime use	70.0	74.3	25.7	33.0	44.0	41.3	30.3	30.3	39.5	44.0	81.0	47.1	37.8	20.1	43.0	27.0	30.6	14.3	50.3	33.9	
Past 12 months' use	42.0	67.0	16.5	32.1	25.7	34.9	13.8	30.3	28.4	38.5	59.0	38.6	26.4	15.3	32.6	23.3	22.3	12.7	36.8	26.5	
Marijuana																					
Lifetime use	10.1	-	8.3	-	1.8	-	1.8	-	8.3	-	10.9	11.1	7.8	8.5	3.1	2.7	1.0	2.7	9.8	8.5	
Past 12 months' use	6.4	-	5.5	-	0.9	-	1.8	-	4.6	-	6.0	9.0	4.7	6.9	1.6	2.1	-	2.1	6.2	6.9	
Total N	109	109	109	109	109	109	109	109	109	109	193	189	193	189	193	189	193	189	193	189	

* The table reflects only the most commonly reported psychoactive substances.

5.4 CONCLUSION

The Global Initiative in the evaluation sites in South Africa took place against the backdrop of various broad socio-economic “pressures” towards psychoactive substance use, e.g. a large youth component, limited licit employment opportunities, organized crime networks trafficking in illicit psychoactive substances, and limited technical/financial resources for preventing psychoactive substance use. Comparison of the results (as summarized in Table 56) of the pre- and post-project surveys points to various attitudinal/behavioural changes over the intervention period. For example, in Bela-Bela (rural site), (1) reported psychoactive substance use declined among young people, supported by (2) an increased awareness of the risks of psychoactive substance use among their seniors, notwithstanding (3) an increase

in psychoactive substance use among the adults. In Greater Pretoria (urban site), psychoactive substance use among young people as well as their seniors decreased.

In short, the local Global Initiative partners’ evaluations of their preventive activities showed that they widely mobilized local prevention resources/initiatives towards greater collaboration and stronger action. Moreover, the psychoactive substance use-related information distributed during the intervention period spread to various sectors and translated into increased support of psychoactive substance use-related prevention action. The young trained peer supporters in both sites voiced a better understanding of psychoactive substance use-related issues, and in Bela-Bela some even decided to abstain from psychoactive substance use as a result of their training.

Table 56. RSummary of key attitudinal and behavioural changes over the intervention period in the evaluation sites in South Africa

Data collection method	Bela-Bela		Greater Pretoria	
	Psychoactive substance use-related attitudes	Psychoactive substance use	Psychoactive substance use-related attitudes	Psychoactive substance use
Youth KAP Survey	No information available	<ul style="list-style-type: none"> • Decrease in the use of cigarettes and marijuana (lifetime use of cigarettes decreased from 19% to 9% and lifetime use of marijuana from 10% to zero (Table 55)) • Some increase in lifetime use of wine and cider (from 6%-9% and 17%-26%) (Table 55); decrease in past 12 months' use of wine (from 6% to zero) and cider (from 16%-14%) (Table 55) • Increase in non-medical use of painkillers (lifetime use from 70% to 74% and past 12 months' use from 42% to 67% (Table 55)) 	No information available	<ul style="list-style-type: none"> • General decrease in psychoactive substance use, except in the case of marijuana use which remained largely constant (e.g. lifetime use of cigarettes decreased from 32% to 20%, wine from 51% to 36%, cider from 54% to 27% and painkillers from 81% to 47% (Table 55))
Adult KAP Survey	<ul style="list-style-type: none"> • Increased sense of the riskiness of psychoactive substance use (24%-85% in 2001 and 62%-94% in 2003 indicated psychoactive substance use among people in general as entailing a great risk; 43%-91% in 2001 and 74%-100% in 2003 indicated youth psychoactive substance use as entailing a great risk (Table 49)) • Increase in strong disapproval of psychoactive substance use (18%-82% in 2001 and 47%-83% in 2003 strongly disapproved of psychoactive substance use among people in general; 46%-79% in 2001 and 57%-80% in 2003 strongly disapproved of youth psychoactive substance use (Table 53)) 	<ul style="list-style-type: none"> • Increase in past 12 months' use of psychoactive substances (3%-45% in 2001 and 9%-79% in 2003 admitted use (Table 54)) 	<ul style="list-style-type: none"> • Increased sense of the riskiness of psychoactive substance use (36%-98% in 2001 and 62%-96% in 2003 stated that psychoactive substance use by people in general exposed them to a great risk (Table 52); by far the majority of respondents in 2001 and in 2003 indicated youth psychoactive substance use as entailing a great risk (Table 52)) • General decline in strong disapproval of psychoactive substance use (43%-98% in 2001 and 42%-72% in 2003 strongly disapproved of psychoactive substance use among people in general; 76%-100% in 2001 and 70%-92% in 2003 strongly disapproved of youth psychoactive use (Table 53)), except in the case of taking 1 or 2 drinks several times a week (27% in 2001 and 47% in 2003 strongly disapproved of such use among people in general; 66% in 2001 and 71% in 2003 strongly disapproved of such use among young people (Table 53)) 	<ul style="list-style-type: none"> • Some decrease in past 12 months' use of psychoactive substances (12%-72% in 2001 and 12%-68% in 2003 admitted use (Table 54)); increase in past 12 months' use of sedatives (from 12% to 18% (Table 54))
Focus groups, in-depth interviews and key informant interviews	No information available	Increase in psychoactive substance use and related problems	No information available	Increase in psychoactive substance use and related problems

Project outcome in the evaluation sites in the United Republic of Tanzania

6.1 INTRODUCTION

This chapter provides an overview of the key findings of the overall evaluation of the outcome of the Global Initiative in two urban communities in the United Republic of Tanzania, namely Old Stone Town and Kinondoni. Tanzania stretches over 945 000 km² and consists of mainland Tanzania and the Zanzibar islands, Unguja (1 500 km²) and Pemba (900 km²). Old Stone Town is a municipality on Unguja Island, and Kinondoni is one of three municipalities in Dar es Salaam in mainland Tanzania. Historically, these sites were part of two independent states—Kinondoni was part of the former Tanganyika on the mainland and Old Stone Town was part of the former Zanzibar Sultanate (the Zanzibar islands of Unguja and Pemba).

The chapter, more specifically, describes the main demographic features of the evaluation sites, as well as broad

socioeconomic developments and the preventive activities of the agencies selected as the local Global Initiative partners in these sites. It then compares the key results of the pre- and post-project situation assessments in the evaluation sites and concludes with an integrated summary (e.g. in tabulated format).

6.2 EVALUATION SITES, LOCAL PARTNERS, PREVENTIVE ACTIVITIES AND SOCIOECONOMIC DEVELOPMENTS

Projections for the year 2000 suggest that the evaluation sites were demographically largely similar, with more or less even proportions of males and females and a young rather than an old population (Table 57).

Table 57. Demographic features of the project sites (projections for the year 2000) (percentages)

Variable	Old Stone Town	Kinondoni
Gender		
Males	49.0	53.0
Females	51.0	47.0
Age		
≤14 years	48.2	46.8
15-64 years	49.0	49.0
64 years or older	2.8	4.2
Mean age of the population (years)	24.4	26.0
Total population (N)	*	621 389

* Data not available.

Table 58. Description of local partners and the nature and outcome of their preventive activities

Old Stone Town	Kinondoni
<p>Local partner</p> <p>The NGO, ZAIADA, was the local Global Initiative partner in Old Stone Town.</p> <p>Problem</p> <p>The most commonly used psychoactive substances used by young people were tobacco, alcohol, marijuana, sleeping pills, heroin and glue. Most psychoactive substance users were 13-35 years of age and male. Psychoactive substance use and related problems occurred among in- and out-of-school young people and started as early as 9-10 years. Community leaders recognized the importance of treatment/prevention, although options were limited. An advantage was that persons of the Muslim faith opposed psychoactive substance use, although they did not always know how to prevent it. A number of NGOs and other agencies were involved in psychoactive substance use-related prevention. These agencies included teachers, Youth Centre, the Mental Health Association, Chief Government Chemist, President's wife, the Ministry of Health and Social Welfare and the Office of the Chief Minister.</p> <p>Aims</p> <p>The main aims were to increase awareness of the risks of psychoactive substance use and prevention options among especially young people in and out of school, and facilitate/strengthen prevention action in the community.</p> <p>Preventive activities</p> <p>The project trained young peer supporters/educators and distributed information (e.g. via television, radio, theatre productions, peer-support group discussions and seminars/lectures) among young people and other key community members on the risks of psychoactive substance use and related issues (e.g. HIV/AIDS). A peer educators' guide was developed for the peer educators. An effort was made to mobilize NGOs and other community agencies (e.g. religious and political leaders) towards concerted psychoactive substance use prevention.</p> <p>Project leaders' evaluation of project delivery/outcome</p> <p>Participants' evaluation of the project showed that activities proceeded as planned and were well received. For example, 2 000 brochures and 1 000 posters were distributed, and nine radio programmes, a television drama and other educative television programmes were aired. As a result, various people sought assistance from ZAIADA. The brochures reached an estimated 43.3% of the literate young people in the community. Altogether 20 peer educators were trained and trainees reached about 6.0% of the young people in the community. Peer educators were acknowledged as accessible references among young people on problems related to psychoactive substance use, but indicated that they themselves needed more experience and confidence. Various agencies became more involved in psychoactive substance use-related prevention. Participants reported that the risks of psychoactive substance use were more widely and more freely discussed among community members. Although ZAIADA was committed to long-term follow-up, it stressed the need to solicit wide/sustained government support/leadership to ensure adequate action/collaboration in the community.</p>	<p>Local partner</p> <p>The Kinondoni Youth Centre (AMREF) was the Global Initiative partner in Kinondoni.</p> <p>Problem</p> <p>Alcohol, tobacco, marijuana (especially among young people), heroin (including injecting use) and sleeping pills were the most commonly used psychoactive substances. Alcohol was widely accepted as long as the users were male and above 18-20 years. Adults of the Muslim faith tended to be opposed to their children using alcohol. Despite parental opposition, many young boys were thought to use alcohol in the absence of their parents. The out-of-school and unemployed young people tended to use cheap traditional alcoholic beverages. The community generally frowned on the use of psychoactive substances by women, associating such use with promiscuity, prostitution and rebellion. Community leaders did not know how to deal with psychoactive substance use-related problems. It was also not easy to mobilize wide support for prevention action (including young peer-support groups), e.g. because some families survived on trafficking in psychoactive substances, and parents sometimes distrusted youth groups. The site lacked agencies specializing in psychoactive substance use-related treatment/prevention. Some agencies sporadically ran information campaigns on the risks of psychoactive substance use. These agencies included religious leaders, school authorities and NGOs like the Mental Health Association.</p> <p>Aim</p> <p>The aim of the project was to reduce substance use among young people through especially the distribution of reliable information on the risks of psychoactive substance use and training/education (e.g. young peer-support groups) in prevention action.</p> <p>Preventive activities</p> <p>Project activities included the following events: (1) a one-day sensitization seminar for (potential) prevention agents; (2) a one-week programme to train/educate young peer supporters/educators to raise awareness regarding the risks of psychoactive substance use; (3) edutainment activities with the goal of involving 15 000 young people; (4) ten-day training of youth theatre clubs in distributing messages on the risks of psychoactive substance use and prevention options; and (5) two-week training of young girls in constructive life skills.</p> <p>Project leaders' evaluation of project delivery/outcome</p> <p>An evaluation of the outcome of the project confirmed that awareness of the risks of substance use spread to various groups, e.g. the 84 community members who participated in the sensitization seminar, the 34 peer educators who were trained in life skills, the about 17 000 community members (young and old) who participated in different edutainment activities (e.g. games, sport events), and the estimated 14 000 people reached through the Umoja youth theatre club. The project was integrated into the main activities of the local partner. Participants in the activities noted that they had developed a better understanding of psychoactive substance use-related issues in the course of the project. Because of limited resources, project leaders still needed to solicit wide and sustained government support/leadership to ensure adequate prevention action at community level.</p>

Broad socioeconomic developments in the evaluation sites complicated psychoactive substance use-related prevention action, and contributed to a general sense of hopelessness among community members. More particularly, the sites had a fast-growing population and a disproportionately large youth labour force. For example, census figures showed that between 1992 and 2000 the proportion of 15-34 year olds in Old Stone Town grew by 40.0%, with "late" adolescents (15-19 year olds) comprising 33.5% of this group. The

population density in the West District within which Old Stone Town was situated increased from 931 persons per km² in 1988 to an estimated 1 478 persons per km² in 2000. According to projections for the latter year, Kinondoni had an estimated annual population growth rate of between 7.0% and 8.0%, inter alia because of a heavy influx of refugees from neighbouring conflict-ridden regions. Female-headed households were also increasing. Basic infrastructure/services and economic conditions (e.g. employment opportuni-

ties) were deteriorating. The evaluation sites had high levels of poverty-related diseases such as respiratory infections, diarrhoea, skin infections, worms, burns and malnutrition, as well as high rates of malaria and increasing rates of HIV/AIDS. The demand for health care services related to the use of psychoactive substances, especially alcohol, heroin, marijuana and sedatives (e.g. sleeping pills), was also increasing. Reported crime—including dealing in or being in possession of illicit psychoactive substances—was rising, thus further complicating the day-to-day life of community members.

Psychoactive substance use was spreading in Tanzania generally, especially among vulnerable groups such as young people and street children (Nkowane et al. 2004; World Health Organization 2003a; Kilonzo 1999). The range of psychoactive substances used was also widening, including injectable ones such as heroin and cocaine, and usage increasingly started early in life, e.g. as young as 10 years. An increase in trafficking in illicit psychoactive substances facilitated the rise in psychoactive substance use. Zanzibar, for example, had become a transit point for trafficking in illicit psychoactive substances, and the commercial capital of Tanzania, Dar es Salaam, was a major seaport for trafficking in illicit psychoactive substances in East Africa. Although the Tanzanian government recognized the importance of preventing psychoactive substance use and related problems—including the need for collaboration between the private and the public sector in this respect—limited human/material resources hampered the mobilization of adequate and sustained counter action. Legal statutes for preventing psychoactive substance use and related problems focused on the reduction of the supply of psychoactive substances, especially illicit substances. Indeed, treatment/rehabilitation opportunities were limited.

Table 58 shows that the Global Initiative **preventive activities** in the evaluation sites focused on the distribution of information on the risks of psychoactive substance use and training of young peer-support groups. The activities generally proceeded as planned and achieved the expected outcomes.

6.3 COMPARISON OF THE PRE- AND POST-PROJECT SITUATION ASSESSMENT RESULTS

This section compares the key results of the pre- and post-project situation assessments. Concern is with the focus group and key informant interviews and especially the Adult and Youth KAP Surveys conducted during the assessments. It is important to note that practical difficulties such as small survey samples and especially low response rates for various attitudinal and behavioural sections in the KAP Survey questionnaires complicated analysis and interpretation of the results of these surveys.

6.3.1 DEMOGRAPHIC PROFILE OF RESPONDENTS

Available information (Table 59) shows that the samples of the 2001 (pre-project) and 2003 (post-project) KAP Surveys mostly included persons of the Muslim faith. The Adult KAP Survey samples included unemployed rather than employed persons, especially in Kinondoni. The Youth KAP Survey samples were mostly drawn from the older age group, i.e. 15 years or older. The Kinondoni Youth KAP Surveys had smaller proportions of students than the Old Stone Town Youth KAP Surveys.

Table 59. Demographic features of the respondents in the Youth and Adult KAP Surveys of 2001 and 2003 (percentages)

Variable	Old Stone Town				Kinondoni			
	Adults		Youth		Adults		Youth	
	2001	2003	2001	2003	2001	2003	2001	2003
Age								
10-14 years	*	*	25.1	*	*	*	24.4	*
10-15 years	*	*	*	24.2	*	*	*	29.1
15-21 years	*	*	74.9	*	*	*	75.5	*
16-21 years	*	*	*	75.8	*	*	*	70.9
20-29 years	*	65.0	*	*	*	29.0	*	*
30-39 years	*	19.0	*	*	*	31.0	*	*
40-49 years	*	10.0	*	*	*	14.0	*	*
50-59 years	*	4.0	*	*	*	13.0	*	*
60 years and older	*	2.0	*	*	*	13.0	*	*
Total N	*	100	299	297	100	99	302	302
Employment status/ school attendance								
Employed	30.2	32.0		8.1	17.0	12.1	-	10.3
Unemployed	69.8	42.0	-	24.7	83.0	46.5	11.7	28.8
Student	-	10.0	24.7	65.2	-	2.0	38.6	48.7
Other	-	16.0	68.0	2.0	-	39.4	49.7	12.2
Total N	100	100	299	296	100	99	302	302
Religious affiliation								
Muslim	93.6	91.0	90.3	90.6	69.0	66.0	68.2	59.3
Christian	6.4	7.0	9.7	8.0	34.0	33.0	31.8	39.7
Other	-	2.0	-	1.3	-	1.0	-	0.9
Total N	100	100	299	299	100	100	302	302

* The relevant data were unavailable or inapplicable.

2.2.2 Psychoactive substance use-related attitudes and practices among adults and young people

The results of the 2001 and 2003 **Adult KAP Surveys** generally underlined that adults tended to be negatively oriented towards psychoactive substance use, and more so in 2003 than in 2001. For example and as shown in Table 60, in Old Stone Town the respondents were more prepared in 2003 than in 2001 to assign a **moderate/great risk** to psychoactive substance use among people in general. Although the Kinondoni respondents were generally less inclined in 2003 than in 2001 to assign a moderate/great risk to psychoactive substance use among people in general, there were exceptions: Larger proportions of the Kinondoni respondents in 2003 than in 2001 stated that people in general who smoked “10 or more cigarettes a day” and/or took “marijuana/hashish occasionally or regularly” exposed themselves to a moderate/great risk. In the case of youth psychoactive substance use, larger proportions of the Kinondoni respondents in 2003 than in 2001 assigned a moderate/great risk to a number of patterns of psychoactive substance use, i.e. alcohol, cigarette, marijuana, cocaine and occasional heroin use. Moreover, larger proportions of the Kinondoni respondents in the Adult KAP Survey in 2003 (between 19.0% and 64.0%) than in the 2001 survey (between 14.0% and 33.0%) **(strongly) disapproved** of licit and illicit psychoactive substance use among people in general.

As illustrated in Table 61, **psychoactive substance use** generally decreased among adults in the evaluation sites, specifically when considering reports of such use in the 12 months before the respective Adult KAP Surveys. This decrease (1) occurred with regard to licit (e.g. cigarettes and malt beer) as well as illicit (e.g. marijuana and heroin) psychoactive substances; and (2) related to reports of having used the relevant substances at least once in the 12 months before the respective surveys as well as to reports of (almost) daily use during these 12 months. A more mixed set of changes occurred over the intervention period with regard to the non-medical use of medicine (e.g. painkillers, tranquillizers and sedatives). For example, in Old Stone Town, reports of the non-medical use (at least once in the 12 months before the respective surveys as well as (almost) daily use) of sedatives decreased, whereas the non-medical use (at least once in the 12 months before the respective surveys) of painkillers and tranquillizers increased over the intervention period. In Kinondoni, (1) the non-medical use of painkillers decreased (from 35.0% to 25.0% in the case of reports of having used it at least once in the 12 months before the respective surveys; and from 4.0% to zero in the case of reports of (almost) daily use); (2) the non-medical use of tranquillizers (on the basis of at least once in the 12 months before the respective surveys) increased (from 54.0% to 74.0%); (3) (almost) daily non-medical use of tranquillizers decreased (from 11.0% to 2.0%); and (4) the non-medical use of sedatives at least once in the 12 months before the respective surveys decreased (from 5.0% to 1.0%), whereas (almost) daily use of sedatives remained stable at 1.0%.

The **Youth KAP Surveys** generally underlined that young people’s behaviour and especially attitudes regarding psychoactive substance use became generally more liberal over the intervention period. For example, in Kinondoni the proportions of respondents who **(strongly) disapproved** of the patterns of psychoactive substance use listed in the survey questionnaire decreased, except in the case of cigarette use (Table 62). In 2001, between 31.0% and 58.0% of the surveyed young people in Kinondoni (strongly) disapproved of the relevant patterns of psychoactive substance use, and between 17.0% and 41.0% did so in 2003 (Table 62).

In Old Stone Town, whereas the proportions of respondents who reported **using psychoactive substances** at least once in the 12 months before the respective KAP Surveys generally increased over the intervention period, a decrease generally occurred in reports of (almost) daily use (Table 63). There were some exceptions: Reports of using heroin at least once in the 12 months before the respective surveys declined from 3.7% to 1.8%; (almost) daily use of cigarettes increased from 8.8% to 12.0%; (almost) daily use of sedatives remained stable at about 1.0%; and (almost) daily use of marijuana remained at about 3.0% (Table 63).

In Kinondoni, somewhat more favourable changes emerged with regard to youth psychoactive substance use. In 2003, generally lower proportions than in 2001 admitted using psychoactive substances, especially with regard to (almost) daily use (Table 63). The non-medical use of medicines such as tranquillizers, sedatives and painkillers, and to some extent the use of heroin and alcohol were exceptions. Larger proportions of the Kinondoni respondents in 2003 than in 2001 admitted using the mentioned medicines non-medically at least once in the 12 months before the respective KAP Surveys. Reports of (almost) daily use of heroin also increased somewhat (from zero to 1.0%) as well as reports of using alcohol at least once in the 12 months before the respective surveys (from 11.6% to 14.6%).

Focus group discussions and key informant interviews underlined that psychoactive substance use was increasing among young people in both sites, with parents ever so often setting the example. The emergence of heroin injection and thus the risk of using contaminated needles was a special concern, considering the country’s HIV/AIDS epidemic. Various environment, group and individual issues were noted as contributors to the initiation into and continuation of psychoactive substance use/trade. Environmental contributors included the generally stressful living conditions caused by intense poverty; widespread unemployment; the lack of constructive recreational facilities; the mass media’s widespread and persuasive “advertising” of psychoactive substance use; poor government support to psychoactive substance use-related prevention/treatment; widespread corruption in the criminal justice system; as well as the generally limited resources within the country. At the group level, peer pressure, a poor family example and family breakdown were noted as conducive to psychoactive substance use. Individual-related contributors were particularly curiosity, stress reduction and rebelliousness.

Table 60. Respondents in the Adult KAP Surveys of 2001 and 2003 reporting selected patterns of psychoactive substance use by people in general/young people as entailing a moderate/great risk (percentages)

Patterns of psychoactive substance use	Old Stone Town		Kinondoni			
	People in general*		People in general		Young people	
	2001	2003	2001	2003	2001	2003
Smoke 10 or more cigarettes a day	67.0	79.0	79.0	87.0	14.0	69.0
Take marijuana/hashish occasionally	63.0	80.0	80.0	85.0	19.0	69.0
Take marijuana/hashish regularly	79.0	85.0	84.0	89.0	23.0	78.0
Take cocaine once/twice	70.0	95.0	79.0	74.0	24.0	55.0
Take cocaine occasionally	66.0	95.0	77.0	72.0	23.0	53.0
Take 1 or 2 drinks several times a week	45.0	78.0	62.0	30.0	12.0	32.0
Take 5 or more drinks once/twice a weekend	47.0	79.0	55.0	51.0	14.0	52.0
Take amphetamines once/twice	52.0	77.0	60.0	31.0	27.0	26.0
Take amphetamines occasionally	36.0	79.0	54.0	27.0	29.0	21.0
Take heroin once/twice	33.0	87.0	53.0	30.0	31.0	28.0
Take heroin occasionally	57.0	87.0	60.0	28.0	30.0	34.0
Take mandrax once/twice	47.0	95.0	50.0	20.0	33.0	24.0
Take mandrax occasionally	43.0	95.0	35.0	18.0	22.0	21.0
Total N	100	100	100	100	100	100

* Related attitudinal data on psychoactive substance use among young people were not available.

Table 61. Respondents in the Adult KAP Surveys of 2001 and 2003 reporting the use of selected psychoactive substances at least once or (almost) daily in the 12 months before the respective surveys (percentages)*

Psychoactive substance	Old Stone Town				Kinondoni			
	At least once		(Almost) daily	At least once		(Almost) daily		
	2001	2003	2001	2003	2001	2003	2001	2003
Cigarettes	41.0	23.0	32.0	21.0	20.0	15.0	15.0	12.0
Malt beer	28.0	14.0	3.0	2.0	41.0	33.0	3.0	2.0
Painkillers	45.0	53.0	9.0	-	35.0	25.0	4.0	-
Tranquillizers	9.0	14.0	1.0	-	54.0	74.0	11.0	2.0
Sedatives	18.0	6.0	1.0	-	5.0	1.0	1.0	1.0
Marijuana/hashish	15.0	5.0	7.0	2.0	11.0	5.0	1.0	-
Heroin	7.0	2.0	6.0	1.0	3.0	1.0	1.0	-
Total N	100	100	100	100	100	100	100	100

* The table is restricted to the most commonly reported psychoactive substances.

Table 62. Kinondoni respondents in the Youth KAP Surveys of 2001 and 2003 (strongly) disapproving of selected patterns of psychoactive substance use by young people (percentages)*

1 Patterns of psychoactive substance use	Kinondoni			
	2001		2003	
	(Strongly) disapprove	Don't know/No response	(Strongly) disapprove	Don't know/No response
Smoke 10 or more cigarettes a day	31.0	8.0	35.0	10.0
Take marijuana/hashish occasionally	31.0	8.0	26.0	10.0
Take marijuana/hashish regularly	34.0	7.0	31.0	11.0
Take cocaine once/twice	50.0	10.0	41.0	29.0
Take cocaine occasionally	48.0	11.0	41.0	29.0
Take 1 or 2 drinks several times a week	36.0	8.0	17.0	11.0
Take 5 or more drinks once/twice a weekend	42.0	10.0	32.0	12.0
Take heroin once/twice	58.0	25.0	34.0	34.0
Take heroin occasionally	56.0	25.0	34.0	45.0
Take mandrax once/twice	55.0	21.0	37.0	48.0
Take mandrax occasionally	56.0	21.0	33.0	53.0
Total N	303	303	302	302

* Related attitudinal data for Old Stone Town were not available.

Table 63. Respondents in the Youth KAP Surveys of 2001 and 2003 reporting the use of selected psychoactive substances at least once or (almost) daily in the 12 months before the respective surveys (percentages)*

	Old Stone Town				Kinondoni			
	At least once		(Almost) daily		At least once		(Almost) daily	
	2001	2003	2001	2003	2001	2003	2001	2003
Cigarettes	16.9	24.3	8.8	12.0	15.4	8.9	8.2	3.6
Alcohol	12.8	16.4	3.4	0.7	11.6	14.6	2.0	1.3
Painkillers	31.3	67.8	8.4	0.3	43.3	58.6	5.8	1.7
Tranquillizers	8.1	9.6	1.4	0.3	1.4	2.0	1.0	0.3
Sedatives	10.8	12.8	1.3	0.7	1.0	2.0	0.3	0.7
Marijuana/hashish	11.4	14.0	2.7	3.2	6.2	3.0	3.1	1.0
Heroin	3.7	1.8	3.0	0.7	4.5	1.7	-	1.0
Total N	299	299	299	299	302	302	302	302

* The table is restricted to the most commonly reported psychoactive substances.

6.3 CONCLUSION

The available results of the pre- and post-project assessments in Tanzania pointed towards various developments over the prevention period. A deteriorating **broad socioeconomic environment** and, in particular, unemployment and intense poverty were major contributors to psychoactive substance use and related problems and hampered effective prevention action. Project participants pointed out that a general sense of hopelessness prevailed in the evaluation sites.

Notwithstanding the debilitating broad socioeconomic environment, various positive psychoactive substance use-related changes emerged in the **behaviour and attitudes** of community members (as summarized in Table 64). For example, the results of the pre- and post-project KAP Surveys in **Kinondoni** in mainland Tanzania showed that adults more commonly came to regard various patterns of psychoactive substance use among young people as entailing a moderate/great risk. Among both adults and young people, usage at least once in the 12 months before the respective KAP Surveys decreased for various psychoactive substances (e.g. cigarettes and marijuana), although levels of use increased for the non-medical use of medicine (e.g. tranquilizers in the case of adults, and painkillers, tranquilizers and sedatives in the case of young people). Levels of regular use—(almost) daily use—of various psychoactive substances decreased among adults as well as young people.

Particularly notable in **Old Stone Town** were the following behaviour and attitudinal changes: (1) Respondents in the Adult KAP Surveys were more inclined in the post-project

than in the pre-project survey to assign a moderate/great risk to various patterns of psychoactive substance use by people in general; and (2) lower levels of reported psychoactive substance use at least once in the 12 months before the relevant surveys and especially (almost) daily among the surveyed adults supported this change towards more widespread acceptance of the risk of taking psychoactive substances. The Youth KAP Surveys in Old Stone Town underlined that the lower levels of psychoactive substance use among adults also occurred to some extent among young people, at least in respect of (almost) daily use of psychoactive substances.

As for the Global Initiative **preventive activities** in the evaluation sites, these largely proceeded as planned. The focus was on increasing awareness about the risks of psychoactive substance use, interest in prevention action, and mobilization and training of young peer-support groups towards facilitating the prevention of psychoactive substance use. The project's efforts to increase awareness of the risks of psychoactive substance use reached widely into the evaluation sites, inter alia resulting in an increased demand from community members for assistance with psychoactive substance use-related problems (e.g. in Old Stone Town). Evidence of increased attention to and understanding of the prevention of psychoactive substance use and related problems also emerged among community members/agencies/leaders. The local partners in the Global Initiative committed themselves to long-term follow-up by including the relevant activities within their regular/day-to-day tasks. However, limited resources constrained long-term (collaborative) prevention action.

Table 64. Summary of key attitudinal and behavioural changes over the intervention period in the evaluation sites in Tanzania

Data collection method	Old Stone Town		Kinondoni	
	Psychoactive substance use-related attitudes	Psychoactive substance use	Psychoactive substance use-related attitudes	Psychoactive substance use
Youth KAP Survey	No information available	<ul style="list-style-type: none"> • Increase in cigarette use at least once in the 12 months before the relevant surveys (from 17% to 24%) and in (almost) daily cigarette use in the 12 months before the relevant surveys (from 9% to 12%) (Table 63) • Increase in alcohol use at least once in the 12 months before the relevant surveys (from 13% to 16%) and in (almost) daily alcohol use (from 3% to 1%) (Table 63) • Increase in non-medical use of painkillers (from 31% to 68%), tranquilizers (from 8% to 10%) and sedatives (from 11% to 13%) at least once in the 12 months before the relevant surveys (Table 63) • Decrease in heroin use (from 4% to 2%) at least once in the 12 months before the surveys (Table 63); increase (from 11% to 14%) in marijuana use at least once in the 12 months before the relevant surveys (Table 63) 	<ul style="list-style-type: none"> • General decrease in (strong) disapproval of psychoactive substance use (31%-58% in 2001 and 17%-41% in 2003 (strongly) disapproved of psychoactive substance use (Table 62)); (strong) disapproval of cigarette use increased from 31% to 35% (Table 62) 	<ul style="list-style-type: none"> • Decrease in cigarette use at least once in the 12 months before the relevant surveys (from 15% to 9%) and in (almost) daily cigarette use in the 12 months before the relevant surveys (from 8% to 4%) (Table 63) • Increase in alcohol use at least once in the 12 months before the relevant surveys (from 12% to 15%); and decrease in (almost) daily alcohol use in the 12 months before the relevant surveys (from 2% to 1%) (Table 63) • Increase in use of painkillers (from 43% to 59%), tranquilizers (from 1% to 2%), and sedatives (from 1% to 2%) at least once in the 12 months before the relevant surveys (Table 62) • Decrease in marijuana use at least once in the 12 months before the relevant surveys (from 6% to 3%) and in (almost) daily use of marijuana in the 12 months before the relevant surveys (from 3% to 1%) (Table 63) • Decrease in heroin use at least once in the 12 months before the relevant surveys (from 5% to 2%) and increase in (almost) daily heroin use in the 12 months before the relevant surveys (from zero to 1%) (Table 63)

Data collection method	Old Stone Town		Kinondoni	
	Psychoactive substance use-related attitudes	Psychoactive substance use	Psychoactive substance use-related attitudes	Psychoactive substance use
Adult KAP Survey	<ul style="list-style-type: none"> • Increased sense of the riskiness of psychoactive substance use (33%-79% in 2001 and 77%-95% in 2003 indicated psychoactive substance use by people in general as entailing a moderate/great risk (Table 60)) 	<ul style="list-style-type: none"> • Decrease in cigarette use (41% in 2001 and 23% in 2003 admitted using cigarettes at least once in the 12 months before the relevant surveys; 32% in 2001 and 21% in 2003 admitted (almost) daily use of cigarettes in the 12 months before the relevant surveys (Table 61)) • Decrease in alcohol use (28% in 2001 and 14% in 2003 admitted using malt beer at least once in the 12 months before the relevant surveys; 3% in 2001 and 2% in 2003 reported (almost) daily use of malt beer in the 12 months before the relevant surveys (Table 61)) • Decrease in the (almost) daily non-medical use of painkillers, tranquilizers and sedatives (1%-9% in 2001 and zero in 2003 (Table 61)); increase in non-medical use of painkillers (from 45% to 53%) and tranquilizers (from 9% to 14%) at least once in the 12 months before the relevant surveys (Table 61)) • Decrease in illicit psychoactive substance use (from 15% to 5% in the case of marijuana and from 7% to 2% in the case of heroin with regard to usage at least once in the 12 months before the relevant surveys (Table 61)) 	<ul style="list-style-type: none"> • Increased sense of the riskiness of youth use of cigarettes, marijuana, cocaine, alcohol and heroin (occasional use) (12% - 23% in 2001 and 32%-55% in 2003 indicated youth use of these substances as entailing a moderate/great risk (Table 60)) • Decreased sense of the riskiness of youth use of amphetamines and mandrax (Table 60) 	<ul style="list-style-type: none"> • Decrease in cigarette use (from 20% to 15% for usage at least once in the 12 months before the relevant surveys; from 15% to 12% for (almost) daily use in the 12 months before the relevant surveys (Table 61)) • Decrease in alcohol use (from 41% to 33% for use of malt beer at least once in the 12 months before the relevant surveys; and from 3% to 2% for (almost) daily use of malt beer in the 12 months before the relevant surveys (Table 61)) • Decrease in the use of painkillers (from 35% to 25% for use at least once in the 12 months before the relevant surveys, and from 4% to zero for (almost) daily use in the 12 months before the relevant surveys (Table 61)) • Increase (from 54% to 74%) in use of tranquilizers at least once in the 12 months before the relevant surveys; decrease (from 11% to 2%) in (almost) daily use of tranquilizers in the 12 months before the relevant surveys (Table 61) • Decrease in use of marijuana (from 11% to 5%) and heroin (from 3% to 1%) at least once in the 12 months before the relevant surveys (Table 61)
Focus groups, in-depth interviews and key informant interviews	No information available	<ul style="list-style-type: none"> • Progressive increase in youth psychoactive substance use, including injection use 	No information available	<ul style="list-style-type: none"> • Progressive increase in youth psychoactive substance use, including injection use

Project outcome in the evaluation sites in the Republic of Zambia

7.1 INTRODUCTION

This chapter discusses key findings of the overall evaluation of the outcome of the Global Initiative in two adjacent sites, Kanyama and Chinika, in the capital city of Lusaka in the Republic of Zambia. It in particular describes the main sociodemographic characteristics of the evaluation sites, as well as broad socioeconomic developments and the preventive activities of the agency selected as the local Global Initiative partner in these sites. The chapter then compares the key results of the pre- and post-project situation assessments in the evaluation sites. It concludes with an integrated summary (e.g. in tabulated format) of these results. As the two sites are largely similar, this chapter does not distinguish between them, except when describing their main features.

7.2 EVALUATION SITES, LOCAL PARTNERS, PREVENTIVE ACTIVITIES AND BROAD SOCIO-ECONOMIC DEVELOPMENTS

Kanyama, situated about five minutes' drive west of the centre of Lusaka, was the larger of the two evaluation sites. One of the oldest residential areas in Lusaka, it was a high-density informal settlement of about 4 957 dwellings and an estimated 200 000 inhabitants. Chinika, situated between the Superior Milling Company and the Chinika Basic School, was divided into six subsections: Malata, Chileshe, Karvasa, Mutti Enterprises, Village Industries and Namboard. A semi-industrial settlement of medium density, it had about 700 inhabitants of whom half lived in the industrial sections.

The sites were characterized by various debilitating **broad socioeconomic conditions**. For example, dwellings were

mostly informal structures; water was not necessarily close by and not free; no formal sewage/waste removal service existed; roads were defective; health care was only available in neighbouring districts; and constructive recreational facilities were lacking. An estimated 90.0% of the households lived below the poverty line, surviving through informal means. Moreover, in Zambia as a whole, unemployment and crime rates (including psychoactive substance use-related offences) were rising. The general levels of **psychoactive substance use**, related problems and related trade were rising. The range of psychoactive substances used was broadening, that is apart from alcohol, tobacco and marijuana, cocaine and heroin were also being used. Alcohol and tobacco trade outlets were spreading—including informal trade outlets providing homebrews—because of inter alia the Government's participation in the production and distribution of these products. Dispensing of prescription medicine at pharmacies was indiscriminate, indeed enforcement of the Drugs and Poisons Act was lax. Police records of seizures of illicit psychoactive substances suggested that Zambia was also becoming a transit country for illicit psychoactive substances destined for other Southern African countries.

Notwithstanding the rise in psychoactive substance use and related trade, prevention and especially specialized treatment services were almost non-existent. Psychoactive substance use-related treatment facilities were, for example, restricted to the psychiatric wards of two hospitals in Zambia. The main agency engaged in countering psychoactive substance use, the Government's Drug Enforcement Commission, focused on enforcing the law against trafficking in and use of illicit psychoactive substances.

Table 65 profiles the local **Global Initiative** partner and its particular **preventive activities** in the evaluation sites.

The table shows that the activities generally proceeded as planned and achieved the expected outcomes, e.g. increased awareness of the risks of psychoactive substance use, and mobilized stronger and more widespread services

related to the prevention of (youth) psychoactive substance use and related problems through soliciting the involvement of various agencies in the planning and delivery of the project.

Table 65. Description of local partner and the nature and outcome of its preventive activities

<p>Local partner</p> <p>The Kanyama Youth Programme Trust (KYPT) was the local partner in the Global Initiative in the evaluation sites in Zambia. Founded in the late 1980s, the organization only became truly operational in 1993. KYPT was a nongovernmental, non-profit organization that provided vocational and life skills training to underprivileged young people. In fact, KYPT ran both long- and short-term vocational skills courses. Long-term courses included auto mechanics, carpentry and joinery, catering, bricklaying and construction, tailoring and designing. Short-term courses included batik work, entrepreneurship, basic business management, leadership and basic management. KYPT provided free accommodation to eight youth NGOs, and had links with other agencies.</p> <p>Problem</p> <p>The pre-project assessment of the evaluation sites highlighted widespread use/approval of alcohol, tobacco, marijuana, prescription medicine and inhalants, and youth psychoactive substance use especially among males and 15-16 year olds. Contributors to psychoactive substance use included (1) individual/group issues such as (in)direct social pressure to use psychoactive substances; and the need to be socially acceptable, enjoyment and curiosity; and (2) broad socio-economic conditions such as unemployment/poverty; limited prevention/treatment options and easy access to psychoactive substances; and few constructive leisure activities.</p> <p>Aims</p> <p>The main aims of the Global Initiative were to: (1) raise awareness of the risks of psychoactive substance use among in- and out-of-school young people; (2) equip young people between the ages of seven and twenty-two years with constructive psychosocial and vocational skills; (3) provide accessible and constructive recreational facilities/activities for young people in the 10-18 age group; (4) increase the provision of peer-support services for youths in the community; and (5) sustain prevention projects by networking with organisations working in the area of substance abuse.</p> <p>Preventive activities</p> <p>The preventive activities included (1) sport and recreation (football, netball, volleyball, darts and other indoor games); (2) public awareness activities (e.g. newspaper advertisements, radio programmes, video productions, film production, drama performances); (3) training of peer-support groups in life skills/counselling and vocational skills (e.g. tailoring, bricklaying, auto mechanics, auto electrical work, batik work, catering and carpentry, basic business management); and (4) negotiation of support from agencies such as the Drug Enforcement Commission as well as the Technical, Educational, Vocational, Entrepreneurship and Training Authority (TEVETA) in Lusaka (who provided technical assistance in the preparation of educational material and training); the Residents' Development Committees; and the Pentecostal Church and Roman Catholic Church (who selected/recruited the young people who were trained in peer support); the Sport in Action and the Lusaka Playhouse (who provided the human resources/expertise needed in the project's recreational activities as well as in the development of the project's educational film and documentary).</p> <p>Project leaders' evaluation of project delivery and outcomes</p> <p>Evaluation of the activities by the local participants in the project showed that the activities proceeded largely as planned. In general, key informants and focus group participants found it difficult to assess the quality of project activities, except noting that the peer-support group training was very useful though the debilitating socioeconomic conditions made long-term involvement in such work difficult. Indeed, the generally high mobility of community members restricted to some extent the project's efforts to increase awareness of the risks of psychoactive substance use and solicit support for prevention action. Information on psychoactive substance use-related issues was, however, widely distributed, e.g. (1) the trained peer educators counselled about 720 young people and reached about 14 400 pupils at information seminars; (2) 37 835 young people attended the drama productions; (3) two educational videos were produced; (4) 7 000 educational leaflets were distributed; and (5) educational advertisements were put in a local newspaper with a distribution list of 30 000. Stronger and wider community action against psychoactive substance use was mobilized through soliciting the support of various (non)government agencies.</p>
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7.3 COMPARISON OF THE PRE- AND POST-PROJECT SITUATION ASSESSMENT RESULTS

This section compares the key results of the pre- (2001) and post-project (2003) situation assessments in the evaluation sites as a whole. The focus is on the changes, if any, in behaviour and attitudes underlined by the Adult and Youth KAP Surveys, the focus group discussions and the key informant interviews.

7.3.1 Demographic profile of respondents

Table 66 presents the main demographic features of the respondents sampled in the 2001 and 2003 Adult and Youth KAP Surveys in the evaluation sites. By far most of the respondents in the surveys were of the Christian faith. Whereas males and females were more or less evenly distributed in the 2001 Adult and Youth KAP Surveys, males were in the majority in the related 2003 surveys. The 2001 and 2003 Youth KAP Surveys, however, were largely similar in terms of the age distribution and educational background of the respondents, i.e. they were in the older age group (16-21 year olds) and the majority had completed 1-7 years of formal education (primary school). Most of the respondents in the Adult KAP Surveys were unemployed.

Table 66. Demographic features of the respondents in the Adult and Youth KAP Surveys of 2001 and 2003 (percentages)

Variable	Adults		Youth	
	2001	2003	2001	2003
Gender				
Males	44.7	63.5	50.3	64.8
Females	55.3	36.5	49.7	35.2
Employment status				
Employed	39.0	37.5	*	*
Unemployed	61.0	62.5	*	*
Years of formal education				
None	-	*	2.8	3.9
1-7 years	48.0	25.0	64.3	56.4
8 or more years	52.0	*	32.9	39.7
Religion				
Christian	90.0	92.5	92.2	92.7
Other religions/none	10.0	7.5	7.1	7.3
Age (years)				
10-15	*	*	36.9	36.5
16-21	*	*	63.1	63.4
22 and above	*	*	*	*
Mean age (years)	*	38	16.31	16.30
Total N	150	200**	398	504**

* Data not available or not applicable.

** In order to provide for an increase in the population size over the intervention period, more participants were selected for the 2003 sample than for the related 2001 sample.

7.3.2 Psychoactive substance use-related attitudes and practices among adults

As shown in Table 67, the results of the **Adult KAP Surveys** in the evaluation sites underlined that in 2001 and especially in 2003 the respondents generally indicated the listed patterns of psychoactive substance use as entailing a **moderate/great risk**, especially if such users were young people. Table 68 shows that reported **use of the licit psychoactive substances**, tobacco and alcohol, as well as the use of the illicit psychoactive substance, marijuana, increased substantially over the intervention period among adults in the evaluation sites. For example, reported lifetime use of tobacco increased from 34.0% to 50.0%; reported lifetime use of alcohol from 61.0% to 79.0%; and reported lifetime use of marijuana from 12.0% to 37.0%. The level of reported use of other illicit psychoactive substances remained more or less stable at a comparatively low level, e.g. at 5.0% and lower for lifetime use. Reports of the non-medical use of painkillers remained at a very high level, i.e. above 80.0% for both lifetime and past 12 months' use. Reports of the non-medical use of sedatives declined (e.g. from 21.0% to 8.0% for lifetime use), and reported use of tranquillizers remained more or less constant (e.g. at 7.0% in 2001 and 6.0% in 2003 for lifetime use).

As shown in Table 69, the **Youth KAP Surveys** underlined that the tendency among young people in the evaluation sites to **(strongly) disapprove** of psychoactive substance use among their peers remained intact over the intervention period, although to a lesser extent in 2003 than in 2001 with regard to the use of licit psychoactive substances such as cigarettes and alcohol as well as the illicit psychoactive substances, marijuana and cocaine (occasional use). Moreover, (strong) disapproval of youth use of illicit psychoactive

substances such as amphetamines, heroin, mandrax, hallucinogens and to some extent cocaine (“taking cocaine once or twice”) increased over the intervention period (Table 69).

Table 70 highlights that **psychoactive substance use**—as reported in the Youth KAP Surveys—changed in various respects over the intervention period. For example, whereas reported tobacco and alcohol use decreased somewhat among males, it increased to some extent among females. Another positive development among males was the fact that the average reported age of onset of alcohol and tobacco use increased somewhat (from 14.6 years to 16.2 years for alcohol and 15.2 years to 15.4 years for tobacco). The average age of onset of alcohol and tobacco use remained more or less the same among females (e.g. 15.1 years in 2001 and 15.3 years in 2003 for tobacco; and with regard to alcohol 15.2 years in 2001 as well as in 2003). Reported non-medical use of painkillers increased generally—among males and females as well as the younger and older age groups. Reported non-medical use of tranquillizers remained at relatively low levels (e.g. below 5.0%), even though it increased somewhat, specifically among the older age group. The non-medical use of sedatives increased substantially, specifically among females and the older age group (e.g. lifetime use increased from 5.1% to 22.0% among females). The use of marijuana increased somewhat, e.g. reported lifetime use increased from 4.8% to 7.6% among 10-15 year olds; from 19.0% to 21.3% among 16-21 year olds; from 21.0% to 22.3% among males; and from 6.6% to 8.3% among females. Reported use of inhalants also increased, e.g. on a lifetime basis among females (from 2.0% to 5.5%) and past 12 months' basis generally.

Notwithstanding the mentioned increases in reported psychoactive substance use among respondents in the Youth KAP Surveys, Table 71 points to a general decline in

reported experiences of negative **consequences** related to psychoactive substance use among the respondents in the 12 months before the respective Youth KAP Surveys. For example, in 2001, between 17.3% and 38.7% reported that they did not experience the negative consequences listed in the survey questionnaire, and in 2003 between 33.5% and 50.8% did so.

The focus group discussions and key informant interviews generally approximated the KAP Survey results.

Interviewees emphasized that although community members in the evaluation sites generally disapproved of psychoactive substance use, indeed perceived such use as risky, psychoactive substance use was widespread among young and old in practice, particularly alcohol, marijuana and solvents such as petrol and glue. The participants in the discussions/interviews were also unanimous that the earlier mentioned broad socioeconomic conditions made it difficult for community members to avoid taking risks.

Table 67. Respondents in the Adult KAP Surveys of 2001 and 2003 reporting selected patterns of psychoactive substance use by people in general and young people as entailing a moderate/great risk (percentages)

Patterns of psychoactive substance use	People in general		Young people	
	2001	2003	2001	2003
Smoke 10 or more cigarettes a day	83.3	97.0	97.0	98.0
Take marijuana/hashish occasionally	91.0	95.5	97.0	98.5
Take marijuana/hashish regularly	95.0	96.5	96.3	98.5
Take cocaine once/twice	77.0	87.0	82.0	91.5
Take cocaine occasionally	76.3	85.0	82.0	90.5
Take 1 or 2 drinks several times a week	56.0	68.5	84.0	84.5
Take 5 or more drinks once/twice a weekend	61.0	66.5	88.0	84.5
Take amphetamines once/twice	57.0	84.0	65.0	89.5
Take amphetamines occasionally	57.0	84.0	66.0	89.5
Take heroin once/twice	68.3	84.0	74.0	89.5
Take heroin occasionally	68.3	84.0	73.0	89.5
Take inhalants once/twice	76.0	86.5	80.0	92.5
Take inhalants occasionally	79.0	86.5	80.3	92.5
Take mandrax once/twice	80.0	86.5	78.0	92.5
Take mandrax occasionally	75.0	86.5	78.0	92.5
Take hallucinogens once/twice	57.0	84.5	61.0	89.5
Take hallucinogens occasionally	57.0	84.5	61.0	88.5
Total N	150	200	150	200

Table 68. Respondents in the Adult KAP Surveys of 2001 and 2003 reporting the use of selected psychoactive substances at particular periods in time before the respective surveys (percentages)*

Psychoactive substance use	2001	2003
Tobacco generally		
Lifetime use	34.0	50.0
Past 12 months' use	20.0	41.5
Past 30 days' use	18.0	36.0
Alcohol generally		
Lifetime use	61.0	79.0
Past 12 months' use	48.0	61.5
Past 30 days' use	39.0	50.0
Painkillers		
Lifetime use	93.0	95.5
Past 12 months' use	84.0	84.0
Past 30 days' use	52.0	74.5
Sedatives		
Lifetime use	21.0	8.0
Past 12 months' use	11.0	4.0
Past 30 days' use	4.0	-
Tranquillizers		
Lifetime use	7.0	6.0
Past 12 months' use	-	3.5
Past 30 days' use	-	-
Inhalants		
Lifetime use	8.0	9.0
Past 12 months' use	-	-
Past 30 days' use	-	-

Psychoactive substance use	2001	2003
Marijuana		
Lifetime use	12.0	37.0
Past 12 months' use	3.0	16.5
Past 30 days' use	3.0	11.5
Mandrax		
Lifetime use	4.0	5.0
Past 12 months' use	-	-
Past 30 days' use	-	-
Total N	150	200

* The table is restricted to the most commonly reported psychoactive substances.

Table 69. Respondents in the Youth KAP Surveys of 2001 and 2003 (strongly) disapproving of selected patterns of psychoactive substance use by young people (percentages)

Patterns of psychoactive substance use	2001	2003
Smoke 10 or more cigarettes a day	91.7	85.3
Take marijuana/hashish occasionally	89.4	81.1
Take marijuana/hashish regularly	92.7	83.1
Take cocaine once/twice	20.9	74.0
Take cocaine occasionally	81.1	74.0
Take 1 or 2 drinks several times a week	71.1	57.7
Take 5 or more drinks once/twice a weekend	70.9	58.9
Take amphetamines once/twice	56.8	73.1
Take amphetamines occasionally	57.3	71.9
Take heroin once/twice	67.1	71.9
Take heroin occasionally	67.4	71.9
Take mandrax once/twice	74.3	77.7
Take mandrax occasionally	74.3	78.3
Take hallucinogens once/twice	59.1	73.3
Take hallucinogens occasionally	59.1	72.7
Total N	398	504

Table 70. Respondents in the Youth KAP Surveys reporting the use of psychoactive substances at particular periods in time and by age and gender (percentages)*

Psychoactive substance use by age and gender	Lifetime use		Past 12 months' use		Past 30 days' use	
	2001	2003	2001	2003	2001	2003
Tobacco generally						
10-15 years	9.5	8.7	4.8	4.9	2.0	3.3
16-21 years	27.1	30.0	19.1	19.4	14.3	14.4
Males	33.5	28.4	23.5	19.0	17.0	14.1
Females	7.6	10.7	4.0	5.1	2.5	3.4
Alcohol generally						
10-15 years	31.3	27.2	23.8	14.7	8.8	6.5
16-21 years	56.2	60.0	40.6	40.6	25.5	27.5
Males	55.0	50.5	40.5	37.2	27.5	23.4
Females	38.9	43.1	28.3	26.6	11.1	15.6
Painkillers						
10-15 years	85.4	90.2	64.6	76.6	39.5	67.9
16-21 years	92.0	95.0	67.7	86.3	43.0	61.9
Males	90.0	93.6	61.5	84.6	40.0	63.8
Females	89.9	96.3	71.7	90.8	43.4	69.7
Tranquillizers						
10-15 years	0.7	1.6	0.7	0.5	0.7	0.5
16-21 years	0.4	3.1	-	2.5	-	1.9
Males	1.0	3.7	0.5	3.7	0.5	3.2
Females	-	4.6	-	1.8	-	0.9
Sedatives						
10-15 years	3.4	2.4	2.7	0.5	0.7	0.5
16-21 years	5.2	13.1	2.8	6.9	-	3.1
Males	4.0	6.4	2.0	3.2	0.5	1.6
Females	5.1	22.0	3.5	12.8	-	5.5
Marijuana						
10-15 years	4.8	7.6	2.7	1.6	0.7	0.5
16-21 years	19.1	21.3	10.0	13.8	6.0	8.4
Males	21.0	22.3	11.5	15.4	7.0	10.1
Females	6.6	8.3	3.0	3.7	1.0	1.8

Psychoactive substance use by age and gender	Lifetime use		Past 12 months' use		Past 30 days' use	
	2001	2003	2001	2003	2001	2003
Heroin						
10-15 years	-	-	-	-	-	-
16-21 years	0.4	0.6	0.4	0.3	0.4	0.3
Males	-	1.1	-	0.5	-	0.5
Females	0.5	-	0.5	-	0.5	-
Hallucinogens						
10-15 years	-	-	-	-	-	-
16-21 years	0.4	0.6	0.4	0.6	0.4	0.3
Males	-	1.1	-	1.1	-	0.5
Females	0.5	-	0.5	-	0.4	-
Inhalants						
10-15 years	4.1	6.0	0.7	3.8	0.7	0.5
16-21 years	8.0	8.8	2.4	3.4	0.8	1.6
Males	11.0	10.6	3.0	5.9	1.5	2.1
Females	2.0	5.5	0.5	2.8	-	-
Total N	398	504	398	504	398	504

* The table is restricted to the most commonly reported psychoactive substances.

Table 71. Respondents in the Youth KAP Surveys reporting psychoactive substance use-related negative consequences (percentages)

Consequences	At least once		Never	
	2001	2003	2001	2003
Absent/poor performance	4.9	3.4	27.1	50.8
Suspended/expelled from school	1.6	2.8	27.1	57.3
Drunken driving	1.6	1.0	17.6	33.5
Drunken operation of machine	2.3	1.6	17.3	34.5
Arrested for disorderly conduct	3.4	3.8	38.7	50.8
Fights/arguments	9.6	9.2	34.4	48.2
Total N	389	504	389	504

7.4 CONCLUSION

Analysis of the pre- and post-project situation assessments in Zambia pointed to various **broad socioeconomic pressures** towards psychoactive substance use, such as limited human and material resources. Regarding psychoactive substance use-related **behavioural and attitudinal changes** over the Global Initiative intervention period (Table 72), the results of the KAP Surveys showed that the level of reported psychoactive substance use decreased in some respects among young people amidst an increase in such use among adults. Particularly positive also was the increase among males in the age of initiating the use of the commonly used psychoactive substances, alcohol

and tobacco. The fact that adults were generally disapproving of psychoactive substance use, especially among young people, and that this orientation became more pronounced over the intervention period might prompt reduced psychoactive substance use among young people, if reinforced.

Notable also was the finding that the Global Initiative **preventive activities** increased awareness of the risks of psychoactive substance use and drew support for prevention action. Indeed, information on psychoactive substance use-related issues was widely distributed and through various means. The project also contributed towards stronger/long-term and more widespread psychoactive substance use-related prevention services.

Table 72. Summary of key attitudinal and behavioural changes over the intervention period in the evaluation sites in Zambia

Data source	Kanyama and Chinika	
	Psychoactive substance use-related attitudes	Psychoactive substance use
Youth KAP Survey	<ul style="list-style-type: none"> • Sustained general tendency to (strongly) disapprove of psychoactive substance use, even though disapproval diminished in some cases (use of cigarettes, marijuana, cocaine (occasional use), and increased in other instances (use of alcohol, amphetamines, heroin, mandrax and hallucinogens (Table 69) 	<ul style="list-style-type: none"> • Decrease in tobacco and alcohol use among males (lifetime use of tobacco from 34% to 28%; lifetime use of alcohol from 55% to 51%); some increase among females (lifetime use of tobacco from 8% to 11%; lifetime use of alcohol from 39% to 43%) (Table 70) • Increase in non-medical use of painkillers (lifetime use among males from 90% to 94% and among females from 90% to 96% (Table 70)) • Sustained low levels of non-medical use of tranquilizers (below 5% (Table 70)) • Increase in non-medical use of sedatives, especially among females (lifetime use among males from 4% to 6%; lifetime use among females from 5% to 22% (Table 70)) • Some increase in the use of marijuana (e.g. from 5% to 8% among 10-15 year olds (Table 70)) • Some increase in inhalants (e.g. from 4% to 6% among 10-15 year olds (Table 70))

Kanyama and Chinika		
Data source	Psychoactive substance use-related attitudes	Psychoactive substance use
		<ul style="list-style-type: none"> • Increase in age of onset of alcohol use among males (from 14.6 years to 16.2 years); the age of onset of tobacco use among males remained about the same (15.2 years in 2001 and 15.4 years in 2003) • More of less sustained age of onset of tobacco use (15.1 years in 2001 and 15.3 years in 2003) and alcohol use (15.2 years in 2001 as well as in 2003) among females
Adult KAP Survey	<ul style="list-style-type: none"> • Increased sense of the riskiness of (youth) psychoactive substance use (56%-95% in 2001 and 67%-97% in 2003 indicated psychoactive use by people in general as entailing a moderate/great risk; 61%-97% in 2001 and 85%-99% in 2003 stated that youth psychoactive substance use entailed a moderate/great risk (Table 67)) 	<ul style="list-style-type: none"> • Increase in tobacco, alcohol and marijuana use (lifetime tobacco use from 34% to 50%, lifetime alcohol use from 61% to 79%, and lifetime marijuana use from 12% to 37% (Table 68)) • Sustained low lifetime use of illicit psychoactive substances other than marijuana (5% and lower (Table 68)) • Sustained high level of non-medical use of painkillers, i.e. above 80% for lifetime and 12 months' use • Decrease in non-medical use of sedatives (lifetime use from 21% to 8% (Table 68)) • More or less sustained non-medical use of tranquilizers, i.e. 7% in 2001 and 6% in 2003 (Table 68)
Focus groups, in-depth interviews and key informant interviews	<ul style="list-style-type: none"> • Community members generally disapproved of psychoactive substance use and assigned risk to it 	<ul style="list-style-type: none"> • Widespread psychoactive substance use in the community, particularly regarding alcohol, marijuana and inhalants

PART 3

Conclusion

Key implications of the outcome of the Global Initiative

8.1 INTRODUCTION

This part of the report discusses the implications of the findings of the overall evaluation of the outcome of the Global Initiative. First, however, the outcomes of the project in the evaluation sites in the project countries are briefly reviewed. Some attention is also given to the key findings of the process evaluation of the overall project and, more specifically, project delivery within the outcome evaluation sites. Second, the relevance of the prevention strategies of the project for future use is discussed. Third, the key enabling factors and constraints that the project participants experienced are noted. The chapter concludes with the key lessons that were learnt on what works in the primary prevention of psychoactive substance use and recommendations for future action, as recorded by the project participants.

8.2 MAIN PROJECT OUTCOMES

A comparison of the results of the pre- and post-project situation assessments in the evaluation sites in the project regions—as summarized in Table 73—shows that the Global Initiative achieved positive outcomes across the evaluation sites and issues (e.g. psychoactive substance use among young people, prevention programmes, organizations and partnerships/networks).

Youth **psychoactive substance use** decreased, and even where it did not (markedly) decrease, other positive developments occurred: the age of onset of psychoactive substance use rose; youth psychoactive substance use remained stable and/or decreased in certain demographic/age groups; attitudinal support for the lowering of youth psychoactive

substance use manifested among young people and/or their seniors; and/or the rate of use of psychoactive substances among adults declined.

For example, in Ivanovo in the Russian Federation, not only did (1) the overall level of psychoactive substance use among young people remain more or less constant over the intervention period, but (2) the tendency among young and old to regard youth use of psychoactive substances as risky also stayed intact, while (3) the level of use of particular psychoactive substances decreased markedly among particularly vulnerable demographic/age groups, e.g. tobacco use among older males (14-21 years) and alcohol use among younger females (10-13 years). In Partizanski District in Belarus, the tendency towards increased psychoactive substance use among young people was offset by the increased inclination of their seniors to (strongly) disapprove of psychoactive substance use and regard such use as risky. In Old Stone Town in Tanzania, amidst an increase in the general level of psychoactive substance use among young people, regular use (i.e. (almost) daily use) of a range of psychoactive substances declined. In addition, adults' level of use across a range of psychoactive substances declined.

Particularly notable are the largely positive results that were achieved in the evaluation sites with regard to **preventive activities**. These activities generally reached widely into the evaluation communities—more particularly the school community (learners, teachers, parents)—with the mass media ever so often facilitating the wide transfer of prevention messages. Existing services were strengthened and in some cases new services and partnerships were established, e.g. between various government agencies (such as schools and the police), between government bodies (such as the police) and civil society agencies (such as youth groups),

and between various civil society agencies (such as youth and women's groups). Project participants (e.g. young people trained in rendering peer support) reported personal growth in constructive life skills and knowledge in facilitating prevention in the course of the project.

The positive changes in the evaluation sites are remarkable, considering the complexity (e.g. the wide range of project sites and preventive activities) of the project and the fact that they took place amidst **broad socioeconomic "pressures"** towards psychoactive substance use (e.g. economic debility, limited essential services and positive conditions for trading in psychoactive substances). It is also important to note that the generally positive outcome of the Global Initiative within the outcome evaluation sites occurred against the background of a carefully planned set of systematically interrelated and logically ordered project activities, namely training of local/country project partners, situation/needs assessment, primary prevention action, documentation of project activities, sharing of experiences of good practices, and evaluation. The local/country

partners' evaluation of their preventive activities within the respective outcome evaluation sites underlined that the work proceeded as planned and was well received by the target groups. More generally, the results of the **process evaluation of the overall project** were also positive. The coordination/managerial activities—for which the WHO and UNODC were responsible—integrated more or less isolated preventive activities into a bigger whole, giving the participants a feeling of "belonging" and boosting their motivation. The training material and the training of the local partners were received well by the trainees, particularly as the latter participated in the process and the training workshops strengthened relationships between project participants. The high demand from agencies outside the Global Initiative for the training materials underlined their usefulness. The local Global Initiative partners also expressed great satisfaction with the experience-sharing meetings. Information exchange was, furthermore, strengthened through newsletters and various electronic and traditional communication means.

Table 73. Main outcomes of the Global Initiative in the evaluation sites in six project countries

Outcomes	Russian Federation			Belarus		Thailand		South Africa		Tanzania		Zambia
	Ir-kutsk	Iva-novo	Lublino District	Central District	Partizanski District	Wat Chaiyaprukmal	Sulaw Jorakaekob	Bela-Bela	Greater Preto-ria	Kinondoni	Old Stone Town	Kanyama & Chinika
Youth lifetime use of alcohol	—*	0**	—	—	+***	+	+	+(Wine & cider)	—	+ (Past 12 months' use)	+ (Past 12 months' use)	— Males + Females
Youth lifetime use of tobacco	—	0	—	—	+	—	+	—	—	— (Past 12 months' use)	+ (Past 12 months' use)	— Males + Females
Youth lifetime use of painkillers	+	0	—	—	+	—	—	+	—	+ (Past 12 months' use)	+ (Past 12 months' use)	+
Youth lifetime use of marijuana	—	0	+	+	+	0	0	—	0	— (Past 12 months' use)	+ (Past 12 months' use)	+
Youth lifetime use of other illicit psychoactive substances	—	0	+	+	+	0	0	...****	...	— (Past 12 months' use of heroin)	— (Past 12 months' use of heroin)	0
Awareness of risks of psychoactive substance use	0 a + c	0 a + c	— a + c	— a + c	0 a + c	— a + c	— a + c	+ b + c	+ b + c	+ b + c	+ b + c	+ b + c
Prevention programmes, services, networks	+	+	+	0	0	+	+	+	+	+	+	+
Human resource capacity	+	+	+	+	+	+	+	+	+	+	+	+

* Decrease

** No marked change

*** Increase

**** Data unavailable

a Data source: Youth KAP Survey

b Data source: Adult KAP Survey

cData source: Local/country partners' evaluation of their Global Initiative preventive activities

8.3 RELEVANCE OF THE GLOBAL INITIATIVE PREVENTION STRATEGIES

The fact that the Global Initiative largely proceeded as planned and generally produced positive outcomes underline the fruitfulness of the prevention strategies adopted by the local/country partners in the project. Moreover, these outcomes point to the relevance and feasibility of countries experiencing rapid change, including developing countries with limited resources, employing prevention strategies found useful in other parts of the world (cf. World Health Organization 2004b, 2004c, 2002a, 2002b, 2002d; Canadian Centre on Substance Abuse 2001; Morgan 2001; European Monitoring Centre for Drugs and Drug Addiction 2000; Centre for Addiction and Mental Health 1999; Springer & Uhl 1998; Spooner 1997; US Department of Health and Human Services 1991). In fact, the local projects (1) adopted a multi-component prevention strategy; (2) were science/evidence-based (i.e. tailored to the results of the pre-project situation assessments); (3) operated on the level of individuals as well as communities; and (4) were planned/executed with the active participation of target groups (e.g. young people).

More specifically, the local projects not only (1) provided target groups (e.g. young people and their parents) with information on the risks of psychoactive substance use; but also (2) raised the personal/social competence (life skills) of the target groups; (3) drew target groups into constructive social support networks (e.g. peer support groups) and leisure/vocational activities and in this way improved access to educational and employment opportunities; (4) increased broad community support for prevention action; and (5) involved target groups in project planning and execution. Furthermore, by adopting a mix of individual- and community/environment-oriented activities, the projects acknowledged social science evidence that

... individual choices ... are shaped and constrained by social conditions—by the knowledge one has about the effects of [psychoactive substances] ... by the patterns of [psychoactive substance use] ... among one's family and friends, by advertising, by the legal sanctions on ... [psychoactive substance use], by the price and availability of [psychoactive substances] ... by available networks of social support, by the presence or absence of a job or home ... (Bertram et al. 1996:199).

8.4 ENABLING FACTORS IN PROJECT DELIVERY

In view of future action and considering the generally positive outcome of the Global Initiative, it seems appropriate to draw attention to the following main enabling factors that participants in the project identified:

- The early and meaningful/active involvement of community agents and target groups in the planning and execution of project activities contributed towards the (1)

identification of local prevention needs, challenges and potential solutions; and (2) the sustainment and expansion of local/“community” support (e.g. in the form of the allocation of human and material resources), indeed local/“community” ownership of the project. In some instances (e.g. in the project sites in the Russian Federation and Belarus) the project facilitated the formation of relationships/partnerships between traditionally independent agencies (e.g. government and civil society groups). In other communities (e.g. project sites in Thailand) a key advantage was the good relationships that already existed between government and civil society agencies and, more particularly, the Government's demonstrated commitment to securing the well-being of community members.

- The training of trainers also eased human resource demands and facilitated expansion of the project.
- Regular contact between the global and regional coordinators/technical officers and the local project teams/partners, as well as the presence of a national focal partner/coordinating body in each country contributed significantly to
 - o the development of strong and smooth relationships between key participants in the local projects, e.g. global/regional coordinators/technical officers, local project (co-)leaders and financial administrators;
 - o better understanding of the reason and procedure for completing documents crucial to the success of the project, e.g. project proposals, grant application forms and data collection instruments;
 - o focused and timely project delivery; and
 - o hands-on and timely assistance when shortfalls emerged and project adjustments were required.
- The periodic project site visits of the regional coordinators/technical officers gave local project partners the opportunity to ask questions, boosted the morale of project team members and provided technical assistance where required.
- The experience-sharing meetings among project participants in the respective project countries/regions led to cross-fertilization and enriched/reinforced participants' ideas and experiences on topics such as the planning, execution and use of situation/needs assessments.

In short, the project participants noted that the Global Initiative preventive activities established a foundation for strengthening and expanding the primary prevention of psychoactive substance use and related problems among young people in the project countries.

8.5 CONSTRAINING FACTORS IN PROJECT DELIVERY

The participants in the project underlined that their work was not free of difficulties. They stressed, though, that these difficulties taught them perseverance and challenged them

to think and act innovatively. Solutions were, however, not always easy/possible, especially with regard to the issue of post-project continuation/expansion. The following main constraints were mentioned:

- A high turnover among especially the lead members of project teams as well as a general lack of prevention expertise increased the burden of project managers and the focal partner/coordinating body in some project sites/countries.
- It was difficult and time consuming to reach out to and build rapport and maintain a relationship of trust with out-of-school and historically neglected/disadvantaged young people, because of their transient lifestyle and/or trauma-laden backgrounds.
- Because of the generally poor economic conditions and a variety of competing social and physical burdens in the project countries/sites, it was difficult to procure adequate and long-term funding for the primary prevention of psychoactive substance use and related problems.

8.6 LESSONS ON WHAT WORKS IN PRIMARY PREVENTION

The Global Initiative participants in the project countries/regions highlighted a variety of lessons as to what works in primary prevention project delivery, i.e. “good practices”. The project participants in Southern Africa, for example, noted the following:

- A **comprehensive and evidence-based approach** works well in community-oriented prevention programmes. Such an approach consists of the following consecutive stages: (1) situation/needs assessment in the area/community concerned (baseline assessment); (2) design of a strategic prevention action plan that is based on the identified needs, and includes a monitoring and evaluation plan; (3) implementation of the planned intervention; (4) programme evaluation; and (5) adaptation of the intervention in terms of the evaluation results.

The project participants in the Russian Federation, Belarus and Southeast Asia added the following:

- Designing prevention programmes in terms of a **carefully planned and participatory assessment of the local situation/needs** in the prevention community ensures relevant preventive activities that are widely supported in the community.
- A **culture of continuous learning** among prevention agents—and thus the practice of developing programmes with strong monitoring and evaluation components—ensures the incremental improvement of prevention action.

In all three regions project participants also noted the following as to what works in the primary prevention of psychoactive substance use and related problems:

- A **strong institutional framework** is essential to complete and expand prevention programmes. In fact, sustained primary prevention projects/actions require:
 - o pre-implementation assurance that the human resources (e.g. sustained leadership/managerial structures) and material resources needed to operate a programme (e.g. beyond initial sponsorship) are available;
 - o capacity building (e.g. training of trainers, opportunities for information sharing);
 - o government support (e.g. policy/institutional assistance) of preventive initiatives; and
 - o networking/coalition building between agents in civil society, business and government. (In terms of capacity building, it is important that service providers proactively attend to leadership/managerial continuity.)

In addition, project participants in Southern Africa underlined the following:

- In-depth **research into ways of mobilizing and sustaining grassroots action within communities experiencing extreme poverty** is essential.

Project participants in the Russian Federation, Belarus and Southeast Asia highlighted the following regarding project execution:

- **Comprehensive prevention programmes** are required, that is prevention programmes need to involve a range of sectors in the communities such as schools, parents, youth groups as well as law enforcement and health service officers. The focus should be on the range of risk and protective factors at play in the development of psychoactive substance use and related problems (risk factors put individuals and communities at risk of psychoactive substance use and related problems, whereas protective factors do the opposite). By addressing the range of risk and protective factors at play, prevention programmes can provide individuals (e.g. young people) and their communities with the information, skills and opportunities to follow healthy and safe lifestyles.

Bearing in mind the specific findings of the overall evaluation of the outcome of the Global Initiative, the above point inter alia suggests, that comprehensive and integrated prevention action prevents an increase in (1) the range of psychoactive substances used; (2) user groups (e.g. girls turning to beer and cigarette use); (3) long-term use; and (4) the substitution of some psychoactive substances for others (e.g. cigarette and pipe-tobacco for snuff). Preventive action therefore has to:

- target young people and significant others in their lives (e.g. parents, teachers, city/village authorities, mass media agencies);

- focus on the range of psychoactive substances used and user groups in the community;
- reduce the demand for and availability of substances;
- redress individual vulnerability (e.g. low self-esteem), small-group vulnerability (e.g. family breakdown) and broad environmental vulnerability (e.g. few economic and recreational opportunities).

8.7 CONCLUDING RECOMMENDATIONS

Note needs to be taken of the following recommendations of participants in the Global Initiative as to what is needed for continued action:

The Russian Federation and Belarus

- Seek wider and active support (e.g. funding) for psychoactive substance use prevention from the government and civil society (e.g. youth and parents).
- Continue contact and information sharing among participants in the Global Initiative, e.g. through the UNODC's Global Youth Network.
- Strengthen and expand psychoactive substance use-related prevention programmes managed by the youth among minority groups and prevent the adoption of substance injection, e.g. through peer education and sport events.
- Continue to develop locally relevant and acceptable "good practices" and training materials on primary prevention.
- Include psychoactive substance use prevention on the national socioeconomic development agenda.

Southern Africa

- Stronger support for psychoactive substance use-related primary prevention should be sought from politicians and government agents. Such support should include at least assistance in obtaining funding and ensuring that standard practices are adhered to. Government can also exercise leadership by bringing together representatives of business, the media and non-governmental organizations to seek solutions.
- Agencies should put in place right from the beginning plans to ensure the self-sustainment of projects in terms of financial and human resources. Having such plans in place will help to raise the credentials of the organizations working on psychoactive substance use prevention. It will also enable the organizations to develop quality relationships in the community.
- Measures for continued networking and information sharing among participants in the Global Initiative in Southern Africa as well as in the other regions should be considered, e.g. a quarterly newsletter administered by the participants in each project region.
- An integrated approach to tackle issues related to the development and health of young people should be encouraged. Indeed, closer linkages/partnerships between,

for example, schools on the one hand and law enforcement agencies and labour, sport, recreation and community development institutions on the other hand could enhance young people's access to psychoactive substance use-related prevention services.

- On-going research on what works in the primary prevention of psychoactive substance use and related problems should be promoted. Without a well-funded and sustained research infrastructure, progress towards effective and innovative prevention will be limited.
- Training manuals on social skills development among young people should be developed locally for prevention agents.
- The skills of workers engaged in prevention should be updated regularly.
- Psychoactive substance use-related prevention should be included on poverty reduction agendas.

Thailand

- (Continued) technical/financial support from, for example, international preventive agencies as well as government structures in the respective countries is essential.
- Efforts towards establishing long-term partnerships between local (non) government agencies (in)directly engaged in the prevention of psychoactive substance use should be continued.

Finally, the following comment regarding the prevention of psychoactive substance use and related problems among young people generally (US Department of Health and Human Services 1991: Foreword) could/should guide the way forward:

As we move forward in the field, we need to use what is learned to enhance the capabilities of individuals, organizations, and communities to tailor their efforts to the diverse ... groups they serve ... New knowledge should be used to continually improve programmatic efforts ... [Furthermore, one] of the keys to good programming is to translate what is known into viable strategies that can be applied in practice.

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Process evaluation results

1. INTRODUCTION

This annex presents the results of the process evaluation. The material has been organized according to the main outputs that the Global Initiative was supposed to deliver:

- Project management/ coordination
- Training
- Implementation of prevention activities by local partners
- Documentation and sharing of experiences on prevention substance use

Evaluation of the process of a project generally assesses “the implementation of an intervention and the reactions of the participants. Such evaluation describes how and if the prevention intervention took place ... and whether the designated target group was reached. It is also concerned with the quality of the intervention” (European Monitoring Centre for Drugs and Drug Addiction 1998:191). Moreover, process evaluation presupposes the monitoring of project activities, i.e. the tracking/recording of what and how planned activities are delivered and resources are used (Rossi, Lipsey & Freeman 1999). The process evaluation plan of the Global Initiative, consequently, set out the manner in which the process evaluation, including the monitoring of the project activities, had to be conducted.

The plan entailed the two main components noted by Rossi, Lipsey and Freeman (1999:100-101): (1) an organizational plan that sets out what and how resources and activities need to be configured and deployed in order to develop and maintain a particular service; and (2) a service utilization plan that deals with whether and how the target population receives the intervention. Indeed, the plan

identified (1) the criteria (e.g. timeliness, adequacy, quality) by which the respective implemented project activities and resources expended had to be assessed; (2) what qualitative/quantitative information had to be collected/recorded and submitted as well as by whom, how and when it had to be collected/recorded. To facilitate comparison across project regions, countries and sites, the plan provided for standardized data collection/entry.

It is important to note that the project participants did not always report the required data in the prescribed format. Instead, they sometimes provided more detail on the project process than the prescribed format required—in which case evaluation was facilitated—and sometimes provided information on issues other than those prescribed and as a result complicated the evaluation process. The findings should also be treated with some caution because of the rather broad categories (e.g. low, medium and high quality) in terms of which project participants sometimes assessed project activities. In some cases this problem was overcome in that project participants qualified their ratings of the project activities in some detail.

2. PROJECT MANAGEMENT/COORDINATION

2.1 Introduction

As per project document, the overall responsibility for project delivery was shared as follows:

- WHO was responsible for the development of the training materials and the provision of training in the three project regions. This included the pre-testing of the materials

during the three regional training-of-trainers workshops and the presentation of one national training workshop for the local partners in each project country.

- WHO was also responsible for the disbursement and monitoring of grants and the provision of technical support to local partners in Southern Africa, while UNODC did the same for Central and Eastern Europe and South-East Asia. After successfully completing a situation/needs assessment in the respective communities in which they planned to implement preventive activities, local partners had to submit applications for grants to WHO or UNODC.
- UNODC was to be responsible for the development of good practices through the organization of annual regional experience-sharing meetings in each of the project regions. Prior to the respective meetings, local partners were guided in documenting their experiences on selected issues in a comparable way, using documentation forms and guidelines developed by UNODC.
- WHO was, furthermore, responsible for the overall evaluation of the project as well as the development of a communication system.

The processes of management and coordination were divided into the following activities and the results of the process evaluation are presented accordingly below.

- Recruitment/appointment of global and regional coordinators/ technical officers
- Selection of project countries
- Identification of local partners
- Coordination of project activities

2.2 Recruitment/appointment of global and regional coordinators/ technical officers

A global project coordinator/ technical officer per executing agency (WHO and UNODC global coordinators) was appointed to implement selected activities, to manage/coordinate the overall implementation of activities and liaise with the other global executing agency, as foreseen by the project document. The appointments were timely, with the UNODC project coordinator selected in June 1997 and taking responsibility for Central and Eastern Europe as well as South-East Asia, and with the WHO project coordinator selected in July 1999 and taking responsibility for Southern Africa.

As per project document, a field project coordinator (regional coordinator) per region was appointed to implement and monitor activities in the field. All the appointments were timely under the circumstances. They occurred in December 1999 for Southern Africa, in March 2000 for Central and Eastern Europe. The profile (e.g. in terms of experience) of the appointed regional coordinator was consistent with regional circumstances. In South-East Asia, the appointment occurred in August 2000 due to difficulties

in finding someone with the required qualifications (i.e. a person who had prevention experience and was fluent in English, Vietnamese and Thai), which informed the decision to be less stringent on the language requirement and provide for translation costs. A replacement for the appointed regional coordinator had to be found after one year, but the replacement was timely and was arranged in such a way that the first and second coordinator were able to work together for a month. Apart from the issue of language, the profiles (e.g. in terms of experience) of all three regional coordinators was consistent with regional circumstances.

2.3 Selection of project countries

According to the project document, project countries needed to be selected in terms of whether they experienced rapid socioeconomic change and/or were developing, and had high levels of substance use and related problems. The Global Initiative was implemented in the following countries:

- Southern Africa: South Africa, Tanzania and Zambia
- Central and Eastern Europe: Belarus and the Russian Federation
- South-East Asia: the Philippines, Thailand and Viet Nam

A short description of these socioeconomic circumstances of the countries at the time of the initiation of the project can be found in Annex II, as well as in the introductory paragraphs of chapters presenting the results of the outcome evaluation (where available). All countries selected had a significant level of substance use and related problems and were either undergoing rapid socioeconomic change (e.g. the transitional countries) or were developing.

2.4 Identification of local partners

Local partners to undertake prevention activities were fulfilled the following criteria.

- To be part of an established organizational structure with a community-based profile.
- Include an accountability mechanism.
- Possess experience in working with and for young people.
- Possess an ability to mobilize adequate human, technical and financial resources.

The overall level at which partners met selection criteria was assessed on a three-point scale (high, medium, low), with partners receiving a medium or high score being viewed as having met the selection criteria.

Table 1 below summarizes the number of local partners that were identified in each country/ region in terms of the pre-planned criteria and included in the project.

Table 1 – Number of local partners included in the Global Initiative

Region	Country	No. of local partners
Southern Africa	South Africa	9
	Tanzania	7
	Zambia	9
Central and Eastern Europe	Belarus	16
	the Russian Federation	39
South-East Asia	Philippines	10
	Viet Nam	12
	Thailand	13

Upon identification, it was clear that the identified partners in Viet Nam had few technical resources, but were included in the project anyway in view of facilitating capacity building in this respect.

2.5 Coordination of project activities

As planned, the global and regional coordinators worked in partnership with one another, with local (non-) government representatives and with the local partners. Interaction was direct (e.g. meetings and site visits) and indirect (e.g. electronic and other communication media) as planned.

Project coordinators expended available material resources prudently by combining their coordination activities with other responsibilities, e.g. the rendering of technical support to local project activities and the provision of global/regional networking opportunities to local partners.

Furthermore, the establishment of a coordinating body at the launching of the project in each participating country functioned as a crucial local focal point, assisted in the monitoring of project activities and facilitated communication between participants at all levels. This body included a project focal person designated by the country to the project—a WHO or UNODC local official—and others from other locally based international organizations such as UNICEF.

The local prevention partners generally experienced the support of the project coordinators positively, e.g. noting that the coordination activities facilitated the integration of more or less isolated preventive activities into a bigger whole, and especially contributed towards feelings of “belonging” and commitment to the project.

2.6 Conclusion

The management/ coordination process occurred largely as planned:

- The identified project countries fulfilled the pre-specified selection criteria.
- The selection of the project coordinators was timely under the circumstances and their profile consistent.
- The selected local partners met the specified criteria
- Finally, coordination meetings and site visits occurred as planned, facilitated the integration of more or less isolated preventive activities, and contributed towards a sense of “belonging” and commitment among participants.

3. TRAINING

3.1 Introduction

According to the project document, two sets of training workshops were to be organised following the drafting of the training materials. First, a series of 3 regional training-of-trainers workshops, where participants would also provide input on the draft training materials. Following the finalisation of the training materials, a series of nine national training workshop was to be organised for the local partners. The assessment of this process is presented according to the following three components:

- Overall development of the training materials.
- Regional training-of-trainers workshops.
- National training workshops for local partners.

3.2 Development of the training materials

The project facilitated the development and pre-testing of training material (i.e. exposed it to potential users for review, comments and recommendations) during regional training-of-trainers workshops, with a core group of local partners facilitating the interactive training of local prevention partners at a subsequent national workshop in each project country. Although the WHO global coordinator took overall responsibility for the development of the training materials, UNODC (both at Headquarters and at regional level) and WHO Southern Africa as well as the core group of local prevention partners were fully engaged in the development, revision and finalization of these materials.

The training and associated training materials covered topics such as effective approaches to primary prevention, the carrying out of local situation assessments, and project design, monitoring and evaluation. The text of the training material was initially in English and then translated into local languages, i.e. Swahili, Bemba, Nyanja, Vietnamese, Russian and Taloge (national language in the Philippines).

In the development/ finalization of the training material, the participants in the regional workshop in all three regions rated the review process highly. For example, participants in Southern Africa felt that the opportunity they got to review and develop the draft Workbook for Project Operators and the Facilitator Guide made them feel they had made a significant contribution to the development of the project and therefore afforded them “ownership” of the project.

Workshop participants rated the quality of the training materials positively, specifically in terms of their comprehensiveness, clarity, appropriateness, adaptability and applicability. For instance, with regard to the adaptability of the material to national and local contexts, the following comment represented a common viewpoint: “The exercise questions were directed at the situation in one’s community and thus promote relevancy and adaptability to any given country/community.”

Requests for the training documents from other NGOs occurred daily. However, because of limited resources the training materials were provided to the local prevention partners only.

The finalization and distribution of the training materials to local prevention partners were delayed by four months, and consequently received only a medium rating from participants in the project regions. Various factors contributed to this: difficulties in arranging the training-of-trainers regional workshops in close sequence, and the time-consuming nature of the translation, review and publication process.

3.3 Regional training-of-trainers workshops

The three training-of-trainers workshops occurred as planned.

In Southern Africa the workshop comprised 14 participants (mostly male and experienced in prevention of substance use), while in Central and Eastern Europe participants were 17 (mostly female and only 6 with direct experience in prevention of substance use, but most with experience in working with NGOs) and in South-East Asia 8 (mostly female and experienced in prevention of substance use). The workshop in Central and Eastern Europe was larger than the others and was characterised by participants with a lower level of expertise in the prevention of substance use due to give it a stronger training component. Given the level of expertise of most participants, it is not surprising that the workshop organisers overall commented: "Looking back, these meetings were more useful as a way of getting inputs on the materials and in involving stakeholders than as a training tool."

In all three workshops, feedback was requested and overall the participants were highly satisfied with the format and content of the training workshop. In Southern Africa, participants felt the workshop helped to strengthen their knowledge and skills. In Central and Eastern Europe and in South-East Asia, some participants felt they were not given enough information before the workshop and some participants experienced the workshop as very intense and too short. One participant in Central and Eastern Europe commented: "The workshop was adequate and the objectives were carried out at optimal level with optimal choice of time and place."

3.4 National training workshops for local partners

Nine workshops were organised timely over January and February 2001. One workshop was organised in each country, with the exception of the Russian Federation where, given the number of local partners and the vastness of the country, two workshops were organised.

Participants provided feedback, which were overall positive, but also constructive suggestions. In South Africa, some participants were uncomfortable with working in

English. However, most participants contended that the training equipped them with the skills needed to fulfil roles and responsibilities in primary prevention. In Tanzania, participants used a Swahili version of the materials that contributed positively to the value of the workshop. Participants appreciated the opportunity to comment on aspects of the translation that required improvement; felt they had gained adequate knowledge; and that the skills acquired provided an incentive to implement preventive activities in future. Finally, also in Zambia, the use of English appeared to limit the maximum participation of some participants, although participants generally felt they had acquired useful skills.

In all three countries of Southern Africa, participants indicated that more time and exercise in technical aspects such as data analysis and moving from data to primary prevention action could have been allocated. Moreover, the WHO Headquarters project coordinator evaluated the overall quality of all the workshops as high, the quality of organization as moderate/high, the relevance and the usefulness as high. However, she evaluated the learning effect as moderate. This is why in the region, and at the request of the participants, a follow-up training workshop was held by the regional coordinator on prevention knowledge and skills and situation assessment.

In the Russian Federation and particularly in the workshop that took place in Irkutsk, participants reported that the exchange of information and experience gained during the workshop was useful and noted that the workshop served as a starting point for the creation of national networks. Participants commented: "The importance of developing a common strategy for substance abuse prevention work at the community level was stressed by all the participants. The workshop served as [a] starting point for the creation of national and regional networks and the development of common approaches and ways of responding to substance abuse among young people." In Belarus, participants regarded the training as very useful in terms of skills acquired, but also particularly appreciated the sharing of experience with other agencies, the building of networks and especially the fact that for the first time non-governmental and governmental agents were interacting and exchanging experiences and ideas.

In Thailand, participants generally thought the information and the activities were useful. Although, some older participants took a while to get used to the participatory approach, they also found the module on the project approach extremely useful in explaining the role and types of resources that can be mobilized for a project. Suggestions included a field visit and the opportunity to personally summarize their learning experiences. In the Philippines, participants appreciated the opportunity to share experiences and ideas, while in Viet Nam participant comments and appraisals of the training were generally positive, but it was also felt that the training should have been longer and some field visits should have been made.

3.5 Conclusion

The training of the local partners occurred largely as planned. The topics covered in the training materials corresponded with those planned and the demand for these materials from outside the Global Initiative underscored their usefulness. Although the training materials were finalized later than planned, this did not impact negatively on the other activities.

The participants in the regional training-of-trainers workshops evaluated the workshops positively, e.g. as having improved their knowledge and skills and integrated them into the overall project and contributed towards feelings of “ownership” of the Global Initiative.

On the national level the evaluation of the training was complicated by the fact that project participants did not report on this issue in detail. However, the general impression was that participants (especially in Central and Eastern Europe and in South-East Asia) found the training workshops a positive experience because of especially their interactive nature and opportunities afforded for learning through exchanging ideas/ experiences. Participants in Southern Africa felt the workshops should have allocated more time to data analysis and to the process of “translating” the data into primary prevention action. The project responded to this felt need by organising some follow up training. Some participants in Central and Eastern Europe and in South-East Asia felt the workshops could have provided more time and opportunity for field visits. In Central and Eastern Europe the workshops provided a unique opportunity for non-governmental and governmental organizations to interact.

4. IMPLEMENTATION OF PREVENTION ACTIVITIES BY LOCAL PARTNERS

4.1 Introduction

Following the national training workshops, local partners were invited to undertake an assessment of the substance use situation in their community and to develop a substance use prevention proposal on the basis of the assessment. Local partners then submitted the proposals for consideration for funding by the WHO and UNODC in terms of pre-specified criteria. As in the case of their situation assessments, the local partners developed their project proposals on their own. The regional and Headquarters coordinators reviewed and discussed these proposals and then offered suggestions to the local partners. Revised versions were reviewed and discussed again. Once a proposal was finalised, local partners were awarded a grant to implement the prevention activities as detailed in the proposal.

This report assesses this process in terms of the following two main components:

- Local situation assessments undertaken by local partners
- Selection of proposals submitted by local partners
- Prevention activities undertaken by local partners

Although each section discusses results by country/ regions, it should be noted that this is a section of the report where comparisons should be made with extreme caution as: (1) the evaluation criteria used in Southern Africa differed from those used in the other two regions, and as (2) different evaluators evaluated the projects in respectively Central and Eastern Europe and South-East Asia. In South-East Asia, the projects were evaluated by an external consultant, with inputs by the Regional Coordinator, while in Central and Eastern Europe, this assessment was undertaken by the regional coordinator only. Occasionally, the activity reports of the local partners were incomplete, i.e. provided little detail.

4.2 Local situation assessments undertaken by local partners

Following the training, and as planned, virtually all the trained local partners undertook assessments of the substance use situation in selected communities. The local situation assessments were reviewed by the regional and global coordinators, commented on and discussed with the local partners (over the phone or face-to-face), giving special attention to data collection. Most local partners went through two rounds of review, and some through three or more reviews.

In Southern Africa, the local situation assessments undertaken by the local partners were evaluated whether (on a three-point scale comprising a low, medium and high rating) in terms of: technical support provided by the global and regional coordinators; level of involvement of other NGOs/partners; the adequacy of planning for the situation assessment; the duration of the assessment process; and the quality of the results obtained. In Central and Eastern Europe and South-East Asia assessments were evaluated in terms of: the extent to which assessment included a mixture of methodologies (qualitative/ quantitative); the extent to which other partners/ young people participated in data collection; and, the extent to which substance use-related risk and protective factors were identified.

In Southern Africa, the local situation assessments were generally rated highly, particularly in cases where adequate time was spent on planning/ operation and particularly in Tanzania, where local partners all involved other agencies, e.g. (non-) government agencies. In particular, in all countries, local partners experienced difficulties in data analysis and identifying their prevention implications. Therefore, they requested and obtained an additional three-day seminar. Moreover, some local partners in Zambia needed additional technical assistance from the WHO Headquarters and regional coordinators. The WHO global coordinator commented: “Some NGOs had the tendency to collect too much data, for this reason they felt overwhelmed and required individual guidance to help them develop manageable and appropriate interventions.” In view of these efforts, it is not surprising that local partners rated highly the technical support they received.

In South Africa, the planning and duration of the assessments were highly adequate in five of the cases, and moderately adequate in the remaining four cases. The regional coordinator commented: “The duration of the assessments varied from three to six weeks with the NGOs who used varied data collection methods spending more time and those who rushed through the assessment achieving a moderate quality rating.” In Tanzania, local partners took ample time to plan their assessments, while in Zambia, they experienced a shortage of time for data analysis and identification of implications.

As mentioned above, in Central and Eastern Europe and in South-East Asia, local situation assessments were rated on three dimensions on a scale from 1 (poor) through 3 (adequate) to 5 (excellent). In the Russian Federation, the local partners’ assessment activities generally received an overall score at the upper end of the scale, except in respect of data collection methods. In the latter case scores tended to be in the middle range because of limited experience in and, thus, use of multiple methods. In Belarus, although some situation assessments received scores in the upper range on most of the dimensions, scores were generally lower because of limited experience in and, thus, use of multiple data collection methods and involving young people.

In Thailand and in the Philippines, the local partners’ situation assessments generally received mid-scale scores, although on average, the scores in the Philippines were higher than in the case of the Thai assessments. In Viet Nam, assessments received scores at the lower end of a 5-point scale because of little experience in the field. As a result the coordinators decided to provide special/ additional support to the local partners.

4.3 Selection of proposals submitted by local partners

In Southern Africa, project proposals were assessed (on a three-point scale comprising a low, medium and high rating) as to whether: the focus was on prevention among young people; they had the potential to reach a significant number of young people; they were based on scientific evidence; they addressed local needs; and they embraced community involvement.

In Central and Eastern Europe and in South-East Asia individual project proposals were assessed (using a five-point scale with 1= very low, 3=adequate and 5=very high) as to whether: they were comprehensive (i.e. they addressed a range of risk/protective factors) and innovative; young people were to be involved as active partners; and, the wider community (i.e. a range of sectors) were to be involved as active partners.

All the project proposal that were selected for funding had to fulfil minimum requirements, i.e. they had to have at least a medium rating on the relevant dimensions. This means that in Southern Africa, all proposals focused on substance use-related prevention among young people and all had potential to reach a significant number of young

people. About half of the project proposals were rated highly and the other half received a medium rating on the requirement of being based on scientific evidence; all proposals addressed the needs identified in their situation assessments and noted that youth leaders, teachers and parents participated in the planning of the interventions.

Similarly, in Central and in Eastern Europe all projects were at least rated adequate in terms of all three dimensions: comprehensiveness and innovativeness; youth participation and community participation. In South-East Asia, project proposals in the Philippines and in Thailand rated at least as adequate in terms of all three dimensions, with the exception of the Philippines where proposal were rated highly in terms of comprehensiveness, innovativeness and youth participation. Proposal in Viet Nam were rated lower on all three dimensions. Notwithstanding this difficulty, the project decided to support the implementation of the prevention activities in Viet Nam with the provision of additional technical support.

4.4 Prevention activities implemented by local partners

Available information on the preventive activities implemented by local partners in the various project regions underlined that most projects focused on education and skills development, i.e. on efforts at raising awareness/providing information on the risks associated with psychoactive substance use among the youth, parents and the wider project communities. In many cases information on the risks of psychoactive substance use was distributed to the youth through their peers and in the course of life skills education programmes. To raise awareness local partners organized various types of events (marches, concerts, performances, discos, artistic and sport competitions etc.), often in collaboration with young people. Life skills training was widespread, and included youth- as well as family/parent-oriented programmes. In some cases parents were trained as peer educators. Most projects also organized alternative/non-substance use activities (mostly sport, drama and music and/or vocational skills training events) for young people that were often combined with efforts at distributing information on the risks of psychoactive substance use. Indeed, multi-levelled/faceted prevention projects that targeted individuals as well as groups/institutions in the project communities were widespread among local partners, especially in Central and Eastern Europe and South-East Asia.

In Southern Africa, the assessment of the prevention activities implemented by local partners focused on: the timeliness of site visits; the adequacy of planning; the adequacy of the involvement of the local resource persons; and, the quality of information and reporting. In Central and Eastern Europe and South-East Asia, the prevention activities implemented by local partners were rated on a five-point scale (with 1=very low, 3=adequate and 5=very high) in terms of the following three dimensions: the extent to which the implemented activities were faithful to the

project plan/proposal; the extent to which activities targeted young people or involved them as local partners; the extent to which the activities targeted or involved as active partners various sectors of the project community.

In South Africa, as judged by the WHO Headquarters coordinator, sites closer to well-resourced centres (such as the city of Pretoria) benefited more from site visits than those further away, particularly as practical issues such as limited funding prevented more regular (more than three) and, indeed, timely visits from project coordinators. As a consequence the overall quality of prevention action was higher in the sites closer to Pretoria. In general, overall satisfaction was expressed with the way the WHO Headquarters and WHO Southern Africa performed their managerial functions.

The overall quality of local planning was generally high in the region. At two project sites in South Africa, however, project leaders changed and this impacted negatively on activities in especially the case of one site. The major role players such as the health, welfare and education ministries did play a major role as resource persons or institutions. This aspect of the implementation process was rated generally high.

With regard to the analysis of the information collected, most of the sites were assigned high quality ratings regarding the work performed by the partners, but two were rated as of low quality in South Africa. In the projects administered at universities, the students involved in the projects also benefited academically.

In Tanzania, in one site the local partner did not live up to expectations and all aspects of the implementation process were rated lowly. The other sites received a high or medium quality rating generally, except regarding data analysis which was rated medium in all cases. In Zambia, six of the nine projects implemented all the planned activities well. In the case of three projects, some administrative and managerial problems occurred that required supervision.

In the Russian Federation, the projects on average obtained an adequate rating (i.e. a score of at least 3) on two dimensions: extent to which the implemented activities corresponded with the project proposal and they targeted/involved young people. In Belarus, the project on average achieved an adequate rating. However, they mostly did not obtain an adequate score on at least one of the three dimensions.

In South-East Asia, the quality of the projects was rated on average as adequate on all dimensions, i.e. obtained a score of at least 3 in both the Philippines and Thailand. (with one exception). In Viet Nam, only one of the projects achieved an acceptable rating on the dimensions evaluated and full funding support. This occurred notwithstanding the fact that the regional coordinator arranged additional training (e.g. at experience-sharing meetings) and provided technical support to all the projects throughout the implementation phase. Project management therefore decided not to disburse the second instalment of the grants in the

region. Apart from this, in all region, the vast majority of partners submitted at least adequate reports (with one/two exceptions per region) in the required format and they qualified for a second instalment of funds.

4.5 CONCLUSION

As presented in Section 4.2, the local partners' situation assessments in Southern Africa generally obtained a high rating, which was especially ascribed to the special three-day training seminar that the regional coordinator arranged in each country at the local partners' request. Thai and Philippine local partners' situation assessments generally scored higher than those in Central and Eastern Europe, whereas the assessments in Viet Nam received largely low scores.

Section 4.3 describes how proposals in Southern Africa received at least a medium score. The proposals in Thailand, the Russian Federation and Belarus generally received medium ratings, whereas the Philippine proposals generally received a higher score. The Vietnamese project proposals on the other hand mostly received a low rating.

Finally, section 4.4 discusses how in Southern Africa the implemented preventive activities in Tanzania and Zambia were generally rated as satisfactory. In South Africa projects generally rated highly with regard to the issue of planning and involvement of local resource agencies in activities, but received varied ratings on the issue of data analysis and the lowest rating on the issue of reporting. Whereas the ratings of the projects in Central and Eastern Europe and in South-East Asia generally received acceptable ratings, those in Viet Nam mostly did not.

In short, available information underlined that the local situation assessment process and the process of implementing preventive activities were generally satisfactorily implemented, except in the case of Viet Nam, where corrective action had to be undertaken.

5. DOCUMENTATION AND SHARING OF EXPERIENCES ON THE PREVENTION OF SUBSTANCE USE

5.1 Introduction

As per project document, the documentation of the experiences on the prevention of substance use was to be undertaken through three different activities:

- The development and distribution of documentation instruments for reporting/monitoring project activities.
- The identification of good practices through systematic self-evaluation and discussion at regional experience-sharing meetings.
- The overall process and outcome evaluation.

The assessment of these activities, focusing on the timeliness, adequacy and quality of the final product is organised below accordingly.

5.2 Documentation instruments for reporting/monitoring project activities

The process of developing documents for reporting/ monitoring and evaluating project activities as well as the final products were rated by the global coordinators as of high quality in most respects, i.e. in terms of the timeliness and adequacy of the review (e.g. by project coordinators, local partners and peers at both WHO and UNODC Headquarters and Field Offices) and field-testing of drafts as well as the translation and distribution of the final products.

As planned, in Southern Africa, three documents were produced and distributed to project participants: (1) a pre-implementation activity form for documenting activities of the local situation assessment; (2) an implementation phase form for documenting/monitoring activities; and (3) a post-implementation phase form for documenting evaluation activities. In Central and Eastern Europe and in South-East Asia, three documents were also produced: (1) the grant application form, including the opportunity to report the results of the local situation assessment, the proposed activities, the proposed monitoring and evaluation plan; (2) an interim reporting form, including the opportunity to report if and how planned activities had been implemented and feedback of participants; and (3) a final reporting form, including the opportunity to report if and how all planned activities had been implemented, as well as the results of the self evaluation.

5.3 The identification of good practices through regional experience-sharing meetings

As per project document, three series of experience-sharing meetings were foreseen and organised. Each series documented the experience of local partners on one specific substance abuse prevention topic as follows: (1) assessing and planning for substance abuse prevention; (2) alternative

activities for substance abuse prevention; and (3) evaluating and monitoring substance use prevention activities. During the first series of experience-sharing meetings the local partners were consulted on the topics to be dealt with in the second and third series of meetings. Prior to each of the series of experience-sharing meetings, a document was produced, translated and distributed to all local partners to fill in. The information thus collected informed the discussion at the experience-sharing meetings themselves.

A consultant with considerable experience in developing good practices on substance use prevention drafted the document on assessing and planning for substance use prevention. The first draft of the document on alternative activities was produced by the UNODC global coordinator on the basis of a literature review and lessons learnt from the first set of documentation materials. The UNODC global coordinator also produced the first draft of the documents on monitoring and evaluation on the basis of the results of a good practice development meeting organised under another project. This meeting brought together 12 groups from all over the world (including some local partners of the Global Initiative) to review a draft publication developed by a consultant on effective monitoring and evaluation for community-based organizations and youth groups working in prevention.

Although the materials were not field tested, the drafts of the documents were reviewed by the WHO global coordinator, all the regional coordinators and other UNODC staff working on substance use prevention both at Headquarters and in the Field Offices. Useful recommendations for amendments were received from all parties consulted, and were integrated into the final products. The first set of documents was finalized by the consultant, and the second and third sets were finalized by the UNODC Headquarters coordinator.

The meetings occurred timely. In Southern Africa and Central and Eastern Europe, meetings were organised at the regional level, while in South-East Asia, meetings were organised at the national level due to the language barriers existing in the region. Table 2 details the date, location, language and number of participants in the meetings.

Table 2 - Number of local partners included in the Global Initiative

Series	Region	Date & Location	Language	Participants
1 st series – Local situation assessments	Southern Africa	15-18 July 2002, Pretoria, South Africa	English	22 participants Mostly male
	Central & Eastern Europe	29 July–1 August 2002, St. Petersburg, the Russian Federation	Russian	55 participants Mostly female
	The Philippines	10–13 June 2002, Manila, Philippines	English	12 participants Mostly female
	Thailand	5–8 August 2002, Bangkok, Thailand	Thai	13 participants Mostly female
	Viet Nam	23–26 September 2002, Hanoi, Viet Nam	Vietnamese	15 participants
2 nd series – Alternative activities	Southern Africa	2-5 December 2002, Lusaka, Zambia	English	23 participants Mostly male
	Central and Eastern Europe	2-6 February 2003, Minsk, Belarus	Russian	50 participants Mostly female
	The Philippines	18-21 March 2003, Davao City, Philippines	English	13 participants
	Thailand	4–7 February 2003, Chiang Mai, Thailand	Thai	13 participants
	Viet Nam	23-28 March 2003, Hanoi, Viet Nam	Vietnamese	15 participants

Series	Region	Date & Location	Language	Participants
3 rd series – Monitoring and evaluation	Southern Africa	10–12 November 2003, Bagamoyo, Tanzania	English	22 participants Mostly male
	Central & Eastern Europe	15-18 September 2002, Anapa, the Russian Federation	Russian	42 participants Mostly female
	The Philippines	Cebu, Philippines, September 2003	English	13 participants Mostly female
	Thailand	October 2003, Bangkok, Thailand	Thai	11 participants
	Viet Nam	September 2003, Hanoi, Viet Nam	Vietnamese	15 participants

The feedback of participants on the meetings was collected at the end of each meeting through an anonymous questionnaire. In all regions and in all three series, the feedback of participants was positive. For example, regarding the meetings dealing with assessment and planning and alternative activities, all participants felt that the identified good practices were representative of experiences in the region because of the process through which it had been identified and because it was based on open discussion of the practical experiences of participants. Typical answers were: “As the results emanate from the experiences shared for the region, I feel strongly confident about them ... The results are a product of our discussions and we did the summary on a consensus basis as a group...”.

Regarding the aspects of the workshops that were particularly appreciated, participants highlighted the following issues: the opportunity they had to share ideas; the willingness among co-participants to share experiences; the group discussions and sharing of stories; and the way the work was organized (e.g. through small-group discussions). For example, a participant, noted that the friendly and open attitude of the foreign participants provided opportunities for effective and fruitful sharing and learning.

Regarding the question of what the participants thought could be done differently in future meetings, almost half of the participants mentioned that they would not like anything to be different, and most of the rest mentioned that more time was needed for discussion. Some participants indicated that they would have liked more information on how to prepare for and what to expect from the meetings.

With regard to the third series of meetings, besides emphasising that they agreed that the meeting reflected regional good practices with regard to monitoring and evaluation, many participants added that they obtained a better understanding of the concepts of monitoring and evaluation due to the sharing of experiences, but noted some difficulties with tackling the issue of integrating youth within a primarily adult undertaking.

As a general reflection, the UNODC global coordinator commented that the process as whole was a good way to document the experience of the local partners. However, the project obtained most of the information through the documentation instruments. The experience-sharing meetings mostly did not add substantially to this, but were an invaluable tool for local partners to exchange experiences among themselves, which was also one of the primary aims of the process.

5.4 Overall process and outcome evaluation

The first activity in the undertaking of the overall process and outcome evaluation of the Global Initiative was the development of the evaluation framework and instruments. A consultant took approximately two months to develop the framework and instruments, which were technically reviewed by peers at WHO and UNODC.

Regional institutions were then selected to carry out the pre- and post- project assessments. Country-based rather than the originally planned regional institutions were selected. This decision was based on practical issues such as the expected high cost of selecting one institution per region, and expected language and logistical difficulties. The selected institutions all fulfilled the criteria specified in the process evaluation plan, i.e. track records in psychoactive substance use-related research, experience in survey research, and expertise in qualitative and quantitative data analysis.

With regard to the pre-project (baseline) situation assessments, the consultant provided preparatory technical support to research institutions in Belarus and the Russian Federation. The local partners who were working in the evaluation sites were involved in the planning of the assessments and were on standby to respond to researchers' questions. Planning for the activity was done in collaboration with country, regional and the Headquarters offices of the WHO and UNODC.

The results obtained varied, particularly because of language-translation challenges. As a result a substantial amount of time had to be spent on clarifying issues and the summary reports were not published until 2003.

Concerning the post-project (outcome) situation assessments, preparatory technical support was provided at a global level to the research institutions at a meeting of researchers in January 2003. The research design and process as well as the salient information to be collected in the assessment were reviewed. The WHO consultant provided additional technical support on a face-to-face basis during follow-up meetings with the Southern African researchers in Zambia and Tanzania later in 2003. These meetings were found to be useful to the relevant parties. The local partners who were working in the evaluation sites were again involved in the planning of the assessments and were again on standby to respond to researchers' questions. As in the case of the pre-project assessments the results obtained in the post-project assessments varied. The analysis and comparison of the available results of the pre- and post-project assessments were summarised in the present report.

During 2003, information to inform the process evaluation was collected to be summarised in a report finalised in 2004 (Angell 2004), which forms the basis of this chapter.

5.5 Conclusion

The process of documenting the experiences of the local partners and of the Global Initiative ran largely as planned and produced positive results. Although the project did not manage to collect all the information it set out to collect, it should also be noted that the process required the development, distribution and translation of many instruments in a coordinated fashion.

This report is the last output of this process. In the meantime, the good practices statements generated by the exchange of experiences were published and disseminated. Of particular importance was the fact that the local partners gave positive feedback on the process, both in terms of the knowledge acquired throughout the participation in the meetings and in terms of feeling that the good practice statements genuinely reflected their experience.

6. DISSEMINATION OF INFORMATION ON GOOD PRACTICES

As planned, a multi-medium communication system was established to facilitate sharing of experiences and to disseminate up-to-date information on good prevention practice among project participants and their beneficiaries. The global and regional project coordinators jointly established and maintained the communication system.

More specifically, and as planned, a project website was set up on the website of the WHO Headquarters Department of Mental Health and Substance Abuse (http://www.who.int/substance_abuse/topics.htm). It was established while the preparations for the prevention activities were taking place. All project participants had access to the site. It was fairly regularly updated as information became available. Later in the life of the project, some pages devoted to the Global Initiative were created in the UNODC part of the website devoted to drug abuse prevention among youth (<http://www.unodc.org/globalinitiative/index.html>). The results of the process of experience sharing were posted on these pages. Both sites are clearly linked to each other.

Communication through e-mail was complicated in some of the project countries in all three regions, partly due to technological limitations (Southern Africa) and partly due to language problems (Thailand). E-mail was therefore used only up to a certain point to provide technical services to the local partners. The dissemination of the draft results of the experience-sharing meetings was, for example, undertaken both through e-mail and by sending hard copies of the reports by ordinary mail to local partners.

All local partners were included on an internet listserv facility arranged by UNODC Headquarters on which tech-

nical notes on prevention were posted every other week. The results of the local partners' self-evaluation of their experiences and statements of good practice regarding various facets of prevention work were collated in three documents.

Regional information exchange networks were also formed, with interaction mostly occurring within regions, with information exchange mostly relating to topics that participants agreed on (e.g. training on prevention work and research), with regional project coordinators monitoring network activities, and with networking meetings occurring as planned and contributing towards progressively stronger bonding between project participants (e.g. within Southern Africa).

Besides the planned project networking activities, local partners were to a smaller or larger extent involved in various other networks. Local partners in South-East Asia, for example, were part of well-organized national and regional networks (PHILCADSA, ANCC, IFNGO). All local partners were also included in the Global Youth Network, i.e. a network of prevention programmes for and by the youth managed by the UNODC. Through this network, project participants received quarterly newsletters, bi-weekly technical notes and copies of the publications on best practice in prevention work. Later the Global Youth Network was decentralised by creating networks on the regional level in East Africa (including Tanzania), Belarus and the Russian Federation, and South-East Asia.

7. CONCLUSION

Available information on the implementation of the Global Initiative underlined that the process largely occurred as intended and outlined in the project plan and that the experience was positive.

Evaluation of the process highlighted the following issues:

- The project activities, the sequence in which they were delivered and their timing were largely as planned.
- The managerial process occurred as planned, with project coordinators as well as local partners rating the activities in this respect positively. Notable were the project coordinators' efforts at strengthening human, technical and material resources in project countries, notwithstanding the fact that various issues (e.g. language difficulties, high project staff turnover and limited experience in psychoactive substance use-related prevention work among some local partners) complicated these efforts.
- With regard to the training process, special mention should also be made of the fact that the project participants found the training material particularly useful. These materials as well as the documented good practice statements can therefore be expected to facilitate ongoing expansion and strengthening of prevention work, considering for example the fact that electronic copies are available on the project's website.

- The experience-sharing meetings were found to have contributed especially towards strengthening of local partners' understanding of prevention issues, as well as of networking/ interactive relationships between project participants.
- The multi-media communication system implemented in the project also operated to the participants' satisfaction,

especially as local partners who did not have access to electronic communication media (e.g. e-mail) were kept within the information-distribution loop via traditional communication media (e.g. received printed copies of project information through ordinary mail).

List of local/country partners

Southern Africa

the Republic of South Africa

Alcohol and Drug Concerns
Elim Clinic
SANCA Nongoma
SANPARK Community Centre
Siyonqoba Youth Against Drugs
Themba Youth Camp
University of Pretoria, Department of Psychology
University of the North, Department of Sociology
Youth for Christ

the United Republic of Tanzania

AMREF Youth Centre, Dar es Salaam
AMREF Bunda
EMAU
Kimara Peer Educators and Health Promotion Trust.
Taqwa Youth Society
Youth Culture and Information Centre
ZAAIDA

the Republic of Zambia

Family Health Trust, Zambia
Family Life Movement, Zambia
Kanyama Youth Project Trust, Lusaka
Mental Health Association of Zambia
PUSH (Poor Urban Self-Help)
Youth Alive Zambia
STEP AGENCIES -Kanyama Youth Project Trust
Zambia Red Cross Society
Zambia Schools Anti-AIDS Clubs Patrons Association

**Central &
Eastern Europe**

the Republic of Belarus

Gomel Medical Institute, Gomel
Republican Health Centre, Minsk
Educational centre "POST", Minsk
Minsk health centre, Minsk
Centre "Hope and Recovery", Minsk
League of youth voluntary service, Minsk
Belarussian Association of UNESCO clubs, Minsk
Belarussian Association of non-state television "BANT", Minsk
Republican organisation "Awakeness", Vietbsk
Union of women "Uliana", Vietbsk
NGO "Trust", Kobrin
Gomel Health Centre, Gomel
Gomel narcological dispensary, Gomel
Youth organisation "Real world", Svetlogorsk, Gomel region
Brest Health Centre, Brest
Centre of social assistance to creative youth "Intelligence", Brest

the Russian Federation

Club UNESCO "Optimalist podmoskovja", Moscow
"Siberia-AIDS-Aid", Tomsk
Regional organisation "Duchovnoe zdorovje", Ivanovo
Charitable Foundation "Take care", Cheljabinsk
NGO "Committee of women for the protection of children from substance abuse", Omsk
NGO "AntiAIDS", Yushno-Sakalin
NGO "AIDSInfoshare", Moscow
Institute of pedagogical innovations, Moscow
NGO "Union of women of Republic of Altay", Gorno-Altaysk
Russian Charitable Foundation "NAN", Moscow
Bajkal Regional Union of women "Angara", Irkutsk
NGO "Look at the future", Kaliningrad
Anticrisis centre for children and youth, Kaliningrad
Medical prevention centre, Kaliningrad
Consulting point for young people "POST", Kaliningrad
Republican centre for drug and alcohol abuse among youth, Vladikavkaz, Caucasus region
Centre for the support of children and youth "LIGHT", Volzhkiy Southern Russia
Youth organisation "Prospekt mira", Moscow
NGO "Development", Pervouralsk, Ural region
Regional movement "Mothers against drugs", Tjumen, Ural region
Research Institute on mental health, Moscow
NGO "New Century", Kazan
Centre of psycho-pedagogical rehabilitation of children and youth, Mytishi, Moscow region
City centre for drug and crime prevention among youth, Saint-Petersburg
Russian Women Movement, Syktyvkar, Republic of Komi
Charitable Foundation "Harmony", Shelekovo, Irkutsk region
Centre "Harmony", Ulan-Ude, Republic of Buriatya
NGO "Your choice", Tver
Association of humanitarian initiatives, Myrni
NGO "Humanitarian project", Novosibirsk
Regional Organisation "Siberian Initiative", Barnaul
Regional organisation "Siberian alternative", Omsk
Charitable Foundation "Assistance 2000", Ekaterinburg

Charitable centre "Compassion", Moscow
NGO "Take care" and youth studio-theatre "Podval", Moscow
Centre "Innovations", Saint-Petersburg
Drug Abuse prevention centre, Saint-Petersburg
Charitable foundation "AIDS-stop", Novorossijsk
Public movement "No drugs!", Vladivostok

South-East Asia

the Socialist Republic of Viet Nam

An Lac, HCM City
Du Hang Keng, Hai Phong
Huong Vuong, Hai Phong
Lang Ha, Hanoi
Le Mao, Vinh City
Phong Lai, Son La
Phu Nhuan, HCM City
Thanh Xuan Trung, Hanoi
Thai Hoa, Nghe An
Van Ho, Son La

the Republic of the Philippines

Addictus Foundation
Bidlisiw Foundation
Childhope Asia Foundation
Foundation for Adolescent Dev
Foundation for Drug Info & Communication (FDIC)
Higala Association
Kapitran Komunidad People's Coalition (KKPC)
Kaugmaan Center for Children's Concerns Foundation (KCCCF)
Kauswagan Community Social and Development Centre (KCSD)
Metsa Foundation
Person's Enrichment through Encounter and Response Center (PEER)
Red Cross Youth Department, NRC

the Kingdom of Thailand

Bhuddakasettra Foundation
Chorakhe Khop Mosque Community
Duang Prateep Foundation
Indochina Intersection Development Institute
Institute for Juvenile and Family Justice Development (IJFJD)
International Organisation of Good Templers - Thailand (IOGTT)
Konkruat Group
Hug Muang Nan Foundation
Makhamon Theatre Group
Seka School
Takopa
Thai Youth Aids Prevention Project (TYAP)
Wat Chaiprukmalaya Community

The WHO/UNODC Global Initiative on the primary prevention of substance abuse (Global Initiative) was a joint project of the United Nations Office on Drugs and Crime (UNODC) and the World Health Organization (WHO).

The overall aim of the Global Initiative Project was to mobilize communities to respond to the global rise in substance use in young people. The project was run in three regions undergoing dramatic social change, namely Southern Africa, South-East Asia and Central and Eastern Europe. With project implementation in eight selected countries: Belarus, the Philippines, the Russian Federation, Thailand, the United Republic of Tanzania, Viet Nam and Zambia.

This Summary Report presents the findings of the evaluation of the Global Initiative Project.
