Prevention Webinar Series – Webinar II – Research and Policy of Prevention – 21/09/2021

Keynote speaker: Giovanna Campello (UNODC)

Panellists: Brian Morales (INL), Goodman Sibeko (ITTC), Abel Basutu (African Union)

Recorded Webinar: https://vimeo.com/619964138

Keynote presentation by Giovanna Campello (UNODC)

During this presentation, Giovanna shared some successes or prevention science translated into policy since this is not often reflected upon, while also highlighting challenges and possibilities to move forward. The use of science in policy is promoted, especially around a safe development of youth. Although prevention to ensure the health of people is much broader, such as adults and elders, childhood experiences often influence happenings in adulthood. Therefore, the focus in prevention is on the development of children into healthy adults.

Some successes: an example of science used in prevention is the adopted UNODC training on family skills in Uzbekistan. The family skills training is based on what works according to science and implementation. UNODC started working with member states around the word with a pilot programme to make It visible and showcase its effectiveness. Uzbekistan was hesitant at first, but once positive outcomes on the mental health and resilience of children were shown, they joined successfully implementing the programme and currently are continuing scaling it up. It shows the importance of inclusiveness and respect while taking culture into account and that evidence-based prevention works.

The first edition of the UNODC prevention standards was published in 2013 and is a summary of what works and what does not work in prevention according to science. The document is to go to countries and enter a dialogue. It is important to invest in personal and social skills. Either directly or through family. Nigeria is one example of how to use the standards to enter a dialogue with a country and get them to implemented evidence-based standards.

In the European Prevention Curriculum the standards are taken and transformed into a basic curriculum for those working in prevention to give the basis of a common understanding what prevention science means and how to implement. The European Union and the Colombo Plan are trying to create the idea of prevention as a profession, meaning that you have to learn it when exercising it. It shows that there is a competence and science to prevention.

Common Challenge: the common challenge is the constant movement of politicians with different priorities and ideologies where the focus is often on visible and short-term outcomes. This is a challenge for the slower processes of [prevention] science. However, if the programme managers are educated, the science will be packed and led to the politicians to be used in practice.

Global level advocacy: ever since publishing the international standards, the UNODC has campaigned and disseminated it among member states. It has led to a growth of resolutions and operational paragraphs that mention prevention. Advocacy works and is being translated into the commitment by all the UN member states. They have committed to it, let's take them up to the task.

There are some challenges for the way forward. There are regional difference and only some have access to treatment. Prevention is harder to measure in numbers since it is more centralised and covered by different sectors. The coverage of prevention and evidence-based science is generally low. An opportunity lies in the fact that not a lot of prevention is evidence-based. This often happens through a lack of funding but yet there is a lot of funding in non-effective evidence-based programmes. These funds can be used to only support evidence-based prevention, a so-called conditional funding.

Another challenge is the scaling up of prevention programmes. The case in Uzbekistan has shown that the size of the effect is lost since it is harder to measure the implementation when it is not controlled. Therefore, main question remains how to keep the effectiveness when implementing evidence-based prevention science on a larger scale.

The digital world is another challenge but can also bring a lot of opportunities and reach people worldwide. The technology can be used to train the provider [remotely]. Currently, the prevention curriculum is making enormous efforts to go online. The effectiveness of the online trainings and digital prevention needs to be studies more. Also, the challenge will be around ensuring the protection of confidentiality, lower costs for online services in remote areas, and narrowing the digital device rather than widening it. Overall, social networks have an enormous influence on youth, which is not necessarily positive. It is a powerful and influential field and moves fast, whereas research moves slowly. Therefore, document as much as possible not to cause harm and use this for the healthy development. It is an incredibly powerful and difficult field to tackle.

It is also important to be proactive as the world emerges from the pandemic, which is a challenge. There is a need to push for services that help the development of children and youth. During the pandemic, there has been an increase of violence and tension among families, there is a lost protection of school, and families losing their income. The inequalities have been widening and we need to push for basic services, such as school, extra-curricular activities, services for families, outreach to risk youth, etc. Being proactive means linking to other sectors, internationally, nationally, and locally while linking it to the health sector and all prevention sectors. With joint forces, drug use and risky behaviour can be prevented.

In the alcohol and drug prevention sector, which evidence-based methods/tools do you consider to have been most successful for girls and young women?

There is only a fraction of the evidence on sustainable prevention that is focused on women. A study in 2016 wrote about all evidence-based programmes and only 5% of them had disaggregated data. In terms of prevention primary, what seems to work more consistently (for girls as well as boys) is family skills work. There are many reasons to promote community, and working with schools, family, and community at the same time.

Do these programmes target elderly?

There are few programmes that have been evaluated, but hardly any of them in terms of prevention. There is not much data on that, mainly on medical prescribed drugs. While preventing non-medical use would be relevant to work with member states it is not easy to direct a programme to it. We have to think together on what can be done.

Can you see in the design of methods/tools for drug prevention that the CEDAW convention has been implemented to strengthen the health indicators for girls and young women in particular?

The commission has a very strong mandate with regard to the health of women and girls but there is no specifics on their achievements. The UNODC itself works according to the SDG framework, which also has a strong focus on gender, SDG5.

Brian Morales (INL)

Research should inform policy and practice. Research, policy, and practice are three pillars of the drug demand reduction system development. We have around 40 to 50 years of prevention science, in which some areas are rich (school and family) and some are researched less (media). There are many

examples of prevention policy in practice, such as the work of the UNODC. Around the world we find examples of excellence in prevention. However, the evidence-based prevention programmes are reaching only a small number of people. There is a lack of dosage and the amount of prevention may be diluted or insufficient over the years. The effort is not sustained whereas prevention needs to be constantly delivered to ensure that the formation is followed and integrated throughout childhood. When looking at the big picture, there is a challenge of disconnect around policy and practice, not just in the field of prevention, but also in the field of treatment. In the field of prevention there are two sides. One side is comprised of researchers, prevention scientists, university professors, etc., which is a small but mighty and dedicated group, yet under-resourced. The other side is filled with committed implementers from many professions. Their common characteristics is advocacy and passion to build protective factors and minimise risk factors, such as parents, teachers, etc., which collectively comprise a silent majority. Many in the group of prevention workers are non-professionals and there are only a few implementers that are researchers. There is a vast workforce that is not professionalised nor trained. Therefore, the challenge remains that there are many well-intentioned implementers but they are lacking research. Therefore, a solution would be to bring these two groups closer together through the manualised Universal Prevention Curriculum which can help evidence-based practices. Training could have been developed in two ways: either by training evidence-based program or training practitioners on the research so they strengthen existing interventions. Our goal for the next 5-10 years is first to map the existing prevention organizations, train them in evidence-based practices and strengthen their work, including in policy design. Second, we should develop universal Quality Assurance prevention standards. Finally, we should develop a universal accreditation process where national accreditation agencies evaluate and accredit organizations based on a single quality standard. With a single universal standard there is an international benchmark in which governments and the private sector have a point of reference, bringing greater coherence and cohesion of the field.

Dr Goodman Sibeko (ITTC)

ITTC focuses on capacity building within the substance treatment field and in the provision of technical assistance in the implementation of prevention and other substance use policy. ITTC works closely with the African Union. The African Union Plan of Action on Drug Control and Crime Prevention (reference Abel) outlines some key activities to support prevention of drug use, with a particular recommendation that all such activities must be evidence based. These activities include: Establishing a focal unit on drug use prevention; Ensuring multisectoral engagement; Provision for awareness campaigns, debates and other engaging age-appropriate activities; Exploitation of social media while making use of traditional media and entertainment industry; Broad engagement in the provision of training in family and parental skills approaches; Dissemination of visual aids supporting basic coping and parenting skills targeting women and girls; and the exchange of best practices between AU member states.

In South Africa, management for substance use disorders is governed by a few pieces of legislation, the most important of which is the National Drug Master plan (2019-2024) as provisioned by The Prevention of and Treatment for Substance Abuse Act No. 70 of 2008 (29), which provides for a tiered structure of collaboration from municipal to national level for addressing substance use disorders and provides specific guidance for interdepartmental and intersectoral collaboration in drug demand reduction following five key principles: Interventions must be (1) rights-based; (2) Evidence-based; (3)Multi-sectoral and multi-lateral; (4) People-centred; and (5) Inclusive and participative. Two of the provinces that the ITTC works with are the KwaZulu-Natal Department of Health where there is a focus on the creation of safe and protective environments, decreasing desirability, and mobilising champions speak out of substance use while using co-created media-campaigns; and the Western Cape

Department of Social Development where there has been demonstrated success in several interventions including the Strengthening Families Programmes, After School programmes and various awareness campaigns where social media reach has resulted in promising outcomes.

The proposal to move things forward in terms of the mandate of the ITTC is to engage in a comprehensive mapping exercise to establish the extent of prevention intervention, their evidence basis and success, and ascertain how this is linked to Quality Assurance and Accreditation. There needs to be a collaboratively developed set of indicators that meet as many stakeholders and public health needs as possible. There needs to be strengthened support for research and M&E processes. The ITTC is already well positioned to provide support for intersectoral collaboration and to support capacity building in evidence-based prevention programmes in collaboration with other partners such as ISSUP, ICUDDR and Colombo Plan DAP. The placement of resources such as ITTC in Faculty are key in supporting the research and M&E components, as well as capacity building at undergraduate and postgraduate level to support advancement of the field.

Dr Abel Basutu (African Union Commission)

Research influence on policy is very fundamental. The life-skills approach in UNODC's Unplugged Prevention Programme has had positive impact according to reports from African Union (AU) member states - Mauritius, Nigeria, Egypt and Morocco. Mauritius has involved the private sector to contribute substantially to it, so it comes with a sustainable element to it. Many other member states have indicated interest in adopting the programme. Kenya, for example, conducted primary and secondary school surveys which helped to make a case for prevention with the Ministry of Education. Collaboratively National School Guidelines for Basic Learning Institutions (https://nacada.go.ke/publications) were developed and released in July 2021. The same has been done for public sector workplaces. Previously there was much talk about increased substance use in schools but few interventions.

Changing the 'culture of prevention': It is very important for prevention to be integrated and infused in several spheres of life for reinforcement. What does not work is sporadic or stand-alone awareness creation not linked to a specific programme as much effort is wasted on activities whose impact cannot be measured in the short or long term. Schools and community centres among others are **structures that can be used to support evidence-based practice at system level**. A paradigm shift to evidence based/informed programming is needed now than before because a lot of what is still going on in prevention is informed by gut feeling and rather reactive in nature. Professionalization of people working in prevention needs to be supported by funding for actual programmes. The Universal Prevention Curriculum (UPC) already provides programmes for various settings - family, school, workplace, media etc. Some countries have initiated capacity building for prevention (e.g., Kenya, Uganda, Nigeria, Egypt, Tunisia, Cote d'Ivoire etc.) but the challenge has been to leverage this to establish actual programmes due to funding gaps. To move the field forward, we need political commitment with governments taking ownership of prevention from the National to local government (provincial, county or district) level. This requires dedicated resources, where necessary integrating funds in larger programmes (joint ministerial programmes) and mobilizing/partnering with communities and community-based organizations. The impact of prevention programmes takes a while to be seen and many countries struggle to prioritize such initiatives. However, progressive countries have employed dedicated national prevention focal points who among others mobilize resources and run programmes. Multi-lateral organisations like the African Union and United Nations need to engage in high level advocacy for prevention. Countries need to harness the creativity of young people (young influencers) and support them to use social media responsibly with well-tailored

messages. We continue to urge countries to implement al pillars of the African Union continental framework on drug control as well as prevention standards by UNODC

Q&A

How do we ensure that the research and policy of prevention are not influenced by the industry of addictive substances? How can we counteract that influence?

Giovanna Campello: The WHO has a lot of experience in providing guidance and good practices on how to regulate the involvement of tobacco and alcohol industries, which can also be extended to the other industries. These standards have referenced to the tobacco and alcohol frameworks that have been agreed to by the WHO and already indicates policies that are necessary to protect children and youth. From here, we can go into more depth. There are some very important lessons learned that we can imply from these industries.

How do we measure the impact of reach? How have 4 million people been reach through social media been impacted?

Dr Goodman Sibeko: There is a benefit of social media, provide the ability for some landing point beyond the click. The initial reach would be considered the click on the link. Then there should be some activity, which can be used to measure the level of engagement and outcomes of the process. This is the biggest difference between social media and leafletting.

Amy Ronshausen (host): Maybe the reach is the starting point of the conversation. The dissemination of information is the start among other things.

Giovanna Campello: We are trying to develop a tool that would assess the reach but also the quality of the intervention and how much they are in line with the evidence. We still don't know if someone is doing everything according to the evidence-based guidelines, it is still not a given that it has an impact. There will have to be some measures and at the moment we are not able to give that reach. We are not able to say that prevention has reached the goal percentage that it needs to cover. We would like to get to get to that stage, and measure the amount that are covered by non-evidence based and evidence-based intervention to start the discussion to improve the current prevention. This is a necessary path, otherwise we are only going in circles and not improving anything.

How do you recommend that the gap between researchers, theorist, and practitioners can be reduced?

Brian Morales: In short term, we can connect researchers with practitioners but it will not be viable for scale. The group of researchers and universities is small whereas the group of practitioners is large and continuing to grow. We need to build a demand reduction architecture that makes these voices more natural and available to grow at scale. We have the creation of platforms, such as ISSUP, where different networks with different skill sets are put together to build a reoccurring mechanism of technical assistance and dialogue connectivity. By disseminating and interpreting the audience with tools and techniques of interventions, the two groups can be brought together. We need to create a culture of training where the whole workforce can slowly come into contact with the science. There is scepticism that there is already too much curriculum which becomes too difficult to digest. However, this richness is a beauty. It is going to take years of development to build knowledge and skills and we have to strive to promote the goal of personal development in the prevention field. Time needs to be dedicated for this.

What would you say is needed for prevention not to be separated from society and everyday life of the population and instead being included?

Abel Basutu: Stand alone or sporadic programmes are not effective because you can't measure the impact. We need long term evidence-informed programmes infused into our daily life activities. There are many programmes already, such as the Life skills training programmes by UNODC, UNPLUGGED school-based prevention programmes and so on. What is needed is sustainability of the programmes.

What are some of the methods used in the prevention field that can improve prevention programmes if underdeveloped countries/governments want to honour these programmes?

Giovanna Campello: Evidence-based prevention sounds scary but it doesn't have to be. In the past, a lot of evidence-based programmes have been developed and sold by universities for quite an amount of money. It was not cheap to buy the rights to use the programme. However, one of the successes we have had is that we are slowly building programmes that are in the public domain, such as the family programmes, which are specifically tailored to low-resource setting. These can be delivered with minimal resource. In reality, it would only need people open to get training. Also, in case governments are not interested from the start, civil society can start low-key and keep inviting the government to review the updates. In the end, in some examples, the governments were convinced to step on board after positive review.