Evidence based study a priority to sustainable drug prevention interventions

PRESENTATION

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TITLE: EVIDENCE BASED STUDY A PRIORITY TO SUSTAINABLE DRUG PREVENTION INTERVENTIONS

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Africa swells with riches and with her demography of over 1 billion inhabitants she has abundant human capital, most importantly a young population of over 65% which sits on top of great economic, social, health and political potential. Africa has vast opportunities yet all that promise is under serious threat. With an emerging crisis of drug harmful and hazardous use, lies a gap of how evidence based study can reveal the extent to which the continent is losing out because the youths are hooked on one addiction or the other. In this presentation I shall examine how most interventions in the case of Zimbabwe not study based hence are becoming unsustainable.

It is important to understand the alcohol history of Southern Africa in order to compare the patterns of consumption and use of alcohol and other drugs respectively. At some point bottled alcohol was prohibited from black Africans until 1962. Only until then, black Africans were allowed only to consume their traditional homemade opaque brews. The bottled beer "independence" in 1962 created a false status of success, privilege and freedom. Hence, it prompted a rise in the use of alcohol and today over 65 years later that false "independence" attached to alcohol consumption, contributes to heavy drinking and arguably leads to drugs use initiation. Alcohol consumption patterns, its initiation risk factors, provide a key-hole view of the

drugs crisis. They carry almost similar end products as they tax to the social, econonomic and individual health. Most scholars suggest that prevention research is evolving and will continue to develop as a direct consequence of more complex theoretical and conceptual thinking, more valid and reliable measures of drug-related problems, better understanding of individual risk factors, better identification of individuals and groups at high risk, better research design and long-term follow-up studies, and better integration across various settings—family, school, community, religious, and criminal justice.

Prevention programs should be tailored to address risks specific to population or audience characteristics, such as age, gender, and ethnicity, to improve program effectiveness (Oetting et al. 1997). Current preventative interventions in Zimbabwe are based on the uniformity of human behavioral patterns; however the differences in risk and protective factors, call for a need to fill the gap that is lacking due to evidence based study in Zimbabwe. The following example is typical of the Zimbabwean youth; Jacuzzi is an ordinary man, has very limited personal space because he lives in high density area of Glen View Harare, and hence has very little time to self-actualize. He got his passes at secondary school but his parents couldn't afford him further education. He hasn't been employed since he finished secondary school in 2001. So he occasionally peddles marijuana and prescribed cough syrup (Broncleer). He is married, but seldom sleeps home, he dances the night away in local clubs, with different girls he pays for overnight sexual favors, whether he uses protection it is anyone's guess. His government has no policy against and drugs or alcohol, more focus is put on economic and political issues. Today he lies on his bed, it's been two weeks now, he has been coughing endlessly and he has lost a lot of weight.

It is imperative to flesh this example and authenticate it with indigenous research, then provide specific interventions, rather than applying assumed methods based on the uniformity drugs use patterns or behaviors. Lack of research based study culminates in serious health illiteracy, hence most Zimbabweans lack the knowledge that a drug free society is a fundamental freedom.