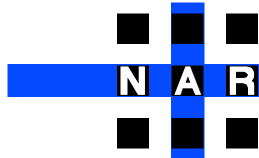


NATIONALE ANTI - DRUGS RAAD

NATIONAL ANTI-DRUG COUNCIL

# FINAL DRAFT

# National Drug Prevention Plan

## 2011 – 2014

Paramaribo, March 2011

## Foreword

We herewith present you the 1st National Drug Prevention Plan (NDPP). This document is compiled by order of the *Nationale Anti-Drugs Raad* (NAR) – National Anti-drug Council – with financing from the Ministry of Health, in close collaboration with active stakeholders involved in drug demand reduction on national level. This plan has the character of a master plan whereby an effort is made, for the first time, to establish a framework for national prevention, make the gaps visible within this prevention and expose the areas for intervention and action. It should not be regarded right away an instrument to approach specific problems although it may indeed, in some cases, give the first initiative thereto. The general goal of this plan is ultimately to formulate national drug prevention goals in joint consultation and to make the mutual commitment to apply research-based and result-oriented methods whereby the actions to be taken need to be complimentary and supportive to the realization of the established goals.

As it is clear, drug demand reduction is not an easy task but rather a very complex matter. This specific problem, as part of the whole of the more extensive drug problem covers a few areas which are interchangeable and independent from one another when we think in terms of solutions. Areas such as: education, information, employment, housing, treatment and care, sports, education, entrepreneurship, re-socialization, research and planning, drugs crime control etc., must be placed foremost in aforementioned list of areas. So it is more than clear that just one organization alone is and will not be able to realize the goal of "drug demand reduction on national level". Based on the previous, it is therefore more than necessary that there is talk of an integral and holistic approach of the problem at hand whereby the responsibilities and roles of the various entities need to be clear and there is talk of an effective and broadly based coordination. Commitment of all stakeholders with the government as the most important player is herewith essential. Within this scope, we should talk of necessary investments and if applicable, reformations on a financial and institutional level as well as with regard to human capacity.

The role of NAR in all of this is the fulfillment of coordination – similar to a bridging function whereby a facilitating role is fulfilled towards the interested parties (institutions) and hereby the whole of projected goals and strategies is monitored and if necessary, supervised. Within this framework, the initiation of more intensive partnerships between government, GO and the private sector will form one of the highest priorities.

The NAR wants to thank all institutions, organizations and persons who, in whatever way, contributed to the establishment of this document and herewith believes that herewith a follow-up and important step is made towards national and effective drug prevention.

**Steven Alfaisi, M.A.**
**Chairman National Drug Abuse Control Council (NAR)**

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# 1 Summary

An important starting point at the development of this prevention plan is the acknowledgment that a anti-drug policy is essentially based on three cornerstones. These are:

1. Prevention intended for non-users and prevention for non-problem users
2. Care, harm reduction and (re) integration for problem users
3. Repression aimed at producers and traders

Components 1 and 2, within the scope of this prevention plan, form part of demand reduction. Repression, regarded more as the work area of supply reduction, falls outside this scope and forms no part of the NDPP.

A prevention plan that could be linked to the actual development within the sector requires some further analysis of the environmental development. Chapter 2 includes an environmental analysis based on:

- Design, structures and processes on a macro, meso and micro level in the area of drug abuse control
- Statistics, records and reports
- Information from deliberations held with executive institutions

This chapter is concluded with a SWOT analysis.

In chapter 3, a strategy is developed based on the analysis and thereof derived sub strategies.

Chapter 4 subsequently outlines the necessary and desired activities to arrive at effective results via a more integrated and evidence–based approach.

The various annexes to the prevention plan are included in chapter 5.

## 2 Introduction

Within the drugs prevention, a distinction is made between the so-called risk factors and protecting factors. Effective drug prevention operates simultaneously with the reduction of risk factors and increase of the (impact) of the protective factors.

| Risk factor | Territory | Protecting factor |
|---|---|---|
| Early aggressive behavior | **Individual** | Impuls control |
| No/insufficient supervision of parents | **Family** | Parental supervision / coaching |
| Use of means | **Peers** | Know-how and skills |
| Easy access to means | **School** | Drug control information |
| Poverty | **Society** | Communal coherence |

*Source: Red book 1 National Institute on Drug Abuse / US Department Health and Human Services*

What the specific Surinamese risk factors are and the degree in which these contribute to the current problem has not yet been adequately studied and will have to be shown from further qualitative research. The available data of already conducted studies primarily contain quantitative information.

A critical note was derived from the Caribbean "demand reduction strategy" document[1], stating that a combination of quantitative and qualitative studies into the nature and scope of the drug problem within the Caribbean region is essential for improvement of the quality and effectiveness of demand reduction interventions. The same report also recommends that, for benefit of the issue of crack-cocaine, a thorough study should provide insight in among others:

1. The characteristics of problematic abuse;
2. Which communities show a serious drug problem and what is the nature and scope of these problems;
3. What are the characteristics of problematic users (age, gender, family situation, drug history, education, work, health situation, among others);
4. Outline of the drug economy in drug inflicted neighborhoods;
5. What are the needs (secondary and tertiary social prevention) of problematic users?

[1] Regional strategy for drug demand reduction; a situational analysis on drug demand reduction issues in the region 2002.

Although the currently available data from previous studies does not or insufficiently answers the abovementioned questions, the NDPP will set out the path to be followed for the coming years based on the available data. Prevention efforts will need to deliver concrete results based on our reality so that we are able to turn around current trends and developments.
Drugs, within this context, are defined as: all legal and illegal substances that have an intoxicating influence on the user (and that are not used upon prescription of a medical practitioner). Without the need to be too complete in the listing of drugs, these amongst others, comply of:

| **Legal and illegal drugs** | |
|---|---|
| Alcohol | LSD |
| Amphetamines | Marijuana |
| Crack / *blaka djonko* | Morphine |
| Cocaine | Paddo’s |
| Hashish | Tobacco |
| Heroin | XTC |

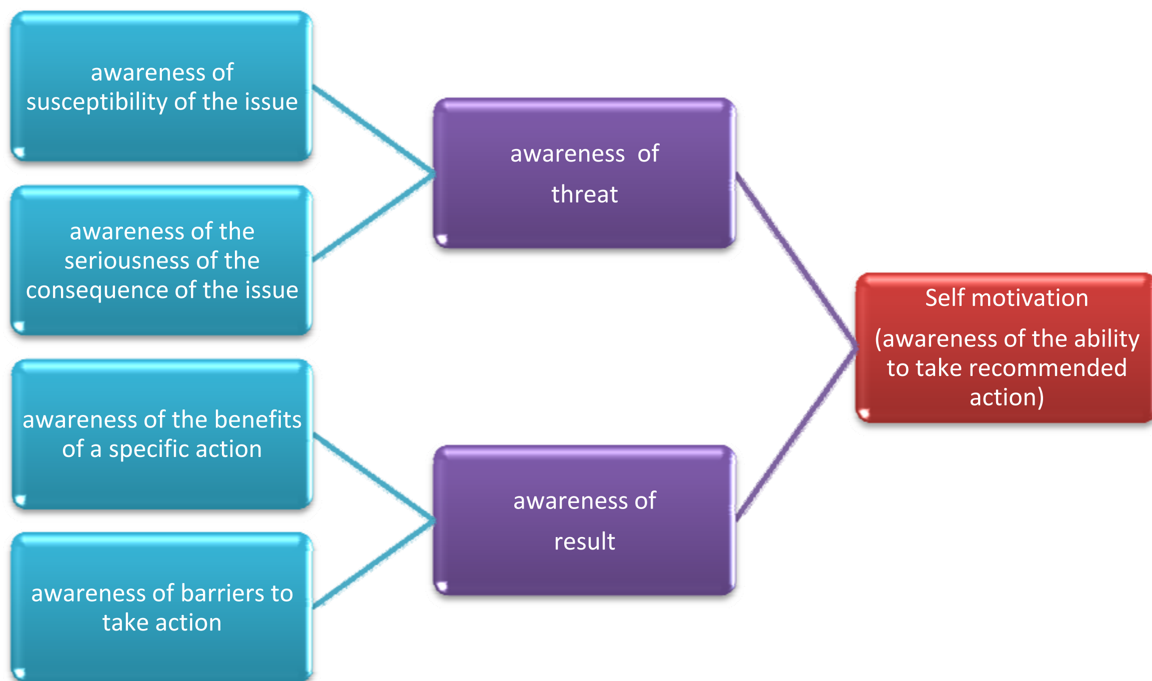
# 3 Environmental analysis drug abuse control and prevention

## 3.1 Theories and models

In addition to social impact, drug abuse also has a direct impact on the user's health. Interventions, necessary to let a user stop using drugs need to be concentrated on the user's behavior. All health promotion interventions within this regard should be based on proven theories. Moving people to start with behavioral change is a complicated process which is not so easy even under the best possible circumstances. Planners can easily waste valuable means in their efforts to achieve the desired behavioral change without use of the direction obtained by the various theories but, as can be expected, the aimed resulted will be poor or completely lacking. It is therefore essential that planners and developers base their planning process on theories which in themselves have been the basis for other successful promotional efforts, in this case for health care.

A number of theories and models are found in literature. For the NDPP, only 2 (two) which are relevant, are discussed in summary:

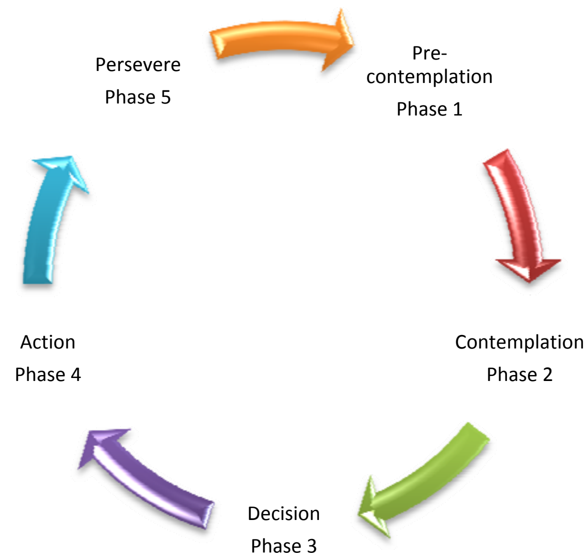
*Health Belief Model:*




*Trans-theoretical Model and Stages of Changes*

The various stages of behavioral change originates from the scientists Prochaska and DiClemente. This model applies for all forms of behavioral change. This implies that social workers can join the stage in which the client finds him/herself: offering counseling to the client with regard to the awareness of the issue at hand, at taking decisions and in the execution and primarily, maintaining of the established change. The model of Prochaska and DiClemente is very much applicable if it regards smoking, drug and alcohol abuse and psychological issues.

*Various stages of behavioral change*
Behavioral change is not a linear process with a clear starting and finishing point but it is rather a circular process. Prochaska and DiClemente distinguish five stages of change. During every stage, the person can relapse in a previous phase or former behavior, often two steps forward and one step back. It is important that these steps are not passed through with too much speed. If the client fails to properly consider all benefits and disadvantages of his/her behavior, changes are that he/she has not made a well-informed choice.




These two theories with additional models appear to be relevant within the framework of drug prevention and shall therefore serve as reference and starting point at the development of specific prevention programs.

### 3.2 Current situation

Worldwide, a distinction is made in drug abuse control, between measures in the area of demand – and supply reduction. Within the demand reduction are included all activities aimed at the drastic reduction of the demand for drugs by offering an integral package of

care, counseling, education and information which should result in a substantial decrease of the demand for drugs.
Within the supply reduction are included all measures in the area of the control of the supply, transit and trade of drugs through interventions in the area of legislation, tracing and prosecution.

The NAR issued a report in February 2009, based on the National Household Survey in 2007 with regard to drug abuse in our society and the following included therein:

- An important relation between illegal drug abuse and the perception of easy access to these means. The reported marijuana consumption shows an easy availability and access to these means.
- Marijuana and 'blaka jonko', in addition to the so-called solvents and inhalants, are the most used types of drugs. Less than 1% of the respondents reports to use cocaine. About 2.1% reported to use hashish.
- There are clear differences between men and women at the use of illegal and legal drugs. With regard to alcohol, 47.9% of the male respondents versus 19.7% of the women, are users. Use of marijuana among men is 6.3%, less than 1% of the women reported to use marijuana.
- With regard the prevalence among the various age groups, the age category 26-34 years shows a higher alcohol use. The use of marijuana is more prevalent among adolescence; the older group (35-44) uses cocaine.
- Nickerie, Coronie and Saramacca are areas with the highest prevalence figures with regard to marijuana use (9.3%), followed by Commewijne and Marowijne (8.5%) and in the interior (Brokopondo and Sipaliwini 3.7%). Cocaine users are more prevalent in Commewijne and Marowijne (1.3%), followed by Nickerie, Coronie and Saramacca.

The school survey, conducted in 2006 (publication July 2007) among school youth in the age category 11-17 years shows, among others, the following:

- Most used drug among youth is alcohol, followed by cigarettes and marijuana. Less than 1% of the surveyed youth use other drugs (cocaine, heroin, hashish, morphine)

| Prevalence of substances used [2] | | | | | | |
|---|---|---|---|---|---|---|
| | Lifetime prevalence | | One-year prevalence | | One-month prevalence | |
| Substance | % | N | % | N | % | N |
| Cigarettes | 35.8 | 1,996 | 15.2 | 1,963 | 7.9 | 1,972 |
| Alcohol | 63.5 | 2,025 | 46.8 | 1,964 | 34.4 | 1,972 |
| Tranquillizers | 9.8 | 1,987 | 5.5 | 1,932 | 3.2 | 1,931 |
| Stimulants | 4.8 | 1,971 | 2.7 | 1,948 | 1.5 | 1,948 |
| Solvents & Inhalants | 7.3 | 1,982 | 3.4 | 1,957 | 2.1 | 1,955 |
| Marijuana | 6.8 | 1,993 | 4.1 | 1,984 | 2.3 | 1,982 |
| Hashishish | 1.5 | 1,981 | 0 | 1,981 | 0 | 1,981 |
| Hallucinogens | 0.4 | 1,963 | 0 | 1,963 | 0 | 1,963 |
| Heroin | 0.5 | 1,984 | 0 | 1,984 | 0 | 1,984 |
| Opium | 0.2 | 1,975 | 0 | 1,975 | 0 | 1,975 |
| Morphine | 0.3 | 1,969 | 0 | 1,969 | 0 | 1,969 |
| Cocaine HCL | 0.6 | 1,983 | 0.2 | 1,985 | 0.1 | 1,985 |
| Coca Pasta | 0.7 | 1,966 | 0 | 1,966 | 0 | 1,966 |
| Crack | 0.6 | 1,972 | 0.3 | 1,976 | 0 | 2,066 |
| Ecstasy | 1.2 | 1,963 | 0.2 | 1,962 | 0.2 | 1,962 |
| Other drugs | 3.5 | 1,910 | 2.0 | 2,066 | 1.0 | 2,066 |
| Any Illegal Drug | 16.9 | 2,066 | 9.0 | 2,066 | 5.2 | 2,066 |

Source: NAR/UBN report on alcohol and drug abuse in schools in Suriname, July 2007

- Drug abuse among boys is greater compared to girls

| Prevalence of use of any illegal drug among students, by gender | | | |
|---|---|---|---|
| Gender | Life time | One year | One month |
| Females | 12.7 | 5.7 | 3.0 |
| Males | 23.4 | 18.8 | 8.9 |
| Total | 17.5 | 9.3 | 5.6 |

Source: NAR/UBN report *Alcohol and drug abuse in schools in Suriname,* July 2007

All efforts aimed at drug abuse control need to be considered against the background of specific outcome of this and other conducted surveys which expose the issue.

Suriname has shown, due to activities carried out in the past, that it acknowledges the essence of a structured approach of the drug issue through among others:

1. Establishment and equipment c.q. strengthening of institutions, whether or not with the help of donor funds (European Union; Drugs Demand Reduction Program and the NAR budget of the Ministry of Health);

[2] N= number of students who responded to the question
Life time prevalence: used drugs once in his/her life
Last year prevalence: used drugs last year
Last month prevalence: used drugs last month

2. Formulation of a National Drug Master Plan 2006 - 2010 and a strengthened mandate from the Ministries of Health and Justice towards the NAR for implementation of this plan;
3. Seek association with regional and international networks, active in the area of drug abuse control and prevention;
4. Ratification of international conventions, among others in the area of mutual assistance with criminal cases and the UN convention against illegal transportation of narcotics and related psychotropic substances;
5. Active participation within the multilateral Evaluation Mechanism process held by the OAS/CICAD and observance, as much as possible, of the recommendations resulting from this evaluation process.

The NDPP forms part of the integral approach advocated by NAR; a short representation and analysis of the development within the sector as a whole is therefore essential. In this chapter, the environment is surveyed on macro, meso and micro level. Within the macro environment, a distinction is made between on the one hand Suriname's participation as a country in both international and regional collaborations and organizations and on the other hand from the government in the area of drug abuse control. In paragraph 2.3, an indication is subsequently made on how the sector (government, NGO and private sector) is organized in the year 2010.

## 3.3 Development within the macro environment

### 3.3.1 Suriname and drug abuse control

Regionally and internationally, Suriname is participating with regard to drug abuse control within, among others, the following forums:

***CICAD (Inter-American Drug Abuse Control Commission.***

The CICAD, established by the General Meeting of the OAS is a policy forum in which all OAS member states participate. It supports the regional collaboration between the member states by means of action programs conducted by the CICAD secretariat. These action programs are aimed at:

1. Prevention and treatment of drug abuse
2. Reduction of the supply and availability of illegal drugs
3. Institutional strengthening
4. Improvement of legislation in the area of the control of laundering practices
5. Development of alternative income sources for cultivators of poppy, marijuana etc.

6. Support of governments at the improvement of data analysis regarding drugs and drug abuse control
7. Support of member states separately and of the western hemisphere as a whole at the periodic measuring of the progress in the fight against drugs. This progress is also put against the objectives as incorporated in the political declaration of the *UN General Assembly Special Session* on the world drug problem (UNGASS 1998)

Suriname actively participates within the CICAD and on the website of the Ministry of Justice and Police, report is made of the following projects realized for Suriname with the financial and technical support of the CICAD:

1. National Household Survey in drug abuse
2. Survey in drug abuse in prisons
3. Establishment of a national drug data management system at the Public Prosecution
4. Integrated information network of the various drug abuse control services

In addition, Surinamese received training from the CICAD in strengthening of the national drug abuse control policy, drug abuse prevention in schools and the minimum standards of care.

The evaluation conducted in 2009 on the progress regarding the implementation of the recommendations by the OAS/CICAD 4th MEM evaluation round (2005-2006), shows that Suriname, out of the 14 recommendations, has fully implemented five, made significant progress in four and that four still need to be implemented[3].

***UNODC (United Nations Office on Drugs and Crime)***

The UNODC is the UN organization active in the work area of the control of illegal drugs and crime. The work program of the UNODC has three pillars:

1. Field-based, technological collaboration projects for improvement of the capacity of member states for control of illegal drugs, crime and terrorism.
2. Survey and analytical work for expansion of the know-how and understanding of drugs and drug related crime and gathering of factual material for substantiation of policy and operational decisions.
3. Support from states at ratification and implementation of international treaties, the development of domestic legislation with regard to drugs, crime and terrorism.

[3] From: 2009 Evaluation of progress in drug control (OAS-CICAD MEM Suriname)

In March 2009, the Minister of Justice and Police addressed the High Level Segment of the 52$^{th}$ session of the committee on narcotics and drugs in Vienna, Austria whereby the national efforts with regard to drug control were expressed on multiple levels. The milestones presented in this regard included among others the international narcotic control conference held in 2006 in Suriname, Suriname's commitment to the UNGASS through implementation of the recommendations and the National Drug Master Plan 2006-2010.

In the Caribbean region, the following organizations are active within drug abuse control:

- Association of Caribbean Commissioners of Police (ACCP)
- Caribbean Customs Law Enforcement Council (CCLEC)
- Caribbean Financial Action Task Force (CFATF)
- Caribbean Epidemiological Centre (CAREC)
- Caribbean Institute of Alcohol/other Drugs (CARIAD)
- Regional Forensic Science Training Centre (RFTC)
- Regional Training Centre in Martinique (CIFAD)
- Regional Drug Training Centre (REDTRAC)

Regionally, Suriname actively participates in collaboration agreements within CFATF, CAREC and CIFAD.

### 3.3.2 National Coordination

***The National Drug Abuse Control Council (NAR)***

The NAR was formally established in 1998 by order of the Minister of Health. After various adaptations of the terms of reference, the current duties were finally formulated 2004:

1. Render advice to the Government on the national drug prevention policy, in particular with regard to the implementation or review of the Drug Master Plan;
2. Evaluation of the effects of the national drug prevention policy;
3. Supervision of an epidemiologic control system regarding national drug abuse, a system which will study and compare the trends in drug abuse and drug traffic;
4. Analysis of obtained epidemiological information regarding the national drug abuse and drug traffic and identification of policy implications based on which the policy starting points will be formulated;
5. Steering of the implementation of effective strategies aimed at reduction of the demand for drugs;

6. Distribution of drug related epidemiologic information to relevant service providers and other social groups, including the media;
7. Monitoring of the network of the government and NGOs involved in drug demand reduction;
8. Coordination of all contacts between Suriname and the regional, continental and international institutions and bodies, involved in drug demand reduction;
9. Support of studies and surveys related to the reduction of drug demand;
10. Supervision of the Implementing Office of the NAR.

Within the current compilation of the NAR, representatives have been delegated by the Ministries of Health, Social Affairs, Education and Justice and Police. Business and trade and the NGO sector as well as significant GOs, are represented within the council. The prevalence of drugs in any society will put pressure on the:

- current social systems
- health facilities and health care system
- Law enforcement institutions, legal system and judicial system

The aim of the multi sectoral establishment of the NAR is to approach the drug problem from multiple points of view. The most important realizations of the current NAR administration in the period 2008 – 2011:

A. Policy advice to the relevant ministries, among others in the area of launching a *pilot* for a Drug Treatment Court in Suriname and minimum standards for drug treatment centers.
B. Signing of a declaration of intent for collaboration in the area of demand reduction with a Dutch expertise Centre for treatment of drug addicts and prevention.
C. Participation of the EU-LAC collaboration which contributed to a twin city agreement with the city of Gent (Belgium), among others in the area of addiction and care and treatment of drug addicts, Drug Treatment Court.
D. Reporting to OAS – CICAD within the framework of the MEM process.
E. Internal evaluation of the NDMP 2006 – 2010 and initiation of the follow-up of the NDMP 2011 – 2015
F. Formulation of the National Drug Prevention Plan 2011 – 2014

***Implementing Office NAR (UBN)***

The UBN is the secretariat of the NAR with the key duty to assist the NAR in the abovementioned duties, appointed by order. These include among others:
- support of the implementation of the NDMP
- implementation of the duties as determined by the NAR

Management of the *Drugs Observatory Institute* for Suriname called SURENDU

***Surinamese Epidemiologic Network related to Drugs (SURENDU)***

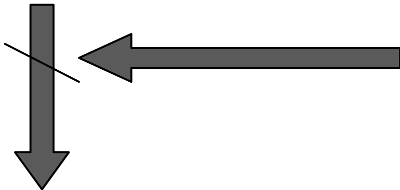
The SURENDU is coordinated by the UBN and has key duty to provide the NAR with information for policy formulation. It is a monitoring system which supplies actual and primarily statistical information with regard to legal and illegal drugs and thereto related judicial aspects, by means of regular collection of data and analysis. This data is primarily intended for policy development and planning purposes. The SURENDU data is derived from the NGO treatment centre, the governmental detoxification clinic, the PCS, BAD and the various departments of the Ministry of Justice and Police. In May 2009, the last comprehensive report of this network was issued with data on the period October 1, 2008 till March 30, 2009. Due to unforeseen circumstances and the national elections in 2010, arrears developed in the collection of data. The pursuit is to approach this issue as much as possible.

The NAR maintains a zone approach at the drug prevention whereby *demand reduction* is sub divided in primary, secondary and tertiary drug prevention, specified in the Green -, Yellow - and Red Zone respectively.

With primary prevention (Green zone) is meant all activities **aimed** at the prevention of drug abuse. This regards information and education, promotion of a healthy life style **aimed** at the care for a healthy body and mind.
Within the secondary drug prevention (Yellow zone) this regards a so-called early intervention for starting drug abuse to prevent addiction/abuse in future. Whilst the tertiary prevention (Red zone) implies the treatment, cure, rehabilitation and re-integration of drug addicts within society and prevention of a relapse in drug abuse.

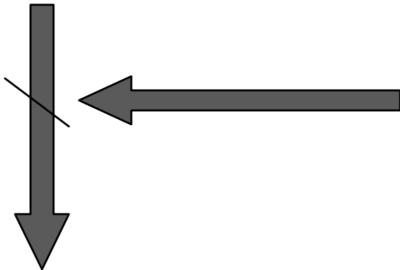
**Health status** | **Levels of prevention**

Healthy: no signs and symptoms of disease, disorder or injury



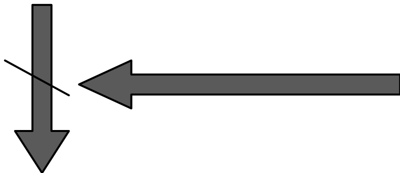
**Primary prevention** – Preventive measures which should prevent the beginning of the disease or injury during the pre-pathogenetic period

Disease, disorder or injury



**Secondary prevention** – Preventive measures resulting in an early diagnose and immediate treatment of a disease, disorder or injury for limitation of a disability, deterioration or dependence and prevention of more serious pathogenesis.

Disability, deterioration or dependence



**Tertiary prevention** – Preventive measures for rehabilitation after considerable pathogenesis

Death

## 3.4 Organizations and developments within the Meso and Micro environment

### 3.4.1 Organizations and structures on Meso level

With meso level is meant all organizations active in exploiting activities within the extensive working area of the drug prevention both within the government, private as well as the NGO sector. In the area of drug prevention, the following organizations are active within the government:

***Bureau Alcohol and Drugs (BAD)***

BAD is a division of the Psychiatric Center Suriname (PCS) and comes under the Ministry of Health. The services offered by BAD comprise of the following, among other things, with regard to primary prevention:

1. Conduct information activities, upon request of schools, companies, community organizations and others

2. Participation in fairs and exhibitions which involve youth

3. Conduct train-the-trainer sessions, among others within the group of health workers active in the hinterland and police neighborhood managers.

In addition, BAD also offers ambulant care to drug users upon referral from this division to more specialist care. On its website (under policy realization), BAD makes notification of the urgency of strengthening in the area of primary prevention, primarily aimed at reaching youth via education. The organization herewith also nominates the possibilities for greater support to professionals and organizations at the development and implementation of prevention policy within the sector.

***Division narcotics squad KPS***

The division narcotics squad of the Police Force Suriname (KPS) has a small team of information officials available. These employees primarily provide information at schools upon request. No separate budget is available for this within the division in question.

***Other primary prevention organizations***

Other organizations which officially form part of the Green zone (information and education) are:

| Name organization | Sector |
|---|---|
| Basic Life Skills Committee MINOV (BLSC) | Government |
| Federation Parent Participation | NGO |
| Kick the Habit | NGO |
| National Women Movement | NGO |
| Stibula | NGO |
| Corporate Health Care Foundation | Private |
| Foundation de Stem | NGO |
| RGD Foundation | Government |

***Secondary prevention organizations***

The organizations within the Yellow zone (early detection) are:

| Name organization | Sector |
|---|---|
| Neighborhood managers KPS | Government |
| Forensic Social Care | Government |
| Youth Child Protection | Government |
| Stichting de Stem | NGO |
| Stichting Man mit Man | NGO |
| Stichting Maxi Linder | NGO |

**Tertiary prevention organizations**

The following organizations operate within the Red zone (rehabilitation and re-socialization):

| Name organization | Sector |
|---|---|
| PCS Detox division | Government |
| Foundation de Stem | NGO |
| Faith and Love Foundation | NGO |
| The Klankbord Foundation | NGO |
| Victory Outreach Foundation | NGO |

### 3.4.2 Developments within the Micro environment

Annually, around June 26 (International Day Against Drug Abuse and Illicit Trafficking Stop Drugs Day), activities are carried out aimed at increasing the awareness regarding the risks of drug abuse. These activities were coordinated by the UBN which mobilizes as much as possible organizations for this purpose, within the sector, to organize target group activities around the annual theme.

Within the period 2007 – 2010, the following studies were produced locally in the area of drug prevalence, abuse and control:

1. CICAD/NAR - Household Survey
2. NAR – policy document based on household survey
3. SURENDU – network reports
4. NAR – drug abuse and community coherence
5. OAS/CICAD – MEM reports
6. EU /DDRP- School Survey Suriname (VOJ grade 3/4 ) and students of VOS (grade 1 and 2).

In addition, guidelines were approved by the Ministry of Health in 2007 for residential care and treatment of drug addicts.

## 3.5. Integrated approach of prevention

The outcome of the National Household Survey (publication February 2009) shows that a majority of the respondents is aware of the risks of the use of both legal and illegal drugs. The outcome of previous RSA (Rapid Situation Assessment - 2005) also shows a similar picture. The table below shows that about 80% of the survey's respondents are aware of the risks involved with frequent use of legal drugs (alcohol and tobacco). Subsequently, this table shows that 'only' 72% of the non-frequent use of marijuana and 83.6% of the frequent use of marijuana can be typified as harmful.

| *Q. In your opinion, please indicate the risk of ….* | **Perception of Risk** | | | | |
|---|---|---|---|---|---|
| | No risk | Low risk | Moderate risk | High risk | Don't know |
| Smoking cigarettes often | 1.7 | 2.3 | 8.1 | 80.3 | 7.7 |
| Drinking alcoholic beverages often | 1.7 | 2.0 | 7.9 | 81.8 | 6.6 |
| Smoking marijuana sometimes | 3.0 | 5.4 | 10.2 | 72.2 | 9.0 |
| Smoking marijuana frequently | 1.0 | 2.0 | 4.5 | 83.6 | 9.0 |
| Using cocaine sometimes | 0.4 | 0.6 | 2.7 | 87.7 | 8.6 |
| Using cocaine frequently | 0.1 | 0.1 | 0.6 | 90.5 | 8.7 |

Source: National Household Survey 2007 – Publication, February 2009

Getting to the cause why, despite the awareness of the risks, behavior (choice for use of drugs) is not in line herewith, requires more information in order to fathom the problem in all its aspects so that the strategy, policy and interventions can subsequently be attuned thereto. Further qualitative survey is therefore required and will have to identify the reason why, despite this awareness, youth, in particular, 'slip up'. This qualitative survey shall be the study through which the answers will have to be provided to the questions with regard to the "how" and "why" round the quantitative outcome of surveys.

### 3.6 SWOT

The SWOT table provides a summarized overview of the starting point situation in the area of national prevention as basis for the NDPP.

| Strength | Weakness |
|---|---|
| NAR's comprehensive compilation and terms of reference offers lead points for an integral approach | De capaciteit van NAR en uitvoerende instanties is beperkt en een tekort aan preventie - specialisten |
| Access to and availability of international networks and information centers (OAS, UNODC).<br>Active participation in international network meetings | Current prevention BAD more upon request and less pro-active |
| Networks and structures for data collection available | Interpretation of data to policy is insufficiently made; survey results are insufficiently used within policy formation |
| Strong commitment from the Ministry of Health through among others a NAR budget | Bringing up for discussion, the scope of competence and authority of the NAR regarding anti-drug policy and the restricted budget for specific projects and national activities |
| A lot of quantitative data available | Insufficient qualitative data and input of other departments or governmental institutions |
| | Non – adequate legislation regarding advertising of legal drugs |
| **Opportunity** | **Threats** |
| Access to national networks within the government (via NAR representation) | New forms of drugs of which society is insufficiently familiar of the prevalence and consequences and easy access with regard to knowledge about production and application via the Internet. |
| Successful and very positively valuated DDRP offers access for follow-up projects with EU as donor | Seductiveness of drugs and drug-related crime on vulnerable youth (bad role models) |
| Institution of Ministry of Sports and Youth offers perspectives for a more oriented approach of youth | Negative influences of the multi – media on youth |
| New partnerships for drug prevention in the world | Non – optimal social economic situation (national & international) and impact hereof on families and youth |

### 3.7 Starting points of an effective prevention policy

Efforts with regard to prevention are most effective if they form part of a greater whole of measures, also in the area of supply reduction. The NDMP 2006 – 2010 is the valid policy document which was used as co-reference for the formulation of the strategy of the NDPP. The assumptions lying at the basis of a successful approach of the drug problem (with NDPP as a significant part thereof) are:

- Continuation of the implemented policy aimed at drug control and drug related crime
- Drug prevention approached as a joint activity with involvement of a large part of the public sector (Education, labor market, Health care, Social Affairs, Justice and Police)
- Acknowledgment of the prevalence of risk factors and awareness of the necessity of interventions in all areas for expansion of the protection factors
- Acknowledgment that the drug problem requires a national approach whereby sufficient consideration is required of the multi-cultural aspects within society
- Active participation of the NGO sector and business and trade at eradication of drugs.

The challenges within this first NDPP are found in the area of:

- Inter-sectoral integration and mobilization within the government (youth, sports and health)
- Development of research capacity aimed at increased qualitative survey as supplement to quantitative data
- Human capital development (for interpretation of survey results into development and implementation of policy and continuous information/education in the area of prevention)
- Combine public education with behavioral skills
- Closer partnerships with NGO sector and the media
- Programs for the work floor

With a more specific approach, the challenges for prevention are:

- Ability to converse the existing foreknowledge on the risks of (legal and illegal) drugs such as shown from the surveys in behavior which is in line thereto.
- Anticipation in and control of identifiable trends of 'mail dispatches' and 'drug mules'.
- Reduction of drug abuse among boys (according to the survey larger number of boys compared to girls) with program and activities specifically aimed at these boys.
- Control of the 'popularity' of marijuana as the most frequently used illegal drug among youth[4].
- Through qualitative research, obtain a detailed insight in the specific risk factors applying to drug abuse in the districts and parts of the interior with relatively high user figures to be able to attune specific prevention thereto.

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[4] See table under 2.1

The current terms of reference of the NAR offers lead points for policy advice, mobilization of parties and coordination and monitoring of sub programs and projects from the NDPP. Within the current set up, the NAR comes under the Ministry of Health. A re-orientation on the official establishment of the NAR on a higher political level within the government structure is desirable to develop more complete, sector-exceeding programs, projects and activities, compared to what is currently defined within the terms of reference, and to present these for implementation to the relevant implementation institutions.

The strategies for achieving concrete results in the coming period, considering the existing challenges, are shortly outlined in the following paragraphs. The SMART detailed outline of the strategy and objectives is subsequently defined in the next chapter based on action plans.

### 3.8 National strategy and goals 2011-2014

The national strategy for the period 2011 - 2014 is:
**An integral approach initiated and coordinated by the government whereby optimally equipped services and evidence-based intervention are applied within the primary, secondary and tertiary drug prevention and to be aware of the support of all governmental services, trade and business and relevant NGO organizations.**

**The final long-term goal to, based on the vision, namely a drug-free society, safeguard Suriname from the consequences of drug abuse, directly or indirectly, on mankind and society.**

The goals for this first NDPP are:

- Structured planning, coordination and implementation (seeing to implementation) of national activities aimed at primary, secondary and tertiary prevention and mobilization and substantial strengthening of all governmental services appointed for this purpose. NAR is herein the independent body which, through an extensive and active representation of the government, business and trade and the NGO sector, takes in a coordinating, facilitating and advisory role.

- Steering of a more fundamental approach of drug prevention through reduction of the risk factors and substantial improvement of the protecting factors through:
    - Focused attention for improvement of the social and economic circumstances (employment, youth shelter and coaching, social counseling in under-privileged neighborhoods etc.)
    - Complementary to awareness campaigns, steering of behavioral change and attitude formation (learning how to make choices, complimentary to transfer of knowledge)

- Promotion of a healthy life style and strengthening of the defensibility of specific groups (among others through sports).

- Realization of legislation for support or otherwise regulation of primary prevention and curative care. This legislation regards, among other things:
  - Increased treatment and implementation of current legislative proposals among others in the area of the Drug Treatment Court and legislation for Special Investigation Competences and simultaneously increased attuning of the shelter capacity of the care center with the anticipated increase.
  - Drugs on the work floor; integral policy for employers
  - Standardization and transparency within curative care (measuring is knowing)
  - Media regulation; regulation of alcohol and tobacco advertising
  - Act on selling of recreational substances and legislation in the area of sales round sports centers and events.
  - Guidelines for collection, analysis and distribution of quantitative and qualitative information on drugs and drug abuse so as to achieve an increased attunement of the prevention efforts with the actual situation.

### 3.9 Target groups and sub strategies of prevention policy

In the broadest sense of the word, the target group for an integral prevention policy is the society as a whole. This society comes directly (as demand factor/user of legal and illegal drugs) or indirectly (advertisements, users within family/work relation) in contact with the extensive supply of legal and illegal drugs and should be able to say no, based on their knowledge of the risks.

Segmentation within this large and rather diverse target group is essential to be able to link the prevention measures as adequately as possible to the specific characteristics and circumstances of each sub group. For goal-oriented prevention activities, the following division is usually maintained.

<u>1. Youth</u>

This group can be further subdivided in:

- School children
- Early drop-outs
- Unemployed youth

School children can be reached via official educations. Via learning programs, pro-active information, access to actual information (library and/or media information center) and input of peers as role models, a continuous contribution can be achieved to the know-how, attitude and responsible behavior. The other two groups are more difficult to reach and are

typified with regard to drug abuse, as vulnerable groups. The development of specific programs for a goal-oriented approach are urgently required. The sub strategy for the target group youth is:

**Prevention / discouragement of drug use among our youth through a goal-oriented policy of strengthening, education and edutainment in order to embrace the full potential of this target group, in supplementation of accessible professional curative care, if necessary, and counseling of drug-dependant youth.**

2. Labor market

Drug use has a negative impact on the labor productiveness and disrupts normal labor relations. Within our labor market, a few, namely larger private and state companies, are already maintaining a goal-oriented anti-drug policy. Components of this policy include, among others, awareness, testing and counseling of employees and development and introduction of an anti-drug code.

Fighting drugs on the work floor, however requires more attention than the current shattered efforts of individual companies. It is recommended to arrive at a national prevention policy for the work floor via the thereto appointed ministry, business and trade organizations and labor unions.

**The prevention sub-strategy labor market is: arrive at an optimal use of Surinamese potential through full eradication of drugs on the work floor via goal-oriented policy initiated by the government and to be implemented with cooperation of the private sector and various labor unions and other business and trade organizations active on the labor market.**

3. Families

Remarkable is that in the year 2010, no government or NGO institution was established with the most important duty to offer coaching and support to families. Churches and social institutions, in or outside the government, take care of sheltering families/family members in urgent need. There is no talk yet of structural support and coaching for the family as an institution and first educational environment. In view of a fundamental approach of drug prevention can be recommended to fill in this coaching duty towards the family, via the government. In this first NDPP, drug prevention coaching should be possible via an existing service (RGD, Medical Mission, teacher etc.) who offers counseling to parents/partners with regard to their queries and problems in relation to drug use among family members and, if necessary, offer referral to specialist care services. These service providers will have to receive the know-how and skills necessary for detection of signs and referral.

**The sub strategy for this target group within the NDPP is strengthening and coaching of families with regard to the role played by the first educational environment (security and safety) and offering then a vocal point aimed at coaching and early detection of drug abuse.**

4. Others: MARPS (Most at Risk Populations)
In addition to the group of vulnerable youth who cannot be reached via the education system, we distinguish between the following vulnerable groups within our society which deserve extra attention as part of the drug prevention policy:

- Sex workers
- Prisoners

The strategy for the vulnerable group is:

**Create a sharp picture, through quantitative and qualitative research, of the problems and needs among vulnerable groups (among others prisoners and sex workers) to subsequently develop a goal-oriented policy and offer tailor-made care aimed at re-socialization and rehabilitation.**

The key terms within the strategy for these target groups are re-integration and re-socialization.

### 3.10 Partnerships

In view of above-formulated strategy, entering into new, and strengthening and expansion of existing partnerships is a *conditio sine qua non*. With partnerships are herewith meant both attunements between actors as well as vertical attunement between competence levels.

The NAR has access to networks both in and outside Suriname that should be used for realization of the goals. The focus with regard to foreign partnerships lies mainly on aspects of capacity strengthening. Within the local partnerships, this means creating the basis and commitment for a national implementation of the NDPP.

Through use of the existing national infrastructure, namely within the government, it is possible to:

- Aim prevention on the local circumstances and in so doing keep it accessible
- Penetrate in even far-away areas at relatively small (training) costs
- Create local expertise in early detection and referral
- Make local communities once again responsible for 'social control'.

| | Partner | Focus for NDPP |
|---|---|---|
| **International / Regional** | OAS and UNODC | Technical support at capacity strengthening<br>Access to know-how networks |
| | UNDP/UNFPA UNICEF | Linking to specific programs, projects and themes |
| | CARICOM | Parts of 'best practices' in relation to care within the region (with similar challenges) |
| | EU | DDR program aimed at youth |
| | PAHO | Apply Public Health approach and instruments |
| | ILO | International anti-drug code for the work floor |
| **Macro/ Meso** | Justice/Public Prosecutor | Lobby for implementation of among others a drug treatment court and other intra-mural prevention within prisons and where necessary, re-classification<br>Prevention legislation and supervision on the compliance of legislation<br>Inventory of current legal framework and necessary supplement |
| | Health | Bring capacity within implementing institutions in line with terms of reference<br>Better utilization of infrastructure within health care for prevention (RGD, BOG and others) |
| | Social Affairs | Parent participation, information and others, social care) |
| | Education | Strengthen monitoring duty and detection function of schools in relation to drug use, with a central registration point<br>Use local infrastructure to provide information and coaching.<br>Basic Life skills (incl. drug prevention embedded within curriculum of all education levels. |
| | ATM | Anti-drug code for the work floor, mobilize social partners for adoption code and support and implementation of policy |

| | Partner | Focus for NDPP |
|---|---|---|
| | | Mediation at employment for re-socialized persons |
| | Business and trade | Drug policy on the work floor and advertisement code with regard to legal drugs |
| | Trade unions | Early detection function on the work floor via shop stewards and other structures |
| | | |
| | Sports and Youth Affairs | Counseling and coaching via among others, neighborhood organizations and sports unions |
| | Neighborhood managers KPS | Detection and feedback with aid services for goal-oriented actions in the field of prevention<br>Access to vulnerable youth in problem neighborhoods |
| | Religious and spiritual NGOs | Soul care and strengthen ability to be better resistant |
| | Oher NGOs | Maintain contacts with community based organizations that have access to specific target groups and use of local networks and expertise |
| | Donor organizations | Project financing elements from NDPP |
| **Micro** | UBN / Surendu | Optimal internal coordination of departments and services at Ministry of Health at implementation of regular prevention measures |
| | BAD | |
| | ZONES | |
| | PCS detox | |
| | RGD | |
| | BOG | |
| | Medical Mission | |

# 4 Action plans NDPP

## 4.1 Introduction

Below are the action plans as defined for the period 2010-2014, sub divided in three phases, namely short term (realization mid 2011), mid-long term (realization mid 2012) and long-term (realization at the end of 2014 and further).

The realization data are solely intended as intermediate markings. Within the different phases, programs / themes are discussed which are implemented, provide sub-results and need continuation, even after the final date. For each of the aforementioned periods, a table is included in general and subsequently per target group, with the activities and intended outcome.

The intended SMART results mid 2011 are:
- Zone networks are thoroughly evaluated and if necessary, abolished, replaced and re-activated
- UBN and BAD are evaluated and if necessary, staffing is expanded, coordination and terms of reference is sharpened and attuned to each other
- The curriculum of primary prevention is screened, preparations have been made for mobilization campaigns against new trends
- Policy document on bringing positioning of NAR in line with sector-exceeding role at the implementation of the NDPP, has been sent to the government
- Minimally 1 national campaign is prepared and implemented (risk of new drugs)
- Adaptation / commitment of NDPP partners at meso level
- NAR government representatives took care of awareness and involvement among top policy makers within their ministries for support of the prevention policy.

In phase 2, efforts are made towards extensive capacity strengthening, expansion of partnerships and shift of accent to a more fundamental approach in drug prevention. Mid 2012, the following shall minimally be achieved at a successful implementation of the NDPP:
- National network available for early detection linked to a central registration desk in Paramaribo, early detectors trained and functioning actively
- Care centers are professionalized (standardization of care, supervision and counseling) and provide patient data
- Minimum of 50% of primary prevention is target group oriented
- Anti-drug code for the work floor is developed and accepted by the social partners
- 75% of the school children has received minimally 1 session annually in the field of drug education
- A minimum of 50% of all education activities combines knowledge increase with learning basic skills (increase of resilience)
- Re-integration of clients from the care centers is centrally monitored and supported (activities, family counseling etc.)

In phase 3, efforts will be made, as follow-up of the results of the first two phases, towards quality assurance, effectuation of more update legislation and minimally 50% more ‘evidence-based’, goal-oriented prevention activities due to the availability of quantitative and qualitative data and the professional and scientifically substantiated interpretation according to policy. By 2014, the following will have to be achieved at a successful implementation of the NDPP:

- Nationally strong institutional framework for prevention
- The necessity for fundamental prevention is acknowledged and supported on governmental level; institute for family affairs is established
- 90% of all primary drug prevention activities combine broadening of knowledge with behavioral skills
- Within secondary and tertiary care, the programs are fully attuned to the specific target groups
- Within drug-related shelter and counseling there are separate programs for specific target groups which are indicated from recent studies (for ex. youth and women).

### 4.2 Action plans phase 1 – short term (realization mid 2011)

The starting point is that the NAR is the final responsible institution for the NDPP. For a good coordination, the UBN will focus on the following key duties:

- Give recommendations and support at professionalization of executor services within the government (BAD/SURENDU)
- Safeguarding of progress of sub-activities of NDPP
- Identify, develop and offer sub projects for financing by government and/or donors
- Take care of optimal staffing and active operation of prevention-related networks
- Further expansion of data collection (quantitative and qualitative).

The short-term action plans for the target groups are included below.

| Action plans general (short term) | Realization mid 2011 | Who |
|---|---|---|
| **Activity** | **Aimed result** | |
| At a higher political level, delegate current coordination authority to NAR | More effective coordination and functioning of the NAR with absence of competency issues | |
| Filling in of vacancies at UBN (among others SURENDU) and sharpening terms of reference related to data analysis and distribution, evaluate processes for data collection and analysis and where necessary adapt these | Continuity safeguarded and onset of quality improvement | Ministry of Health (via RVM) |
| Start qualitative data collection from SURENDU | Peripheral condition for evidence-based prevention established | NAR |
| Establishment of work groups within NAR/UBN/BAD around the target groups (youth, labor market, family and others) including themes (participation, PR, healthy behavior, care and safety) | Division of roles is established for implementation of NDPP | NAR |
| Partnership agreements on meso level for utilization of existing national networks (KPS, RGD, Medical Mission) | Framework for cooperation OK | NAR |
| Mobilization and strengthening of core services within the government in the field of primary prevention and early detection | Availability broadened in the area of early detection | Ministries of Health, Education, Youth and Sport, Social Affairs |
| Assessment of the compliance to the minimum standards within curative care | Quality assurance within provision of care | Min. of Health/NAR |
| Evaluation of area approach, upgrading of staffing and supplementation with active and motivated stakeholders | Networks are active and involved | NAR |

| Action plans general (short term) | Realization mid 2011 | Who |
|---|---|---|
| Inventory BAD and onset of elimination of bottle-necks (capacity and approach) | Capacity development and improvement agenda for mid-long and long term | Ministry of Health |
| Start up lobby for speeding up of law proposal Drug Treatment Court in coherence with expansion of shelter capacity of care center | Effectuate initiated activity for demand reduction | NAR/Min. of Jus & Pol/ Min. of Health |
| Inventory and gap analysis in relation to other legislation | Agenda for upgrading of legislative framework for mid-long and long term | NAR / Min of Justice |
| Set up of a general public campaign via the mass media (focus on threats, so know your responsibility, Su needs you!) | Threats known of existing and so-called new drugs | NAR/Min. of Education/ Min. of Health |
| **Youth short-term** | **Realization mid 2011** | |
| **Activity** | **Intended result** | **Who** |
| Conclude partnerships with education, youth institutions and NGO youth | Network expansion for integral approach | NAR |
| Develop teaching modules for drug prevention per school level | Prevention embedded in regular education | Min of Education/PCS - BAD |
| Identify role models per school type and area and onset of prevention | Association with perception of immediate environment | Min. of Education/ PCS - BAD |
| Prevention booths during youth events | Broadening of access to target group | PCS - BAD |
| Incorporate Min of Sport and Youth Affairs into the NAR and join established committee Youth At Risk | Policy support and advice for new ministry | NAR |
| | | |
| | | |

| Labor market short term | Realization mid 2011 | |
|---|---|---|
| **Activity** | **Intended result** | **Who** |
| Linking through NAR with ATM (labor legislation) and home affairs (employer of largest group of wage-earners) | Expertise and capacity expansion | NAR/ Min of ATM |
| Inventory options via ILO/UNODC | Linkage to recent developments in relation to drugs on the work floor | NAR |
| (Re) activate partnerships with industry and trade organizations and labor unions | More extensive scope of preventive activities | NAR |
| Implementation of at least 1 workshop for preparation/working out of National Anti-drug Policy in the work place | Initiation of an unambiguous anti-drug code for the national labor market | NAR |

| Family short-term | Intended result | Who |
|---|---|---|
| Training Social Affairs staff in early detection and referral options | Capacity strengthening of implementing services | PCS - BAD |
| Drug-prevention booths at local fairs by professionals who are able to respond to goal-oriented questions | Awareness | NAR/PCS - BAD |
| Training of teachers for detection within families | Early detection | PCS - BAD |
| Formulate a policy document for a fundamental approach via family interventions and counseling | Create a foundation for fundamental approach of prevention | NAR |
| Campaigning in public communities | Removal of barriers for care, eliminate taboo sphere around acknowledgment of problem | NAR/PCS - BAD/NGOs |
| **Vulnerable groups short term** | **Intended result** | **WHO** |
| Monthly activities with youth of Opa Doeli through for ex. adoption by service club(s) | Role models available for young delinquents | NGOs/PCS - BAD |
| Measure need for shelter for addicted women | Capacity planning | UBN/SURENDU |

| Family short-term | Intended result | Who |
|---|---|---|
| Information related to care options for addicted commercial sex workers (*Jepi -de*) | Removal of barriers | PCS - BAD |

### 4.1 Action plans phase 2 – mid-long term (realization mid 2012)

Below, the general action plans for mid-long term:

| Action plans General | Realization mid 2012 | Who |
|---|---|---|
| **Activity** | **Intended result** | |
| Institutional reform/adaptation of implementing institutions/bodies within the government related to prevention | More effective and efficient implementation of prevention activities | Min. Of Health/ PCS/ Min of SoZaVo |
| Establishment of a central registration for early detection of drug use (for physicians, teachers, neighborhood managers, sport coaches, shop stewards etc.) | Serving-hatch for pro-active assistance | Ministry of Health/ PCS |
| Training of teachers, members of Police Force, staff of RGD and Medical Mission in relation to early detection and referral options | Capacity strengthening | PCS - BAD/NGOs |
| Six-monthly motivation and discussion sessions with medical practitioners | Quality assurance | PCS - BAD/NAR |
| Set up and central monitoring of a patient register | Output tertiary prevention known and focus thereupon | SURENDU |
| Measuring of output of prevention efforts | Effectiviness control | SURENDU |
| Closing off of protocol with KPS for input of infrastructure for scaling up, early detection by neighborhood managers, making visible of vulnerable youth | Capacity strengthening with primary and secondary prevention | Min Jus & Pol/NAR |
| | | |
| In the informational message of the Narcotics-KPS, more attention for option related to assistance | Information more 'action-based' | KPS |

| Action plans General | Realization mid 2012 | Who |
|---|---|---|
| Recruitment of communication specialist for interpretation of data analysis into an effective communicative strategy | Making primary prevention evidence based | Ministry of Health |
| Discussion of positioning of NAR | Housing of NAR under VP/President | Min VG/Min Jus & Pol / NAR |

The action plans for mid-long term per target group are:

| Youth mid-long term | Realization mid 2012 | |
|---|---|---|
| **Activity** | **Intended result** | **Who** |
| Develop teaching modules for drug prevention per school level and incorporate these into curriculum | Prevention imbedded in regular education | MINOV |
| Develop a national 'social card' for vulnerable youth and specific backgrounds | Specific data for goal-oriented interventions | SURENDU |
| Prevention weeks in specific problem areas whereby collective raising of information and provision of care based on reports of networks | More pro-activity in the area of primary and secondary prevention | NAR |
| BAD's material of informative learning into actively involved, stimulate to discussions and urge on to responsible behavior | In addition to transfer of knowledge, also attitude education and broadening of skills | PCS - BAD with curriculum experts |
| Broadening of peer to peer support | Increase impact | PCS - BAD |
| Campaign aimed at youth between 13 - 23 (make healthy choices and look after yourself and each other) | Broaden awareness and behavioral change | PCS -BAD/Min. of Education |
| Provide sport managers with knowledge and skills for primary prevention care to youth | Capacity building primary prevention | PCS - BAD/Min. of Youth and Sport |
| Put drug prevention on the agenda of youth institutions and expand NAR representation with youth parliamentarian. | Input of youth increased | NAR/Min of Youth and Sport |

| Youth mid-long term | Realization mid 2012 | |
|---|---|---|
| Preparation and execution of campaign Promoting Positive Parenting aimed at stimulating coaching of youth | Guidelines available for parents/coaches on how to deal with experimental behavior among youth | UBN/PCS - BAD |

| Labor market<br>Mid-long term | Realization mid 2012 | |
|---|---|---|
| **Activity** | **Intended result** | **WHO** |
| Mobilization of social partners at executive level (labor unions, trade and industry) | Basis for anti-drug policy | NAR |
| Training of shop stewards, personnel officials and others in early detection | Capacity building | PCS - BAD |
| Start with national campaign in a drug-free zone | Awareness on the work floor | NAR/PCS - BAD |
| Develop and present anti-drug policy on the work floor | Policy document available | NAR and labor market partners |
| Nominate responsible body within government (ATM/ Home affairs) for supervision on compliance to drug policy | Effectuate policy | Min of ATM |

| Family<br>Mid-long term | Realization mid 2012 | |
|---|---|---|
| **Activity** | **Intended result** | **Who** |
| Lobby and work out proposals for media legislation in the area of tobacco and alcohol advertisements | Positive influence of media on behavior | NAR |
| Present proposals to government for educational and stimulating programs regarding parent and child relation programs on TV and radio | Family strengthening | NAR /Min of Social Affairs |

| Vulnerable groups Mid-long term | Realization mid 2012 | |
|---|---|---|
| **Activity** | **Intended result** | **Who** |
| Training en refreshments for personnel of Center for Homeless People and other (day) care centers for homeless people | Capacity strengthening | PCS -BAD |
| Offer accessible care through design of a service window at care center | Care closely available for target group | PCS |
| Increase prevention activities within penitentiary institutions and follow-up training of PAs in early detection | Capacity building | PCS - BAD/Min Jus & Pol/NGO's |

### 4.2 Action plans phase 3 – long term (realization by end of 2014 and further)

The course of phase 3 depends strongly on the sub-results from phase 1 and 2.
An intermediate adjustment of below incorporated activities is therefore recommended for the end of phase 2.

| Action plans General | Realization by end of 2014 and further | Who |
|---|---|---|
| **Activity** | **Intended result** | |
| Establish de-central registration points in neighborhoods | Neighborhood associations as local registration point available (early detection) | Ministry of Health / Min. of Social Affairs |
| Interest media for ideal advertisement campaigns | Attitude education via mass media | NAR |
| Effectuate drug demand legislation and institute supervisors | Supervision on compliance of legislation available | Ministry of Justice |
| Coaching of immediate environment of drug user undergoing treatment | Treatment circle available (for indirect victims) | PCS - BAD/ Treatment Centers |
| Analyze and interpret qualitative and quantitative data in guidelines for specific prevention | Best practices known and available for network | SURENDU |

| | | |
|---|---|---|
| Development of a trade mark for treatment centers | Quality assurance for treatment | NAR/Min VG |
| Development of performance indicators for secondary and tertiary prevention | Safeguard effectiveness of treatment | NAR |
| Training of care providers in specific coaching tasks, among others re-entry of clients on labor market | Quality improvement of treatment | Ministry of Health |

| **Youth<br>Long-term** | **Realization by end of 2014 and further** | |
|---|---|---|
| **Activity** | **Intended result** | **Who** |
| After-school shelter in under-privileged neighborhoods | Positive time-spending of vulnerable youth | Ministry of Youth, Education and Social Affairs |
| Additional primary prevention program for schools in problem areas and in connection thereto, removal of barriers for provision of care through among others peer support | Reduction of addiction among youth | PCS -BAD/Min of Education |
| Introduce social card for mobilization and start of assistance | Tailor-made activities within care | Min of Social Affairs/ PCS – BAD |
| **Labor market<br>Long term** | **Intended result** | **Who** |
| Establishment of a drug official per employer for monitoring and compliance of drug code | Active drug control networks on the work floor | Employers/employees organizations |
| Prevention kits with information for new personnel in both public and private sector | Unambiguousness of policy | PCS – BAD |
| | | |
| **Family<br>Long term** | **Intended result** | **Who** |
| Set up an institute with the primary task to support families in their educational duty | Professional coaching of families available | Min. of Social Affairs |

| | | |
|---|---|---|
| **Vulnerable group<br>Long term** | **Intended result** | |
| Work out re-integration routes for specific groups | Re-socialization upgrade available | PCS - BAD/NGOs |
| Establishment of early detectors per vulnerable group with link to assistance | Early intervention also available for vulnerable group | PCS/NAR in collaboration with NGOs |