

STANDARD SECTOR INDICATOR CODE: HE-022	Showed Improved Knowledge of Health Risks of Over-consumption of Alcohol or Substance Use: Number of individuals who can identify 2 or more health risks associated with over-consumption of alcohol or substance use.	
HEALTH SECTOR	Sector Schematic Alignment <ul style="list-style-type: none"> • Project Area: Life Skills for Healthy Behaviors • Project Activity Area/Training Package: Alcohol and Substance Use Prevention 	
Type: Short-term Outcome	Unit of Measure: Individuals	Disaggregation: Sex: Male, Female Age: 0-9 years, 10-17 years, 18-24 years, 25+ years

To be counted for this indicator the following criteria must be met:

- The individual must have attended training on the harmful effects of alcohol and substance use and the prevention of alcohol abuse and substance use.
- The training must have been provided by the PCV or their partner in an individual or small group setting. Research shows ideal group size is 25 individuals or less, although in some instances group size can be significantly larger. PC/Post staff determines what comprises a small group setting.
- Attendance at educational session/s must be documented by the Volunteer or their partner.
- The individual must correctly identify two or more health risks associated with overconsumption of alcohol or substance use.

Definitions:

Health risks associated with overconsumption of alcohol: Excessive drinking is associated with numerous health problems including liver cirrhosis, cancer of the liver, mouth, throat, larynx and esophagus. Cardiovascular diseases such as congestive heart failure, hypertension, arrhythmias and stroke pancreatitis, gastroesophageal reflux disease, and stomach ulcers and the mal-absorption of nutrients, vitamins, and minerals. Studies have shown that women who drink moderately are at increased risk for damage to the heart muscle and to breast cancer. Binge drinking is a risk factor for sexual assault, injury from falls and motor vehicle accidents. If the woman drinks during pregnancy her baby may be affected with fetal alcohol spectrum disorders and research suggests that women who drink alcohol while pregnant are more likely to have a baby die from Sudden Infant Death Syndrome (SIDS).

Health risks associated with substance use: Health risks associated with substance use vary by substance and by how the substance is used. However, any style of substance use is frequently associated with increased risk for various mental disorders such as depression and anxiety. Substance users are also at increased risk for neuronal and memory loss, overdose, sudden death, impaired short-term memory, impaired attention, impaired judgment, impaired coordination and balance, increased heart rate, and increased appetite. Substance use by snorting is associated with increased risk for nasal damage, problems swallowing, and GI problems. Smoking-related drug use is associated with an increased risk for chronic cough and bronchitis. Injecting drug users are at increased risk for contracting HIV, Hepatitis B, and Hepatitis C. Evidence also suggests that non-injecting drug use is associated with an increased risk of HIV infection. Pregnant women who use drugs are at increased risk for premature delivery, low birth weights, and smaller for gestational age babies as well as some developmental disorders.

Overconsumption of Drugs or other substances: The WHO defines substance abuse as the harmful or hazardous use of psychoactive substances, including alcohol and illicit drugs. Any use of illegal substances is overconsumption.

Overconsumption of alcohol (aka heavy drinking): The Centers for Disease Control define heavy drinking or overconsumption for men as consuming an average of more than 2 drinks per day, or more than 14 drinks per week. For

women, heavy drinking is typically defined as consuming an average of more than 1 drink per day, or more than 7 drinks per week. Anything more than moderate alcohol is considered overconsumption due to increased health risk such as breast cancer, violence, drowning, and injuries from falls and motor vehicle crashes.

1 drink of alcohol: is defined as a ‘shot’ 1.5 fluid ounces (oz.)* of 80 proof liquor or 14.0 grams (0.6 ounces) of pure alcohol. Generally this amount of alcohol is found in:

- 12-ounces of beer.
- 8-ounces of malt liquor.
- 5-ounces of wine.
- 1.5-ounces or a “shot” of 80-proof distilled spirits or liquor (e.g., gin, rum, vodka, or whiskey).

*1.5 ounces is equal to approximately 45 ml.

Moderate drinking: is defined as greater than 2 alcoholic drink a day. This definition refers to the amount of alcoholic drinks consumed on any single day and is not intended as an average over several days.

Heavy drinking: is often defined in terms of exceeding a certain daily volume (e.g. 2 drinks a day for men).

Binge drinking: is defined as a pattern of alcohol consumption that brings the blood alcohol concentration (BAC) level to 0.08% or more. It usually corresponds to 5 or more drinks, within about 2 hours for men.

Rationale: The harmful use of alcohol is a global problem which compromises both individual and social development. It results in 2.5 million deaths each year. Alcohol is the world’s third largest risk factor for premature mortality, disability and loss of health; it is the leading risk factor in the Western Pacific and the Americas and the second largest in Europe. Men consistently have higher rates of alcohol-related deaths and hospitalizations than women. Among drivers in fatal motor-vehicle traffic crashes, men are almost twice as likely as women to have been intoxicated. Excessive alcohol consumption increases aggression and, as a result, can increase the risk of physically assaulting another person or of engaging in risky sexual activity including unprotected sex, sex with multiple partners, or sex with a partner at risk for sexually transmitted diseases. The harmful use of alcohol is associated with several infectious diseases like HIV/AIDS, tuberculosis and sexually transmitted infections (STIs). This is because alcohol consumption weakens the immune system and has a negative effect on patients’ adherence to antiretroviral treatment.

The UNODC estimates that about 12 per cent of annual users develop dependency and become problem drug users, of whom there are currently fewer than 30 million. Injecting drug use, in particular, is also a significant vector for spreading HIV and hepatitis B and C.

Measurement Notes:

1. **Sample Tools and/or Possible Methods (for Peace Corps staff use):** Volunteers should use data collection tools to measure progress against project indicators. Please check PCLive for data collection tools. Once a tool has been developed, post staff should have a few Volunteers and their partners pilot it, and then distribute and train Volunteers on its use.
2. **General Data Collection for Volunteer Activities:** All Volunteer activities should be conducted with the intention of achieving outcomes – knowledge change (short-term), skills demonstration (intermediate-term), and behavioral changes (intermediate to long term) as defined by the progression of indicators within the objectives of a project framework. The progression of measurement for all Volunteer activities should begin with baseline data being conducted prior to the implementation of an activity (or set of activities), followed by documenting any outputs of the activities and then later at the appropriate time, measurements of specific outcomes (see the bullet on “frequency of measurement”).

3. **Activity-Level Baseline Data Collection:** This indicator builds off of indicator **HE-020: *Educated on Harmful Effects of Alcohol and Other Substances***, or a similar training on alcohol and other substances, as it measures an increase in knowledge of alcohol consumption and blood alcohol levels. Therefore, baseline data collected in the form of a pre-test for HE-020 would apply to this indicator as well.

Because Volunteers are expected to implement relevant and focused activities that will promote specific changes within a target population (see the “unit of measure” above), taking a baseline measurement helps Volunteers to develop a more realistic snapshot of where individuals within the target population are in their process of change instead of assuming that they are starting at “0.” It also sets up Volunteers to be able to see in concrete terms what influence their work is having on the individuals they work with during their service. Please note that data collection is a sensitive process and so Volunteers will not want to take a baseline measurement until they have been able to do some relationship and trust-building with the person/people the Volunteer is working with, and developed an understanding of cultural norms and gender dynamics.

4. **Frequency of Measurement:** After taking the baseline measurement (described above), Volunteers should take at least one follow-on measurement with the same individual(s), to assess whether their knowledge of health risks associated with overconsumption of alcohol or other substances was improved. This measurement is typically taken after completing one or more activities focused on achieving the outcome in this indicator and once they have determined that the timing is appropriate to expect that the outcome has been achieved. Once Volunteers have measured that at least one individual has achieved the indicator, they should report on it in their next VRF.

Volunteers may determine to take more than one baseline and one follow-on measurement with the same individual (or group of individuals) for the following valid reasons:

- Volunteers may want to measure whether or not any additional individuals initially reached with activities have now achieved the outcome in the indicator, particularly for any activities that are on-going in nature (no clear end date);
- Volunteers may want to enhance their own learning and the implementation of their activities by using the data collected as an effective monitoring tool and feedback mechanism for the need to improve or increase their activities;
- A Peace Corps project in a particular country may choose to increase the frequency of measurement of the indicator and Volunteers assigned to that project will be required to follow in-country guidance.

In all cases, any additional data collection above the minimum expectation should be based on the time, resources, accessibility to the target population, and the value to be gained versus the burden of collecting the data. Following any additional measurements taken, Volunteers should report on any new individuals achieving the outcome in their next VRF.

5. **Definition of Change:** The minimum change to report against this indicator is an individual was able to correctly identify two or more health risks associated with overconsumption of alcohol or other substances. In the case of this indicator, if the person the Volunteer/partner works with has already identified two or more health risks associated with overconsumption of alcohol or other substances before beginning to work with the Volunteer/partner, then the Volunteer would not be able to count him/her for this activity because the Volunteer’s work did not actually lead to the desired change. However, if as a result of working with the Volunteer/partner, the individual improved their knowledge of health risks associated with overconsumption of

alcohol or other substances, then that would count because the Volunteer's work influenced the individual's knowledge.

- 6. General Reporting in the VRF:** The "number achieved" (or numerator) that Volunteers will report against for this indicator in their VRFs is the number of individuals who are able to identify 2 or more health risks associated with over-consumption of alcohol or other substances. The "total number" (or denominator) that Volunteers will report on for this indicator in their VRFs is the total number of individuals who participated in the activities designed to meet this indicator.
- 7. Reporting on Disaggregated Data in the VRF:** This indicator is disaggregated by "Sex" and "Age". When reporting in the VRF, a Volunteer should disaggregate the total number of individuals by 1) male and female and 2) 0-9 years, 10-17 years, 18-24 years, and 25+ years.

Data Quality Assessments (DQA): DQA are needed for each indicator selected to align with the project objectives. DQAs review the validity, integrity, precision, reliability, and timeliness of each indicator. For more information, consult the Peace Corps MRE Toolkit.

Alignment with Summary Indicator: No link