REPUBLIC OF KENYA

NACADA
FOR A NATION FREE FROM ALCOHOL AND DRUG ABUSE

NOVEMBER 2022 EDITION

FRAMEWORK FOR COMMUNITY ENGAGEMENT IN MANAGEMENT OF ALCOHOL AND DRUG ABUSE

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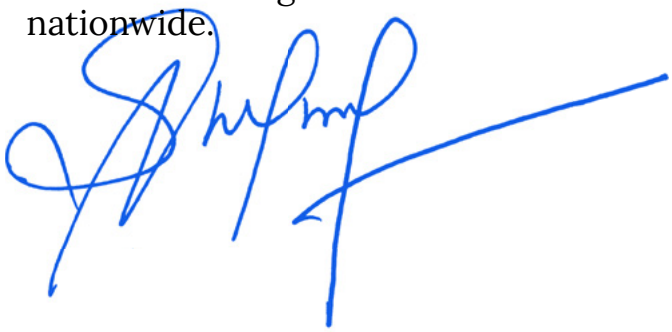
FOREWORD

The Framework for Community Engagement in Management of Alcohol and Drug Abuse is a national guideline on the continuous engagement of multiple sectors of society to ensure the uptake and support of ADA prevention and management programs. This Framework has been developed at a time when alcohol and drug demand reduction measures aspire for the well-being of society as a whole through scientific evidence-based prevention strategies centred on and tailored to the needs of individuals, families, and communities.

It envisages structured efforts towards the provision of home-based care, participation in prevention and advocacy, community outreach and policing; and re-integration of persons with substance use disorders back into society. Community Workgroups connect multiple sectors of society such as businesses, parents, media, law enforcement agencies, learning institutions, faith-based organizations, healthcare service providers, social service agencies, and government to develop policies and strategies for prevention, treatment, and aftercare at the community level.

The involvement of critical stakeholders from both state and non-state actors has ensured a participatory approach during its development. It is our sincere hope that this Framework will provide the necessary guideline to all players interested in ensuring alcohol and drug-free communities within their respective sectors nationwide.



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ACKNOWLEDGEMENTS

The National Authority for the Campaign Against Alcohol and Drug Abuse (NACADA) has coordinated the development of the Framework for Community Engagement in Management of Alcohol and Drug Abuse to provide guidelines aimed at creating changes that reduce the socio-economic and health consequences of alcohol and drug use at the community level.

The development of this Framework was a collaborative effort between diverse stakeholders from both state and non-state actors nationally. Respective representatives from religious bodies, community-based organizations, non-governmental institutions as well as the county government provided valuable inputs into the successful drafting of this document.

Special gratitude to the Technical Working Group: Dr. Elizabeth Njani, Prof. Catherine Gachutha, Brenda Mkwesha, Ismael Shem, Brian Magwaro, Lilian Gitau, Mike Wanjengu, Gideon Ayodo, Harrison Andeko, Grace Mercy Wanjiru, George Ochieng', Susan Maua, Medina Ibrahim, Adrian Njenga, Teresia Mwangi, Ritah Khayo and Diana Ouma, we say thank you.

Dr. Yvonne Olando, PhD
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ABBREVIATIONS/ACRONYMS

ADA	Alcohol and Drug Abuse
GOK	Government of Kenya
M&E	Monitoring and Evaluation
NACADA	National Authority for the Campaign Against Alcohol and Drug Abuse
SUDs	Substance Use Disorders
UNGASS	United Nations General Assembly Special Session on Drugs

DEFINITION OF TERMS

Functional Term	Description
Alcohol and Drug Use	The consumption of alcohol or any other psychoactive substance. This includes all forms of tobacco (e.g. kuber, chavis, shisha, cigarettes), inhalants, non-medical use of prescription drugs and over-the-counter medicines.
Alcohol and Drug Use Management	This entails planning, coordinating, and implementing alcohol and drug use interventions with the aim of preventing, controlling, reversing, or eliminating their harm.
Chairperson	Is a member of the steering committee; has the primary responsibility as spokesperson and provides leadership for the workgroup.
Community	A group of people with diverse characteristics who are linked by social ties, share common perspectives, and engage in joint action in geographical locations and/ or settings.
Drug Demand Reduction	Policies and programs aimed at reducing the desire for and use of alcohol, tobacco, and other drugs.
Evidence-based/ Informed Programs	Scientifically proven practices that over the years have proved to be effective in preventing substance use or impacting known protective or risk factors for substance use when targeting children and youth.
Individual Member	A person who does not represent a specific organization within the workgroup; has a personal or professional interest in alcohol and drug abuse prevention and management but does not have a vested interest in the matter.
Member Organization	Institutions that participate in workgroup activities and send a designated representative to workgroup meetings.
Non-state actors	Refers to a wide range of entities that are non-governmental in nature. This includes non-governmental organizations, civil society organizations, faith-based organizations, think tanks and private enterprises.
Non-state actors	Refers to a wide range of entities that are non-governmental in nature. This includes non-governmental organizations, civil society organizations, faith-based organizations, think tanks and private enterprises.

Policy	A documented regulatory approach or guidelines either within a setting or in the general population that facilitates specific actions
Protective factors	Factors that directly decrease the likelihood of substance use and behavioural health problems or reduce the impact of risk factors on behavioural health problems.
Representatives	Staff from member organizations with an understanding of alcohol and drug abuse matters are selected to participate in the activities or meetings of the workgroups.
Risk factors	Factors that increase the likelihood of beginning substance use, of regular and harmful use, and of other behavioural health problems associated with use.
Specialized Agency	Institution mandated by law to coordinate alcohol and drug use prevention and management efforts at National or County level.
State Actors	Institutions and individuals appointed by the government at National and County Levels into the public service and whom the government authorizes to act on policy issues on its behalf, these include Ministries, Departments, Agencies, and State Corporations.
Steering Committee	Small sub-group of the workgroup that convenes and takes responsibility for the workgroup's overall direction.
Sub-committee	A small team within the workgroup set up to carry out specific tasks for the duration of a given activity.
Substance Use Disorder	A general term used to describe a range of problems associated with substance use (including alcohol, illicit drugs, and misuse of prescribed medications), from substance abuse to substance dependence and addiction.
Treatment and Rehabilitation	Healthcare services that help a person regain physical, mental, social/behavioral, and cognitive abilities that have been lost or impaired because of addiction.
Workgroup	A formal arrangement for cooperation and collaboration between groups or sectors of the community, in which each group retains its identity but all agree to work together towards a common goal of building a safe, healthy, alcohol and drug-use-free community.

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1. INTRODUCTION

1.1 Background

Alcohol and drug use is a global challenge that presents different health, economic and social problems to the community. This calls for joint measures by all stakeholders to manage the problem. The United Nations General Assembly Special Session (UNGASS) on the World Drug Problem held in April 2016 recommended the following drug demand reduction measures:

1. Promote the well-being of society as a whole through the elaboration of effective scientific evidence-based prevention strategies centred on and tailored to the needs of individuals, families and communities as part of comprehensive and balanced national drug policies, on a non-discriminatory basis;
2. Involve, as appropriate different stakeholders including but not limited to: policymakers, law enforcement authorities, civil society, individuals in recovery from substance use disorders and their peer groups, families, as well as the private sector in the development of prevention programmes aimed at raising public awareness of the dangers and risks associated with drug abuse and involve, rehabilitation service providers, teachers, health professionals, religious communities, community leaders, social workers, sports associations, media professionals and entertainment industries, as appropriate, in their implementation.

In Kenya, alcohol and drug use presents a danger to public health and quality of life that consequently affects the social and economic development of the nation. Additionally, the socio-economic effects of alcohol and drug use harm young people and other vulnerable populations more disproportionately. An individual's susceptibility to this problem may be partly predicted by assessing the nature and number of their community, family, and individual-level risk and protective factors.

Significant risk factors for alcohol and drug use at community-level include: poverty, community and cultural norms, positive attitudes towards alcohol and drug use, and easy access to cheap alcohol and other substances. Family-level risk factors include ineffective parenting skills, a family history of alcohol and drug use or mental health disorders, and high levels of family conflict or violence. At the individual level, major risk factors include mental health disorder, low involvement in school, joblessness, a history of abuse

and neglect, and a history of substance use during adolescence among others.

Community-level protective factors include: higher cost for alcohol and tobacco products (often achieved by increasing taxes on these products); regulating the outlet density of shops selling alcohol; preventing the sale of illicit drugs and by enforcing existing laws on alcohol; and drug free entertainment environments. Family-level protective factors include: support for regular monitoring of children and youth and unfavourable attitudes towards substance use. Lastly, individual-level protective factors include involvement in school, engagement in healthy recreational and social activities, and good coping skills.

The Rapid Situation Assessment on Drug and Substance Abuse in Kenya (NACADA, 2017) shows that alcohol use contributes the highest burden of substance use disorders (SUDs) in Kenya. According to the data, the prevalence of alcohol use disorders among respondents aged 15 -65 years stands at 10.4%. Nairobi region has the highest prevalence of alcohol use disorders (18.4%) followed by Western 13.1%, Rift Valley 10.7%, Eastern 10.6%, Nyanza 9.6%, Coast 8.7%, Central 8.3% and North Eastern 1.4%. Analysis of tobacco shows that the prevalence of tobacco use disorders among respondents aged 15 -65 years stands at 6.8%. Nairobi region has the highest prevalence of tobacco use disorders (10.4%) followed by Coast 9.2%, Eastern 8.8%, North Eastern 8.8%, Rift Valley 5.9%, Western 4.9% and lastly Nyanza 4.4%.

Further, a National Survey on the Status of Alcohol and Drug Abuse among Secondary School Students in Kenya (NACADA,2016) showed secondary schools are not drug free environments. Alcohol had highest current use at 3.8% with prescription drugs and miraa following closely at 3.6% and 2.6% respectively and cocaine having the lowest prevalence at 0.2%. The common sources of drugs and substances of abuse included kiosks or shops near school (28.6%); bars near school (25.7%); friends (19.3%); bought from other students (13.7%); and school workers (13.6%).

In addition, the National Survey on the Status of Alcohol and Drug Abuse among Primary School Pupils in Kenya (NACADA, 2018) indicated that the average age of onset of at least one drug or substance of abuse was 11 years. The lowest age of onset of at least one drug of abuse was 4 years. The drug situation in schools will therefore continue to escalate unless comprehensive strategies to prevent and mitigate it are put in place.

A healthy population is an end in itself, along with being one of the most basic requirements for quality of life and a basic foundation for a country's economic growth and development. It is important for the population to live a healthy lifestyle, free from communicable and non-communicable diseases and free from use of harmful substances such as alcohol and drugs. The Kenya Health Policy (2014-2030) defines health as a state of complete physical, mental, and social well-being, not merely the absence of disease or infirmity. Indeed, the Constitution of Kenya (2010) provides that every person has the right to the highest attainable standard of health which includes the right to health care services.
In order to ensure uptake and support of Alcohol and Drug Abuse (ADA) prevention and management programs such as provision of home-based care, participation in prevention and advocacy, community outreach and policing and re-integration of persons with Substance Use Disorders (SUDs), the National Guidelines on Alcohol and Drug Use Prevention (2021) provides for community engagement as one of the prevention strategies aimed to enhance anti-drug use norms and pro-social behaviours at societal level. This underpins the formation and running of community workgroups on alcohol and drug use management.

1.2 Rationale of the Framework

Community workgroups connect multiple sectors of the society – including but not limited to: businesses, parents, media, law enforcement, learning institutions, faith-based organizations, health care service providers, social service agencies and government – to collaborate and develop policies and strategies for prevention, treatment and aftercare at the community level.

By working together, community workgroups shall create changes that reduce the socio-economic and health consequences of alcohol and drug use by changing social and cultural norms that promote such risky behaviours.

i. Additional benefits of workgroups include:
ii. Achieving wider reach within a community than any single organization could attain;
iii. Accomplishing objectives beyond the scope of any single organization;
iv. Have greater credibility than individual organizations;
v. Providing a forum for sharing information;
vi. Providing a range of advice and perspectives to the specialized agency;

vii. Fostering cooperation between organizations, community members, and/or diverse sectors of the society;
viii. Increasing involvement of community members in advocating for safe environments free from alcohol and drug use;
ix. Ensuring quality control in programme delivery;
x. Leveraging on available resources.

1.3 Goal, Objectives and Activities

Goal:
The goal of this Framework is to anchor initiatives aimed at ensuring safer, healthier and substance use-free communities across Kenya.

Objectives:
The objectives of this Framework are to:
1. Reduce alcohol and drug use in the community;
2. Leverage on joint initiatives and resources for alcohol and drug use prevention and management;
3. Standardize and harmonize community efforts in reduction of alcohol and drug use.

Activities:
i. Some of the key activities of the workgroup include but not limited to:
ii. Advocate and lobby for implementation of alcohol, tobacco and drug control policies;
iii. Support mapping of stakeholders to be involved in creation and running of the workgroups and their roles;
iv. Provide a transparent and inclusive strategy and action plan for engagements among stakeholders and communities;
v. Describe the process of stakeholder engagement (including vulnerable groups) and community liaison activities;
vi. Provide a grievance handling mechanism, ensuring that stakeholders are properly informed of their rights and know how to communicate their concerns;
vii. Provide monitoring, evaluation and reporting procedures that ensure continuous learning and improvement.

1.4 Scope of the Framework

This framework will be applicable to workgroups involved in prevention and management of alcohol and drug use at community level.

2. POLICY, LEGAL AND INSTITUTIONAL BASIS

In Kenya, the government response towards tackling alcohol and drug use is two-fold: supply suppression and demand reduction. Supply suppression involves enforcing policy, legislation, by-laws, administrative rules and other means to control production, sale and consumption of licit substances and trafficking of illicit substances.

On the other hand, demand reduction involves giving preventive education, conducting public awareness campaigns, providing life skills training, and supporting treatment and rehabilitation services for persons with substance use disorders.

Key policy, legislative and institutional frameworks that govern supply suppression and demand reduction measures in Kenya include:

1. The Constitution of Kenya (2010)
2. National Authority for Campaign against Alcohol and Drug Abuse Act (2012)
3. The Alcoholic Drinks Control Act (2010)
4. County Alcoholic Drinks Control Acts
5. The Narcotic Drugs & Psychotropic Substances Control Act (1994) (amended 2020)
6. Tobacco Control Act (2007)
7. The Public Health Act (2010)
8. National Guidelines on Alcohol and Drug Use Prevention (2021)
9. National Guidelines for Alcohol and Substance Use Prevention and Management in Basic Education Institutions (2021)
10. National Guidelines for HIV Prevention and Management of People Who Use Drugs (2013)
11. National Standards for Treatment and Rehabilitation of Persons with Substance Use Disorders (2021)
12. National Protocol for Treatment of Substance Use Disorders in Kenya (2017)
13. Mental Health Policy (2015-2030)
14. Sexual Offences Act (2007)
15. The Children's Act (2022)
16. Mental Health Act (1989)
17. Counsellors and Psychologists Act (2014)

3. PRINCIPLES OF COMMUNITY ENGAGEMENT

This framework provides guidelines for workgroups that include state and non- state actors in community engagement and service provision. This shall improve collaboration and promote common understanding among workgroups. In addition, it shall strengthen collaboration and partnership efforts with service recipients.

The following key principles will underpin the formation and operationalization of workgroups:

1. Clarity of purpose. Clear goals on community advocacy and lobbying in prevention and management of alcohol and drug use.
2. Understand the target community. Knowledge about the community in terms of its economic conditions, political structures, norms and values, demographic trends, history, perceptions and experience with engagement efforts.
3. Collaboration and partnerships. Build alliances with formal and informal leadership, and seek commitment from institutions and leaders to create processes for mobilizing the community to create change and improve health.
4. Collective Self-determination. Community has the power to identify their own issues, and should be trusted with self-direction to build and implement strategies that impact their lives.
5. Diversity and inclusion. Multi-cultural awareness, vulnerable, marginalized and hard-to-reach groups and other unique characteristics of a community are important in designing and implementing community engagement approaches.
6. Resource mobilization. Identifying and leveraging on community assets, networks and capacities for decisions and action.

4. STEPS TO SETTING UP A WORKGROUP

Building a workgroup requires planning, capacity building, implementation, multi-cultural competence, monitoring and evaluation of workgroup products and sustainability of efforts. The following identified steps shall guide formation of workgroups:

Step 1: Define the problem and its impact on the community

In order to begin to address the problem of alcohol and drug use in a community, it is essential to know the scope and nature of the problem:

- What kinds of alcohol and drugs are being used?
- How accessible and available are the alcohol and drugs?
- Where does alcohol and drugs come from?
- Who is using alcohol and drugs in the community?
- Where is alcohol and drug use happening in the community?
- Are there advertisements and promotions for alcohol and drugs in the community?
- Has there been a recent increase or decrease in alcohol and drug use?
- Was the change caused by a community event?
- What are the specific negative effects felt by the community due to alcohol and drug use?
- Has an event occurred which has brought more attention to this issue?

Answering these questions is a part of the first step in addressing alcohol and drug use in your community.

This step is intended to offer a number of different ways in which a workgroup can collect data about the problem and use this information to formulate a plan to address the problem. Use as many sources of information as possible and conduct investigation with the goal of targeting resources and problems to meet your community's needs.

Step 2: Identify key stakeholders

Workgroups need to involve representatives from each sector of the community in that specific geographical area or setting: diverse cultural and ethnic groups; people most affected by the problem; opinion leaders; people with influence in the community; residence associations or Nyumba Kumi; business community; and service

organizations in the locality among others.

Answering the following questions will help you to bring together a dynamic group of people who can help confront the alcohol and drug use problem:

- In your assessment of your community's needs did you uncover a specific area that needs to be focused on with greater intensity?
- Who is your target population? For example, is youth your target population? If so, you should have sports coaches, teachers, school administrators, recreation centre representatives, youth groups and other individuals who have vested interest in youth.
- Are there specific geographic areas that need to be given more attention than others?
- Are there community leaders from the particular area involved in your workgroup?
- Who makes things happen in your community? Some of these individuals may be elected or selected in some way. Others may have no such identity but without them, nothing of real importance in your community happens.

Step 3: Formation of the steering committee

Identify organizations that already work on alcohol and drug use prevention and management related matters and look broadly for other organizations that should be involved. Consider those who have influence, those who will be supportive, and even those who may put obstacles in the workgroup's way. Consider individual members who may be community leaders or people who have directly experienced the problem but are not affiliated to any organization but have a vested interest in the matter.

Having identified key organizations, consider who will represent each organization in the workgroup. Directors/Managers may be more effective at policy decisions and establishing credibility as workgroup representatives. However, consider hands-on service delivery staff would be more available to do the work and attend meetings. Participation from both top leadership and technical staff is essential in achieving the workgroup goals. The ideal number for the steering committee should be 12-18 people.
The chairperson and secretary of the steering committee will serve on a rotational basis for a maximum of three years. Each workgroup shall develop terms of reference and by-laws to operationalize its activities.

Step 4: Devise a set of preliminary objectives and activities for the workgroup

The workgroup's objectives shall be made clear, compelling and practical. A balance should be struck between the workgroups objectives and the concerns and interests of each member organization.

It is important to ensure that the workgroup does not become another competitor to its member organizations, but rather should play a complementary role. While dealing with long-term objectives over time, some objectives that can be addressed by all member organizations in the short term should be set.

Member organizations shall record and distribute an up-to-date inventory or list of the types of services provided. The workgroup shall prioritize community needs as appropriate.

Step 5: Convene the workgroup

Schedule the workgroup's meeting in a recognizable neighbourhood facility such as a church, recreation centre, social halls or school. Put a reminder and provide an agenda for the meeting at least two weeks before the date and offer childcare where applicable. Make sure you have a sign-in sheet giving name, address and phone number.

Being the first meeting, the convener shall help to keep the pace of the meeting, remain focused on the meeting objectives, act as mediator in case of disagreement and treat everyone in attendance with respect.

During this meeting a steering committee shall be formed by consensus. Subsequent meetings shall be convened by the steering committee.

Step 6: Discuss the current local reality and the ideal situation the community desires

At the first meeting of the steering committee, the workgroup shall be prepared to:

- Listen to a number of perspectives and facilitate a discussion that allows everyone to be heard;

- Frame the comments to help in the formation of problem statements; and
- Help the workgroup to develop a vision.

The Chairperson shall consider the following questions among others:
- What is the alcohol and drug use reality in your community?
- What does it look like?
- What alcohol and drugs are being used in your community?
- Who is using them?
- Where are alcohol and drugs sold and used?

You shall paint a mental picture of the situation using both hard and soft data whereby hard data involves statistics, survey and other epidemiologic results (from Step 1.) The soft data reflect what the workgroup members and the community believe and observe in the community. Both have equal importance to understanding the scope of the problem.

Craft a clear statement of how you would "prefer" the issue to look in your community. Make a checklist and cut it down to 5 goals. Consider the following questions:
- What would your community like to be known for?
- What would your neighbourhood be proud of?

Step 7: Create a vision for the community

The work group's vision statement shall indicate what the group strives to achieve. The statement is maintained until the goal is achieved or until environmental factors or the stakeholders' needs change. A vision statement should be simple, specific, purposeful, positive and inspirational.

Step 8: Determine the next sustainable steps

With reference to issues identified in step 6, a costed work plan shall be developed in order of priority for implementation. Consider: leveraging on existing programs; mobilizing for resources; developing interventions; advocating for change and influencing policy development and review.

5. CAPACITY DEVELOPMENT AND OUTREACH

5.1 Capacity development

The workgroup shall undertake continuous capacity assessments and partner with relevant stakeholders to address identified gaps so that they can better respond to alcohol and drug use related issues within their settings.

Capacity development will be undertaken for the steering committee and the sub-committees. Capacity development shall focus on critical skills that include but not limited to: advocacy, lobbying, research, communication, comprehensive strategies, cultural knowledge, inter-personal skills, resource mobilization, planning and prioritization, conflict resolution, documentation, monitoring evaluation and learning.

5.2 Community Mobilization and Outreach

The workgroup shall engage as many community stakeholders as possible to raise their awareness of and demand for particular interventions to assist in the delivery of resources and services and to strengthen community participation for sustainability.

The following 7 outreach strategies are proposed for effecting community-level change:

i. Provide information: Educational presentations, workshops or seminars and data or media presentations (e.g., public service announcements, brochures, billboard campaigns, community meetings, town hall forums, Web-based communication).

ii. Enhance skills: Workshops, seminars or activities designed to increase the skills of participants, members, and staff (e.g. training, technical assistance, distance learning, strategic planning retreats, parenting classes, or model programs in schools).

iii. Provide support: Creating opportunities to support people to participate in activities that reduce risk or enhance protection (e.g., providing alternative activities, mentoring, referrals for treatment and rehabilitation services, support groups, youth clubs, parenting groups, Alcoholics or Narcotics Anonymous).

iv. Enhance access/reduce barriers: Improving systems and

processes to increase the ease, ability and opportunity to utilize systems and services (e.g., access to treatment, childcare, sexual reproductive health education, special needs, cultural and language sensitivity).

v. Change consequences (incentives/disincentives): Enhance protective factors and reduce risk factors for alcohol and drug use at community level (e.g., increase public recognition for deserved behaviour, individual and business rewards).

vi. Change physical design: Changing the physical design or structure of the environment to reduce risk or enhance protection (e.g. safe spaces for children, smoking zones, lighting, clearing of thickets/bushes, conservation of riparian land, demolish unsafe structures, recreation centres).

vii. Advocate for review and implementation of policies: Engage in initiatives aimed at influencing formal change in written procedures, by-laws, rules or laws with written documentation and/or voting procedures and their implementation (e.g. Workplace initiatives, law enforcement procedures and practices, public policy actions, systems change within government, communities and organizations).

6. ETHICAL CONSIDERATIONS

Ethical considerations shall be observed in all areas of community workgroup's operations including but not limited to recruitment, needs assessment, community involvement, advocacy, mobilization, reporting and record keeping as well as monitoring and evaluation. Community workgroups shall consider the following ethical principles when conducting their work:

i. Conflict of Interest: The workgroup shall not incorporate members who in any way gain from vested interests in alcohol and drug use. The workgroup shall not partner with the alcohol and tobacco industry.

ii. Competence: Combination of training, skills, experience and knowledge that a person has and their ability to apply them to perform a task effectively.

iii. Confidentiality: The workgroup shall address issues of confidentiality before initiating the program. Confidentiality should be observed at all times while handling participants 'and/or workgroup data or information and further address its limitations such as legal requirements.

iv. Informed Consent: The workgroup shall inform the community of the interventions' objectives, benefits and process before implementation. Participation should be voluntary with consent. Children and minors should assent and their parents or guardians provide consent for their participation.

v. Beneficence: Interventions shall be tailored to address risks specific to population or audience characteristics, such as age, gender, and ethnicity in order to improve effectiveness and meet the needs of the community.

vi. Non-maleficence: Interventions shall not cause intentional or unintentional harm to the community. Workgroups shall refrain from taking actions that may harm others.

vii. Respect: The workgroup shall uphold community's rights, autonomy and dignity.

viii. Integrity: Workgroups shall provide truthful information about their work, while avoiding misleading information or misrepresentation.

7. MONITORING, EVALUATION AND REPORTING

Monitoring shall be a continuous process that will be communicated through bi-annual and annual reports. Monitoring and evaluation of the activities shall be undertaken in line with the National Alcohol and Drug Use Prevention System and based on the Monitoring and Evaluation (M&E) implementation framework.

Reporting shall be based on the reporting framework provided for by the specialized agency that guide alcohol and drug use prevention work.

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Annex 1: Roadmap to Development of Effective Workgroups

Annex 2: List of Technical Working Group Members

	Name	Institution/Department
1.	Dr. Elizabeth Njani	GYMHA – Director, Training and Research
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5.	Harrison Andeko	Non-Communicable Diseases Alliance of Kenya - Programmes
6.	Ishmael Shem	Blue Cross
7.	Brian Magwaro	Blue Cross
8.	Wanjengu Mike	TINADA - Kisumu
9.	Gitau Lilian	Renaissance Treatment & Rehabilitation - Kisumu
10.	George Ochieng'	Slum Child Foundation
11.	Grace Mercy Brenda	National Council of Churches of Kenya – Governance, Peace and Security
12.	Dr. Yvonne Olando	NACADA – Directorate of Public Education Advocacy, Treatment and Rehabilitation
13.	Susan Maua	NACADA – Directorate of Public Education Advocacy, Treatment and Rehabilitation
14.	Medina Ibrahim	NACADA - Directorate of Corporate Services
15.	Adrian Njenga	NACADA – Directorate of Research, Policy and Planning
16.	Mwangi Teresia	NACADA – Directorate of Public Education Advocacy, Treatment and Rehabilitation
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18.	Ritah Khayo	NACADA – Directorate of Public Education Advocacy, Treatment and Rehabilitation

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FRAMEWORK FOR COMMUNITY ENGAGEMENT IN MANAGEMENT OF ALCOHOL AND DRUG ABUSE

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