NATIONAL CAMPAIGN AGAINST DRUG ABUSE AUTHORITY

RAPID SITUATION ASSESSMENT OF DRUG AND SUBSTANCE ABUSE IN KENYA, 2007

Contents

List of Figures

List of Tables

List of Abbreviations

AIDS	Acquired Immunodeficiency Syndrome
CBS	Central Bureau of Statistics
DSA	Drugs and Substance Abuse
GJLOS	Governance Justice Law and Order Services
HIV	Human Immune Virus
IDU	Injecting Drug Use
KIPPRA	Kenya Institute for Public Policy Research and Analysis
NACADA	National Campaign Against Drug Abuse Authority
PPPS	Probability Proportionate to Population Size
RSA	Rapid situation Assessment
SWAp	Sector Wide Approach
UN	United Nations
UNGASS	United Nations General Assembly Special Session
UNODC	United Nations Office on Drugs and Crime
WHO	World Health Organization

Foreword

Drug and substance abuse in Kenya as in other countries permeates every sphere of the society and, indeed, threatens the very fabric of nationhood. Effective response to the challenge of drug abuse as well as mitigation of the negative effects of use of drugs relies critically on accurate information on extent and pattern of use of various drugs and substances by different segments of the population.

This report presents major findings of the **2007 Rapid Situation Assessment of Drug and Substance Abuse in Kenya.** The survey covered the whole country. Its principal goal was to establish the extent of use of various drugs and substances to facilitate evidence-based programming among the government, the private sector, and other players involved in drug abuse prevention programme.

Among other findings, the study established that Kenyans generally hold positive attitudes towards licit drugs such as alcohol, tobacco and tobacco products, and miraa and a good number use such drugs and substances. Peer pressure and availability of drugs in the community are closely associated with drug and substance abuse among children. There are a number of issues that need urgent attention for reduction in drug abuse among the different segments of the population including scaling up of prevention activities, development of behaviour change communication strategy, and review of drug and substance abuse policies.

I would like to acknowledge the efforts of a number of organisations and individuals who contributed immensely to the success of the survey. First I would like to acknowledge financial assistance from the Government of Kenya through the Office of the President. Second, I extend my sincere thanks to the Steadman Group for carrying out the survey on behalf of the National Campaign Against Drug Abuse Authority (NACADAA) and to Mr Peter Koome for the technical backstopping he offered to NACADAA throughout the survey.

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Executive summary

The 2007 Kenya Drug and Substance Use Rapid Situation Assessment sought to understand the nature, extent and patterns of drug abuse in Kenya and subsequent effects to the individual, the family, and the community at large. This is the first attempted snap shot on the status of drugs and substance abuse nationally. Previous studies have been limited in terms of the scope, population segment and geographical coverage.

A total of 3016 households were sampled, 2503 of them from rural areas and 853 from urban centres. From the sampled households, 932 male and female children aged 10 to 14 year and 3356 of men and women aged 15 to 65 were successfully interviewed. The data collected are nationally representative but due to financial limitations, the sample is not representative at regional level. Sub-regional figures are only indicative. All Household members between 10-65 years old were eligible for interview. Eligible members were categorised in three age groups (10-4 years, 15-35 years, and 36-65 years)

The study findings confirm that drugs and substances abuse is a major social problem in Kenya. Results suggest that majority of Kenyans hold positive attitudes towards consumption of licit drugs such as cigarettes (73%), packaged liquor (72%), traditional brew (69%), other tobacco products (68%) and miraa (54%). Clearly, there is a widespread attitude that if a drug is legal, it is alright to use. In contrast, illicit drugs have particularly low acceptability rating.

At least 13 percent of people from all provinces in Kenya except North Eastern province are current consumers of alcohol. Considering children who have ever used drugs, the median age of first use of chang'aa and cigarettes is 9 years and by age ten, half of them have tried chewing/sniffing tobacco, traditional liquor and, miraa. The median age of use of packaged alcohol is 11 years while that of bhang is 14 years.

Overwhelming majority of smokers of tobacco smoke every day (90%), while slightly over 70 percent of miraa users and people who sniff or chew tobacco products use the substances daily. Analyses suggest that friends (peers), availability of drugs within the school environment (including the surrounding community), and presence of a drug user in the home are closely associated with the likelihood of having ever consumed alcohol among children aged 10-14 years.

Misuse of resources meant for family or personal use is the most commonly cited social problem arising from drug addiction. Close to 90 percent of all heron/cocaine users reported that they have diverted resources in order to buy the drugs while 44 percent of bhang users have done so in the 12 months preceding the survey. Close to 40 percent of tobacco and alcohol users too have diverted resources meant for domestic use to buying these drugs.

Seven in every 10 people aged 15-64 with multiple partners are likely to be substance abusers. Users of bhang/hashish, heroin and cocaine are more likely to have multiple partners compared to users of alcohol, tobacco and Miraa. In a country where HIV/AIDS is a national disaster, risky sexual behaviour will only make the HIV/AIDS epidemic worse.

Findings from the study suggest that drug and substance abuse is rendering the affected populations less economically productive. Absenteeism from school and work are commonly associated with drug use. Crime and violence as a result of drug and substance abuse was also demonstrated by the study.

More than 60 percent of all the respondents are not aware of the available drug and substance abuse treatment and rehabilitation services. In fact, the study findings show that some of the drug users are willing to change. But the success rate may not be high since access to relevant treatment and rehabilitation services is low.

The study recommends: a review of policies that address the control of drug and substance abuse; Capacity development in relation to drugs and substance abuse; establishment and strengthening of Promotive, preventive, treatment and rehabilitation services for drug and substance abuse and; development of national Information, Education and Communication strategy for drugs and substance abuse. Drug and substance abuse and, HIV/AIDS in Kenya and, the potential role of traditional practices in the control of drug and substance abuse are important areas for further research.

CHAPTER ONE - INTRODUCTION

This introductory chapter provides an outline of key milestones in Kenya's efforts to control drug and substances of abuse. The chapter further presents an analytical framework based on a situation analysis of drug and substance abuse in the country. The framework presents the setting for presentation of the study findings, discussion, conclusions and recommendations. The chapter closes with a summary of the study rationale and objectives and, materials and methods.

1.1 Background

Kenya has achieved important milestones in the control of DSA over the past two decades. Some of these initial milestones include the ratification of three major UN Conventions on Narcotic Drugs and Psychotropic Substances and development of the National Policy on Drug Abuse. The policy focuses on drug control legislation and the legal framework under which treatment and rehabilitation of drug abuse takes place.

In 1994, the Narcotics Drugs and Psychotropic Substances (Control) Act, 1994 was enacted. The Act is the latest legislation on drug trafficking and abuse in Kenya. In 1998, the development of the national Drug Master Plan was completed. The plan was thereafter approved in 2001. During the same year National Campaign Against Drug Abuse (NACADA) was formed to advocate against drug abuse in Kenya. It was renamed National Campaign Against Drug Abuse Authority (NACADAA) and gazetted as a state corporation (parastatal) in June 2007.

The United Nations General Assembly Special Session (UNGASS 1998) agreed on key international commitments to control drug and substance abuse. The Declaration issued by Member States requested that they address drug abuse in a holistic manner and that they set up effective drug prevention, treatment and rehabilitation programmes, which programmes should be culturally valid and based on knowledge acquired from research as well as lessons derived from past programmes (UNODC, 2005).

The Tobacco bill tabled in parliament in 2004 was a clear indication of major problems of tobacco use in Kenya. The bill, which proposed to regulate production, advertisement and consumption in line with WHO requirements, faced a lot of resistance from the tobacco industry crippling its enactment even after its amendment and reintroduction in 2006 (WHO 2005). The bill was finally enacted in June 2007.

NACADAA has developed a national alcohol policy that will among other things challenge some of the provisions of the law governing children's access to alcohol. Though it is illegal in the Kenyan law to sell alcohol to children under the age of 18 years, the same law, meant to restrict children's access to alcohol, is silent on the increasing trend of children frequenting premises where alcohol is sold and consumed while in the company of adults.

1.2 Drug and substance abuse situation in Kenya

Drug abuse is one of the major social problems in Kenya with common and easily identifiable manifestations in public health. Half of drug abusers in Kenya are aged between 10-19 years with over 60% residing in urban areas and 21% in rural areas (UNODC 2004). Taking drugs at an early age of 14 or younger greatly increases the chances of developing drug problems in future. The most commonly abused drugs in Kenya are alcohol, tobacco, bhang (marijuana), glue, miraa (khat) and psychotropic drugs (NACADA 2004).

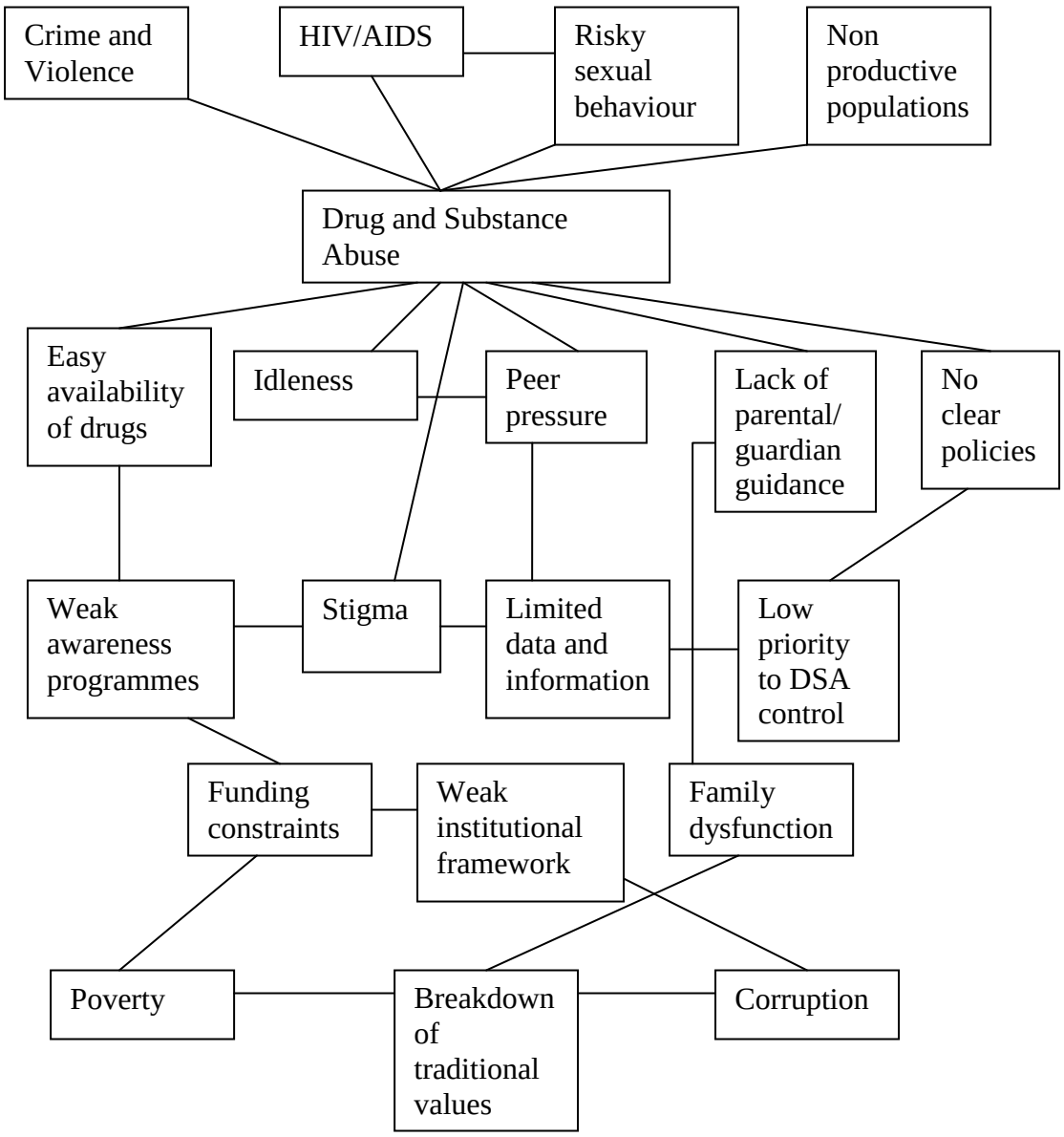
The prevalence of HIV/AIDS among injection drug users is estimated at 68-88 percent (UNODC 2004). The UNODC report documents a relationship between injection drug use and HIV/AIDS. Nairobi and Coast provinces are the most affected with an estimated 10,000 heroin users in Nairobi and 8,000 in Coast province.

Drug and Substance Abuse (DSA) has a complex cause and effect relationship (Figure 1.1). The direct causes of DSA may include easy availability of cheap drugs and other substances. Young adults have the highest DSA prevalence. Idleness in association with peer pressure easily drives them into DSA. In most of these situations, parents and other guardian lack the skills to intervene. Lack of intervention is also further complicated by the stigma that is often attached to DSA. DSA often constitute a crime in Kenyan law. Poor enforcement of the law and weak policies also directly contributes to the high prevalence of drug and substance abuse.

DSA has many possible underlying causes. They include: weak DSA awareness programmes; limited skills and personnel capacity of the law enforcers; unemployment and low prioritization of DSA. The implementation of effective awareness programmes is often affected by limited facilities and personnel skills. Since these programmes may be accorded low priority, they are often underfunded. The programmes are also supported by weak institutional framework in which roles, partnerships and human rights perspectives of DSA are not strongly articulated. We lack appropriate and up to date data and information on DSA in Kenya. Hence, evidence based practices and programmes to address specific DSA problems are not always possible.

The main root causes of DSA in society include: poverty, corruption and break down of traditional values. The effects of DSA in Kenya include: increase in crime levels including domestic violence, risky sexual behaviours and practices including increased exposure to HIV/AIDS (Stimsons et al 2006, Kelli et al, 2004). DSA is therefore a threat to good health status. Other consequence of DSA at individual level include: damaging one's ability to act as free and conscious beings, capable of taking action to fulfil their needs, care for others and contribute positively to society (Ndetei, 2004).

Figure 1.1 Drug and substance abuse cause and effect analytical framework



1.3 Study rationale and objectives

We have not had a nationally representative and comprehensive prevalence study on drug and substance abuse: awareness, experience and availability in Kenya. Previous studies had limited scope (NACADA and KIPRA 2005, and NACADA 2004). They were also confined to specific segments of the population. This study aims at providing information to government departments, policy makers, and the general public on the extent of drug abuse with the view of prompting authorities to take appropriate action to combat the problem. The study also provides the baseline indicators that will be tracked over time, as well as identifying new trends and patterns of drugs abuse.

The rapid assessment of drug and substance abuse sought to understand the nature, extent and patterns of drug abuse in Kenya and its subsequent effect on the individual, family, and community at large. Specifically, the survey had the following objectives:

i. To determine awareness, accessibility, availability and use of various drugs (alcohol, tobacco, bhang, miraa, cocaine and heroin) in Kenya.
ii. To establish the health, social and economic consequences of drug abuse in Kenya.
iii. To identify perceptions, attitude and behaviour related to drug abuse in Kenya.
iv. Extent of chemical dependence and perceptions relating to counseling, treatment and rehabilitation
v. To document trends in drug abuse and traditional practices that regulated production and consumption of various drugs in different communities in Kenya.
vi. To identify the interventions that can be put in place to deal with drug abuse and its health and other consequences in Kenya.

1.4 Sample Design

A sample of 3016 households was derived at as a nationally representative sample that would yield the desired level of accuracy. The allocation of the sample to each province was done proportionately to the population size. This approach ensures that districts with larger populations have a larger allocation relative to the smaller population districts. A conscious effort was made to reduce the disparities between big districts and small districts and to cover as many of the 69 districts (as per 1999 census) as possible.

Weighted data informed the figures of this report for drug use is skewed towards urban areas. Major urban areas (Nairobi, Mombasa, Nakuru and Kisumu) were over sampled while a minimum of 15 households was sampled for districts with very small sample sizes. Sub locations, which were the starting points, were also randomly selected with each generating only 8 households. Once at the starting point, the interviewer used the left hand rule to identify other households (turning left at every junction). The household nearest the starting point was appointed for the first interview. After completing an interview, the interviewer skipped 4 households and called on the 5th household.

A total of 3016 households were sampled, 2503 from rural areas and 853 from urban centres. From the sampled households, 932 male and female children aged 10-14 years and 3356 men and women aged 15 to 65 were successfully interviewed. (See Chapter 2 for more details on sample characteristics).

It should be noted that from the outset the sample was representative only at the national level due to financial limitations. Thus, sub-national (regional) figures are only indicative and all interpretations of the findings should take that caveat into consideration.

1.5 Study Population

All Household members between 10-65 years old were eligible for the study. Eligible members were categorised into three groups according to their ages to ensure that all age groups were captured adequately and systematically. This would not have been possible through random sampling of all eligible members of the household. These categories are:

- 10-14 years
- 15-35 years
- 36-65 years

In cases where there was more than one member in a single age band in a household, the respondent in that age band was selected randomly using the Kish grid. One household could therefore generate a maximum of three questionnaires. Two separate questionnaires were used, one targeting those aged 10-14 years while the other was used for those aged 15-65 years. The younger age group (10-14 years) was included in the survey in order to document various issues (knowledge of drugs, prevalence of use, perceptions about drugs among others) among children who are beginning their transition into adolescence.

1.6 The Questionnaires

Initially, NACADA developed a list of areas from which answers were sought and a review of similar surveys generated further questions. As indicated earlier, there were two separate questionnaires for the 10-14 year olds and the 15-65 year olds. Both of them were translated into thirteen local languages namely Swahili, Kikuyu, Embu, Luo, Meru, Kisii, Maasai, Turkana, Pokot, Luhya, Kalenjin, Kamba and Somali.

The main themes in the survey instruments were as follows:

- Characteristics of respondents
- Awareness of drugs/substances
- Use of drugs/substances
- Age at first use
- Frequency of use
- Perceptions towards drugs/substances
- Drug/substances use and sexual behaviour
- Drugs/substances and domestic violence
- Drugs/substances and productivity
- Drugs/substances and general health
- Counselling and rehabilitation
- Community interventions on drug/substance use now/future

1.7 Training

Supervisors and research assistants underwent six-day training in Nairobi. This involved detailed discussion of each question in the two instruments and mock interviews among participants. Given that drugs and substance of abuse have various street names irrespective of whether they are licit or illicit, training involved extensive discussions of street names of all drugs in the country and compilation of a list of such names for easy referencing during data collection.

A pre-test of the questionnaires was carried out in locations in Nairobi that were not in the sample. The questionnaires were revised to cater for the observations made during the pre-test. (See appendix ii for the questionnaires.)

1.8 Fieldwork

Data collection took approximately two weeks (from 22nd April to 7th May, 2007). Field teams worked in groups made up of a maximum of 8 interviewers and a supervisor. Data collection in Nairobi region was carried out by the whole research team in order to give interviewers an opportunity to test their skills, and brought to light a myriad of experiences they could expect to encounter elsewhere in the field.

One of the key limitations of the survey was underreporting of usage of hard drugs because of the criminal nature of such drugs and the fact that there was a campaign in the mass media on the dangers of hard drugs at the time of data collection. There was also a lot of reluctance among most respondents to disclose the sero-status hence findings on this variable are unreliable.

1.9 Data processing

Data capture proceeded concurrently with fieldwork, enabling queries to be sent back to the field for verification. Questionnaires were captured using automated scanning, and were then randomly re-scanned and checked. Various consistency checks were also applied to the data. Data cleaning and consistency checks involved, among others, checking skip routines as was specified on the questionnaire to ensure that respondents answered only the questions they were supposed to and vice versa. Data audit was also carried out before any analysis was done to ensure that all variables were captured correctly. In order to correct for over-sampling and to adjust the sample to reflect distributions in the actual population, weights were applied to the data set.

1.10 Construction of economic status index

Household economic status was constructed using some indicators of household wealth (Rutstein, Kersten 2004). The following variables were used: ownership of a radio, ownership of a television, ownership of a mobile phone, main dwelling unit has a finished floor (polished wood/vinyl/tiles/cement), main dwelling unit has a roof made of materials other than grass, main dwelling unit is permanent, household's access to own water source (piped into residence, compound, well in the compound) and, household has own toilet facility.

The respondents' households were grouped into high, middle, low and very low categories depending on the number of indicators for which they gave positive responses. Thus, households which recorded positive responses for all the eight factors listed above were classified as "high" while those which scored 61 to 99 percent were classified under "middle". A score of 31-60 percent was defined as "low" and the rest were grouped as "very low".

CHAPTER TWO -
CHARACTERISTICS OF RESPONDENTS

Chapter Two contains details on the background characteristics of the respondents. The chapter is presented in two parts. The first part has details of the 10-14 years old respondent characteristics. The second part has similar details but for the 15-65 years old respondents.

2.1 Characteristics of the 10-14 year-old respondents

Overall males and females formed 52% and 48% of the respondents respectively. The findings indicate that slightly over 70% of these children currently live with both parents though there are huge regional variations. (Table 2.1). For instance, in Rift Valley province, 82 percent of children live with both parents. In Eastern province, 59% of children live with both parents. The main reasons cited for not living with both parents included: death of one or both parents (32%); both or one parent working away from home (26%); parents are separated or divorced (9%); and single parent never married (8%).

About 92% of the 10-14 year-olds interviewed were in school, a pattern that is evident in all the regions except North Eastern province where the proportion of respondents reporting that they are currently attending school is only 84 percent.

Table 2.1 Percent distribution of children aged 10-14 years by background characteristics

	Rural	Urban	Nairobi	Central	Coast	Eastern	Nyanza	Rift Valley	Western	N. Eastern	Total
Gender											
Male	52.7	48.2	56.1	52.2	39.2	49.7	53	55.1	42.6	54	51.5
Female	47.3	51.8	43.9	47.8	60.8	50.3	47	44.9	57.4	46	48.5
Living with both parents											
Lives with both parents	71.2	73.1	74.1	68.1	71.1	59.4	63.1	81.7	74.1	82.4	71.6
Does not live with both parents	28.8	26.9	25.9	31.9	28.9	40.6	36.9	18.3	25.9	17.6	28.4
Education status											
In school	92.4	95.9	96.6	93.7	96.6	93.3	91.8	92.9	96.2	84.3	93.3
Not in school	7.6	4.1	3.4	6.3	3.4	6.7	8.2	7.1	3.8	15.7	6.7
N=	**698**	**234**	**106**	**112**	**62**	**156**	**127**	**231**	**75**	**62**	**932**

2.2 Characteristics of the 15-65 years old respondents

The study respondents were composed of both men (49%) and women (51%). There were no major variations by gender representation across the eight provinces (Table 2.2). Majority of the respondents were in the 25 to 35 age bracket. Over half of the people who participated in the survey were married while 5 percent were widowed. Nyanza province had the highest percentage of widowed respondents at 11 percent. The distribution of respondents by their religious affiliations shows that Christians accounted for highest number of respondents (85%) followed by Muslims and other religions (includes “no religion”) at 11% and 4% respectively.

Table 2.2: Characteristics of 15-65 year old sample

	Rural	Urban	Nairobi	Central	Coast	Eastern	Nyanza	Rift Valley	Western	North Eastern	Total
Gender											
Female	52.1	48.6	49.3	48.2	53.3	54	51.4	52.2	50.8	45.2	51.2
Male	47.9	51.4	50.7	51.8	46.7	46	48.6	47.8	49.2	54.8	48.8
Age											
15 – 17 years	12	10.8	9.5	10.8	7.7	10.4	12.4	13.5	12.7	17.2	11.7
18 – 24 years	22.7	29.9	29.4	23	27.7	20.4	26.7	25.6	23.9	15.9	24.6
25 – 35 years	32.8	36.5	40	35.1	34.6	35.3	31.7	33.3	26	33.3	33.8
36+ years	32.5	22.8	21.2	31.1	30	33.9	29.2	27.6	37.5	33.6	30
Marital Status											
Single/ never married	34.3	49.2	51.1	42.5	33.9	36.3	35.2	37	34.1	32.1	38.2
Married	57.2	46.4	44.7	51.3	56.2	55.8	53.6	57.9	56.6	60.3	54.4
Divorced/Widowed	8.5	4.4	4.2	6.2	9.9	8	11.2	5.1	9.2	7.5	7.4
Have Dependants	60.6	51	53.3	57.1	58.6	64.2	61.8	56	61.9	40.2	58.1
No Dependants	30.1	37.4	35.5	34.4	32.7	24.3	31.7	33.4	31.7	37.9	32
Missing data	9.3	11.6	11.2	8.4	8.7	11.6	6.5	10.6	6.4	21.8	9.9
Religion											
Christian	87.2	80.5	85	96.1	50.5	92.6	97.2	92.2	95	0	85.4
Muslim	9.1	16.2	11.2	1.3	45.1	3.3	1	1.5	3.2	99.4	10.9
Others	3.7	3.3	3.8	2.6	4.4	4.1	1.8	6.2	1.8	0.6	3.6
Education Status											
No formal education	12	4.1	1.8	3	15.8	7.1	6.9	11	8.6	55.7	9.9
Primary education	47.8	25.2	25.2	42.3	47.3	49.8	48	41.4	44.9	23.4	41.9
Secondary Education	33.3	48.3	43.2	45.6	32.4	32.5	38.5	38	37.4	16.5	37.2
Post Secondary Education	6.9	22.4	29.8	9.1	4.5	10.6	6.6	9.6	9.1	4.4	10.9
Employment status											
Self employment	32.6	24.1	25.4	38	21.5	33.3	39.2	25.4	27.4	27.1	30.4
A student	14.3	17.9	15.6	15.5	11.4	13.4	15.5	16.5	17.4	15.2	15.2
House wife/house husband	15.9	11.8	10.8	9.5	19.9	16.5	10.7	19	14.2	19.8	14.8
Unemployed	12.5	14.9	15.3	13.5	12.8	6.9	15.1	11.2	20.8	15.8	13.2
Informal employment	9.1	9.6	9.4	12.5	17.5	14	3.6	8.4	4.8	2.7	9.2
Formal employment	4.7	14.4	15.2	6	9.2	6.1	5.4	6.2	6.1	5	7.2
Casual laborer	5.1	4.5	4.9	3.4	3.4	4.2	3.6	6.1	4.9	12.8	4.9
Others	4.3	1.5	1.8	0.5	2.7	4.6	5.5	5.6	2.2	0.6	3.6
Pensioner/retired	1.5	1.3	1.6	1.1	1.6	1	1.5	1.6	2.2	1.1	1.5
Total	**1263**	**456**	**216**	**238**	**128**	**313**	**274**	**334**	**140**	**77**	**1719**

Of the total respondents within this age category only 11% had some post-secondary education, a proportion that was relatively more likely to be urban (21%). Indeed, Nairobi has the highest percentage of people with post-secondary education (29%). About a third (30%) of the respondents were self employed (with the highest proportions recorded in Central and Nyanza provinces), 15 percent were students and 13 percent were unemployed.

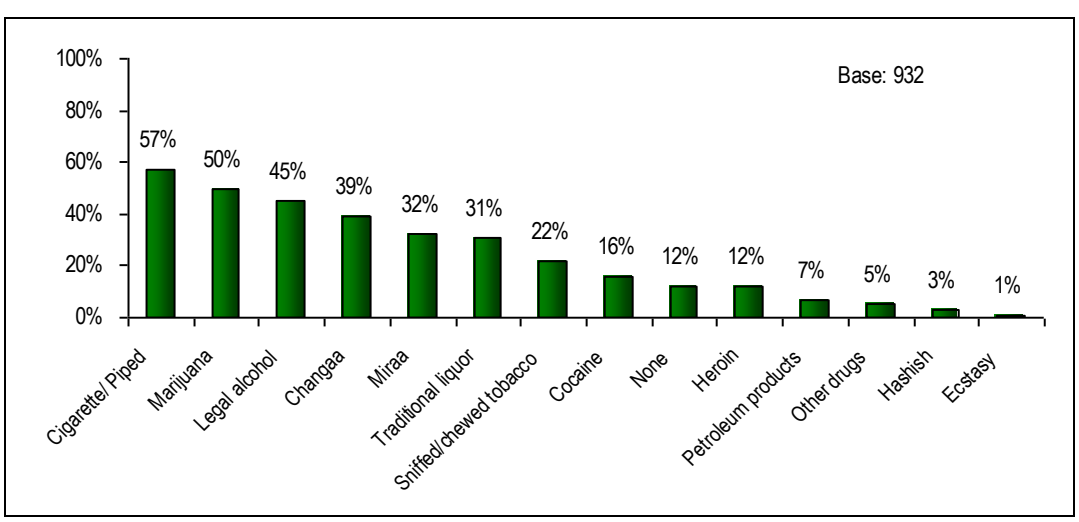
CHAPTER THREE -
AWARENESS, ACCESSIBILITY AND USE OF DRUGS

This chapter presents findings on knowledge of drugs and other substances of abuse among respondents in the two samples. Awareness of drugs was established through respondents' spontaneous mention of various drugs and substances (spontaneously) and awareness after probing. Spontaneous awareness generated information on drugs which have high recognition as substances of abuse. "Overall awareness" therefore is knowledge of drugs and substances of abuse both spontaneously and after probing. The chapter also covers accessibility and use of drugs and substances of abuse. It goes further to present the role of immediate social environment in drug and substances of abuse.

3.1 Awareness of drugs and substances of abuse

Cigarettes and bhang were mentioned spontaneously by over 50 percent of the 10-14 years old respondents (Figure 3.1). Less than 20% of these respondents were aware of hard drugs such as cocaine, heroin, hashish and mandrax after prompting. Over 12 percent of them could not recall any substance of abuse even after prompting.

Figure 3.1 Percentage of spontaneous recall of drugs among 10-14 year-olds



North Eastern showed much lower total awareness of substances of abuse except for cigarettes and miraa compared to other regions (Table 3.1). There were no major differences in awareness across gender. Socio-economic status accounted for differences in levels of awareness of specific drugs with those in high economic status indicating higher awareness of hard drugs compared to those within other socio-economic cadres.

Except for knowledge of miraa and cigarettes, youths who profess the Christian faith showed a higher awareness of drugs and substances compared to Muslims. Respondents who are currently attending school are proportionately more knowledgeable about most drugs compared with their counterparts who are not in school.

Table 3.1: Percentage total awareness among 10-14 year-olds across sample characteristics

		Cigarette/ Piped Tobacco	Sniffed/chewed tobacco	Chang'aa	Legal alcohol	Traditional liquor	Marijuana	Miraa	Heroin	Hashish	Cocaine	Petroleum products	Ecstasy	others	None	No of respondents
Setting	Rural	96.5	85	83.9	87.1	84.4	86.1	77.7	30.5	14	35.4	50.7	7.8	4.2	2.7	698
	Urban	95.9	75.6	91.4	87.8	80.2	87.8	92.4	51.7	25.8	62.9	72.1	17.2	7.6	2.5	234
Province	Nairobi	96.6	70.7	91	89.9	76.4	87.6	94.4	50.4	17.8	64	66.2	15.5	4.5	2.3	106
	Central	95.1	92	87.1	95.3	84.4	94.5	88.8	52	15.4	62.2	79.3	8.5	9.7	2.7	112
	Coast	98.1	87.4	93.2	96.2	92.4	90.9	94.7	56.3	43	55.5	65.8	13.7	6.8	1.9	62
	Eastern	97	90.6	72.6	92.1	82.1	89.7	97	26.6	3.6	33.6	54.1	4.6	6.2	1.8	156
	Nyanza	94.8	72.4	92.4	87.3	89.6	90.3	52.2	12.9	2.4	25	43.1	0.9	1.7	5.2	127
	Rift Valley	97.1	90	93.8	86.8	93.6	85.4	74.5	35.5	17.9	35.7	57	13.5	3.7	2.1	231
	Western	97.5	69.1	98.7	95	93.7	95	69.1	38.2	22.1	46.4	48	11.7	9.1	0	75
	N. Eastern	93.5	71.6	41.4	39.1	23.4	44.4	93.5	29.5	46	32.9	25.3	18.8	0	6.5	62
Gender	Male	94.2	82.5	86.3	84.4	83	85.6	80.7	35.8	18.3	44.6	57	11.2	5.6	4.9	480
	Female	98.6	82.9	85.3	90.3	83.6	87.5	82.1	35.8	15.6	39.8	55.2	8.9	4.5	0.3	452
	In school	99.2	84.5	88.1	89.9	86.1	89.3	83.4	36.5	16.6	43.2	57.8	9.9	5.3	0	869
	Not in school	57.2	57.2	54.2	51.1	45.1	48.1	52.6	26.9	22	29.9	33	13.6	1.9	39.8	63
Economic status	High	96.4	78.6	92.5	94.4	80.6	94.4	94.4	70.6	31.3	82.5	78.6	27.4	19.4	1.6	60
	Medium	96	77.7	89.7	89.7	85.2	89.7	87.4	47.8	20.9	54.7	69.8	12.4	7.7	3.5	264
	Low	97.6	89.6	86.6	93.1	87.4	88.4	81.7	33.2	12.8	44.1	58.6	8	4.2	1.4	230
	Very low	95.7	82.5	81.5	80.9	79.9	81.9	74.9	23.5	14.5	26.2	41.4	7	1.5	3	378
Religion	Christian	98.6	85	90.9	92.7	90.8	91.8	81	36.7	13.8	43.1	59.4	9.3	6	0.2	769
	Muslim	99.2	84	70.2	68.8	54.8	70.6	98.2	39.2	42.6	46.8	46.4	16.8	0.8	0.8	119
	Others	48.7	39.6	39.6	42.2	30.5	38	42.2	11.2	4.3	16	24.6	6.4	0	51.3	44
	Total	**96.3**	**82.7**	**85.8**	**87.3**	**83.3**	**86.5**	**81.4**	**35.8**	**17**	**42.3**	**56.1**	**10.1**	**5.1**	**2.7**	**932**

The low total awareness of drugs among 10-14 years old in North Eastern province was most notable in the case of Marijuana (Figure 3.2).

Figure 3.2 Proportion of total awareness of Marijuana among 10-14 years old across provinces.

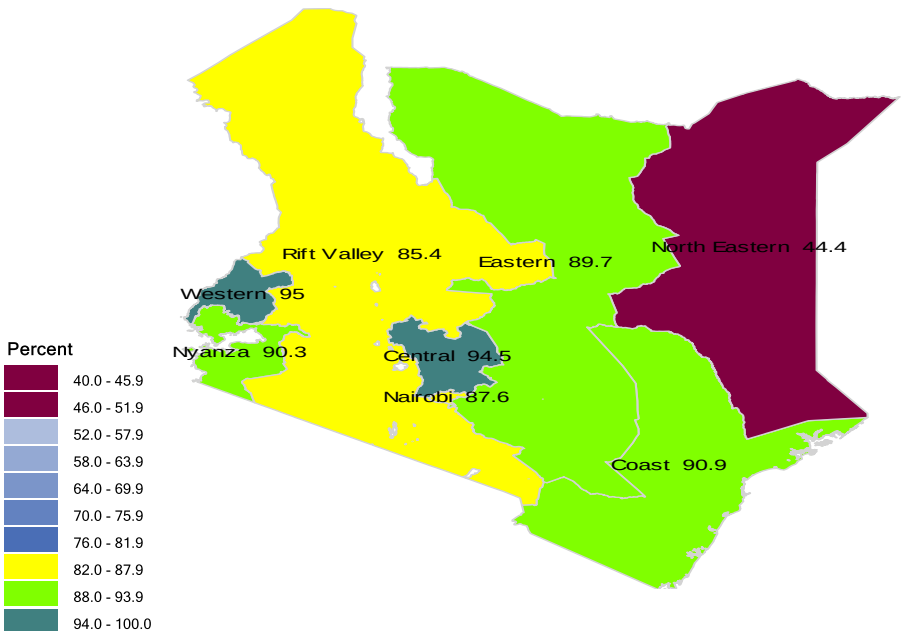
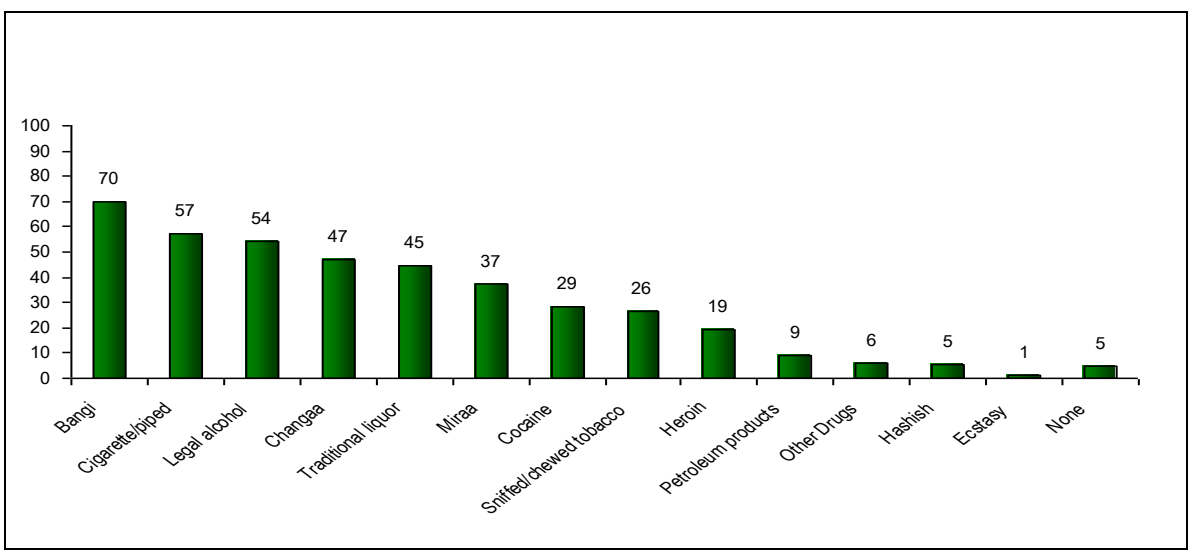


Figure 3.3 summarizes the percentage of 15-65 year-olds who mentioned different drugs unaided. Bhang, cigarette and legal alcohol accounted for the highest levels of spontaneous recall (over 50%). Among hard drugs, cocaine is the most commonly mentioned drug (29%) followed by heroin (19%) and hashish (5%).

Figure 3.3 Percentage of spontaneous recall of drugs among 15-65 year-olds



Among respondents in the age bracket 15-65, the total awareness of common drugs such as tobacco, alcohol, miraa and bhang was over 90% (Table 3.2). On the contrary, hard drugs, glue/petroleum products, and other drugs are less commonly known with less than 70% of the study population reporting awareness of them. Among hard drugs, cocaine is the most commonly mentioned drug (29%) followed by heroin (19%) and hashish (5%).

Table 3.2 Percentage total awareness among 15-65 years across sample characteristics

		Cigarette/piped tobacco	Sniffed/chewed tobacco	Chang'aa	legal alcohol	Traditional liquor	Bhang	Miraa	Heroin	Hashish	Cocaine	Petroleum products	Ecstasy	Other Drugs	None	Total
Residence	Rural	98	94	94	94	93	95	92	56	27	63	68	12	6	2	2483
	Urban	98	95	96	95	92	96	94	80	54	85	88	26	7	1	873
Province	Nairobi	97	93	95	94	92	96	94	82	50	86	89	25	7	2	397
	Central	100	98	98	98	96	99	97	70	33	76	85	13	11	1	399
	Coast	99	97	97	97	97	97	96	84	68	88	84	27	6	1	248
	Eastern	98	98	90	97	95	97	98	51	19	62	75	7	6	1	557
	Nyanza	99	94	99	98	97	98	90	52	19	65	71	10	2	2	534
	Rift Valley	97	94	96	92	95	92	87	57	28	61	67	14	4	2	729
	Western N	96	86	96	93	94	95	86	64	36	68	57	17	6	2	331
	Eastern	100	96	64	68	48	72	99	45	72	51	49	27	12	1	161
Age	15 - 17	99	94	93	93	89	95	93	68	31	75	76	12	11	1	392
	18 - 24	98	95	95	95	94	95	93	66	36	72	76	18	7	1	824
	25 - 35	98	96	94	95	93	96	94	63	36	70	76	17	5	1	1133
	36+	97	93	93	94	92	94	90	55	32	61	66	13	5	2	1007
Gender	Female	98	95	93	94	92	94	91	53	25	60	68	12	3	2	1717
	Male	98	95	95	95	94	96	94	71	43	78	78	18	9	1	1639
	Total	**98**	**95**	**94**	**94**	**93**	**95**	**92**	**62**	**34**	**69**	**73**	**15**	**6**	**2**	**3356**

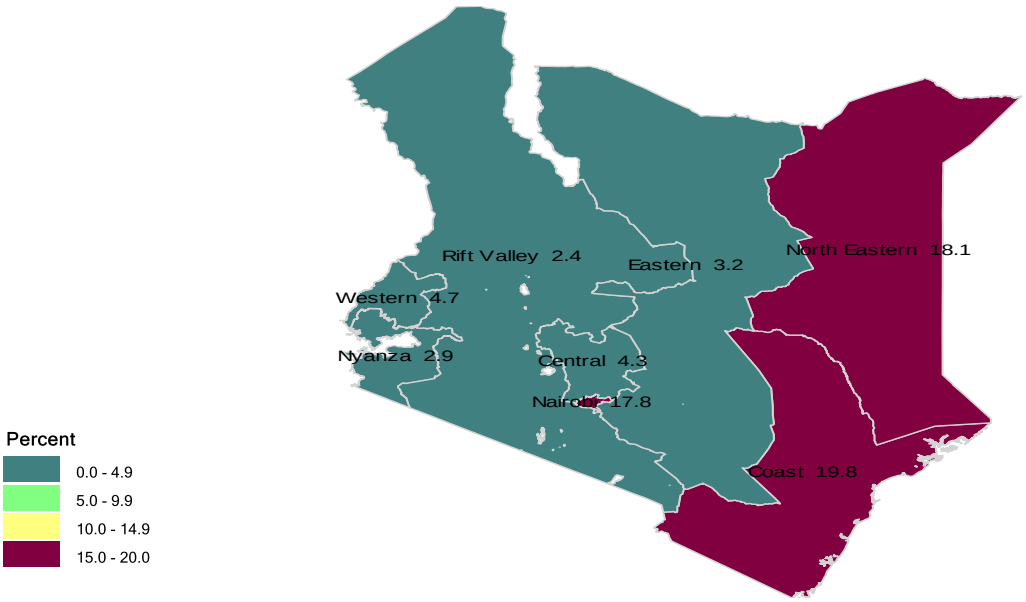
3.2 Drug Accessibility

Results suggest that children who buy drugs borrow money from their parents ostensibly to buy other things and use the money on drugs while others use pocket money without their parents' knowledge, or forego food, or even steal money to finance their drug taking habits. On the other hand, those who do not usually buy drugs (and they are more than those who buy) are given the drugs by friends, older family members, or offered the drug by older people who are not members of their household. As for miraa, children can access it freely if his or her household plants it.

All respondents aged 15-64 years were asked how easy it is to get different drugs and substances in the community. The study has established that the drugs which are most easily accessible are cigarette, chang'aa and packaged alcohol with over 80 percent of respondents rating access to each of the three drugs as fairly or very easy. On the other hand, hard drugs such as cocaine and heroin are not easy to get.

There are wide regional variations on views about ease of accessing various drugs. For instance, while 96 percent of respondents in Eastern province said that packaged alcohol is fairly easy/very easy to access; the proportion holding that view is as low as 28 percent in North eastern province. Ease of access of chang'aa is highest in Western province while that of heroin and cocaine is highest in Coast, Nairobi, and North Eastern provinces (Figure 3.4).

Figure 3.4 Proportion of respondents who reported ease of access to heroin by province



3.3 Ever use of alcohol among respondents aged 10-14 years

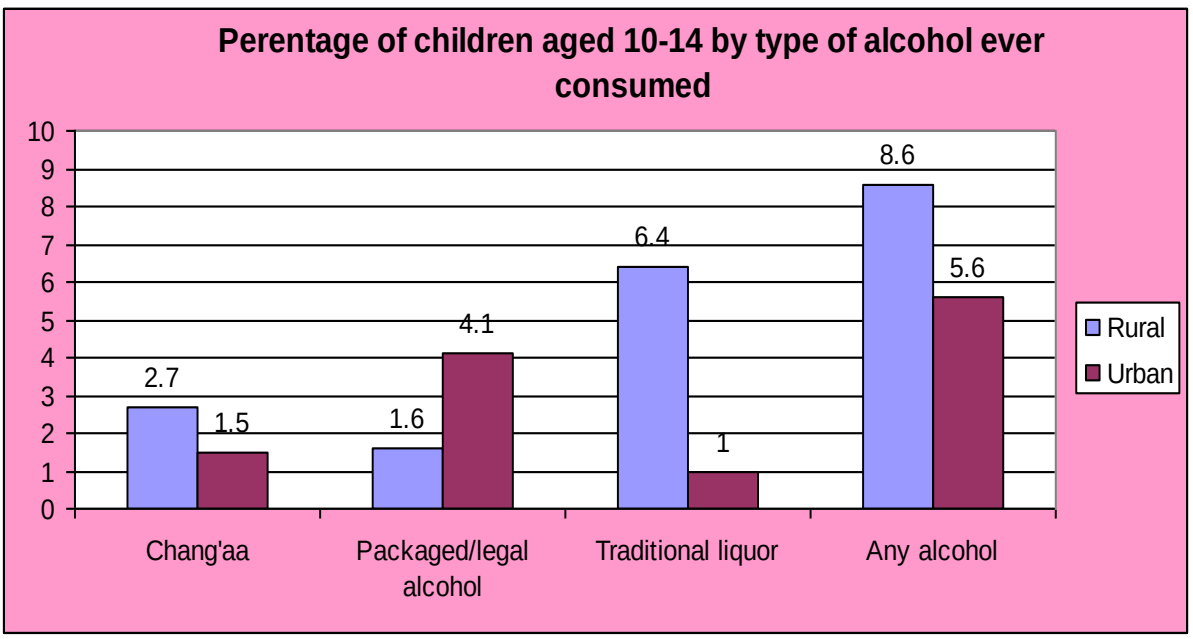
Nationally, 8% of 10-14 year-olds have used some alcohol at least once in their life and the type of alcoholic drink varies with gender, residence (rural/urban), level of education, and economic status of the respondent's household. At this point it should be noted that current levels of alcohol consumption (defined as consumption in the last one month) among these respondents is less than one percent.

Table 3.3: Percentage of 10-14 year-olds who have ever used various types of alcohol by background characteristics

	Setting		Sex		School attendance		Economic Status				Religion			Total
	Rural	Urban	Male	Female	In school	Out of School	High	Medium	Low	Very low	Christian	Muslim	Other	
Chang'aa	2.7	1.5	2.7	2.2	2.2	6.1	0.0	3.2	1.2	3	2.6	0.0	6.7	**2.4**
Packaged/legal alcohol	1.6	4.1	2.8	1.7	2	6.1	4.0	4.9	0.8	1.0	2.	0.0	6.7	**2.2**
Traditional liquor	6.4	1.0	5.8	4.2	5.3	1.5	0.0	3.3	2.9	8.3	6.1	0.0	0.0	**5**
Any alcohol	8.6	5.6	8.6	7.1	7.7	9.1	4.0	8.3	4.5	10.1	9.1	0.0	6.7	**7.8**
N=	**698**	**234**	**480**	**452**	**869**	**63**	**60**	**264**	**230**	**378**	**769**	**119**	**64**	**932**

The findings in figure 3.5 show that there are rural-urban differentials in ever use of alcohol by children age 10-14. For instance, children in rural areas are more likely to have ever consumed chang'aa (2.7%) than those in urban areas (1.5%). Furthermore, children age 10-14 in urban areas are more likely to have ever consumed packaged/legal alcohol (4.1%) than those in rural areas (1.6%). Traditional liquor is also more likely to have been consumed by rural children (6.4%) than urban children (1%). The results also show that rural children are much more likely to have consumed any other alcohol compared to urban children.

Figure 3.5 Percentage of children age 10-14 by type of alcohol ever consumed



3.4 Ever-use of alcohol among 15-65 year-olds

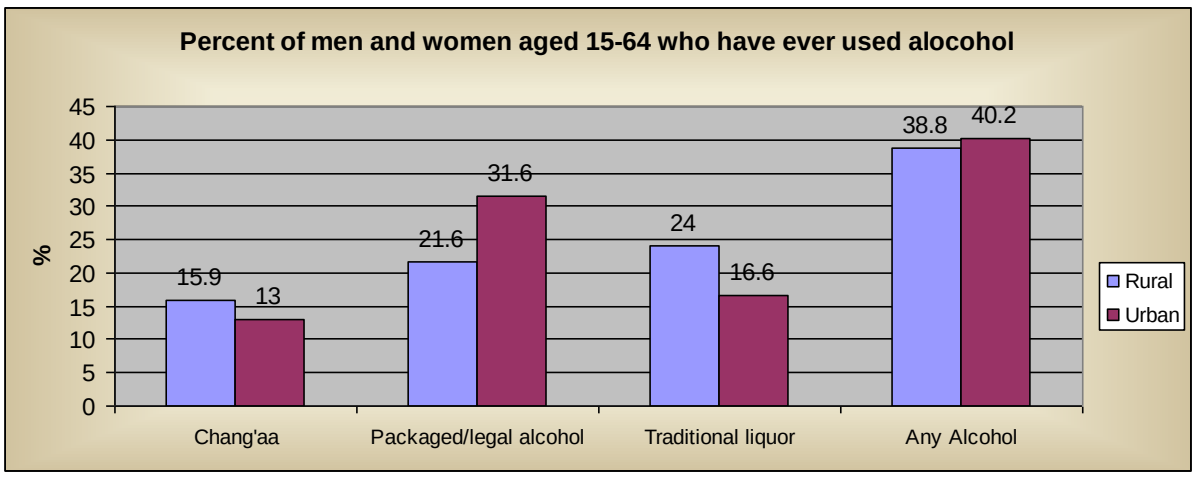
About 39 percent of people aged 15-65 years have ever used at least one type of alcohol with packaged/legal alcohol and traditional liquor reporting the largest proportions (24% and 22% respectively) (Table 3.4). Another 15 percent have ever used chang'aa. Less than one percent of all respondents said they had ever consumed other types of alcohol.

Table 3.4 Percentage of 15-65 year-olds who have ever used any alcohol across background characteristics

		Chang'aa	Packaged/legal alcohol	Traditional liquor	Other alcohol	Any Alcohol	N
Setting	Rural	15.9	21.6	24	0.1	38.8	2483
	Urban	13	31.6	16.6	0	40.2	873
Province							
	Nairobi	11.6	32.6	14.8	0	40.1	397
	Central	9.5	34.9	18.5	0.5	42.4	399
	Coast	8.3	23.1	29.5	0	41.4	248
	Eastern	7.7	29.6	21.5	0	39.1	557
	Nyanza	29.6	23.7	27.5	0	46.1	534
	Rift Valley	16.9	19.3	22.8	0.1	38.2	729
	Western	23.7	16.1	31.2	0	42.7	331
	North Eastern	0	0.6	0	0	0.6	161
Age							
	15 - 17 years	5.9	8.7	8.1	0	18.6	392
	18 - 24 years	11.5	20.4	16.8	0	34.6	824
	25 - 35 years	15.9	27.7	21.3	0.1	41.8	1133
	36+ years	20.8	29.4	32.8	0.2	48.0	1007
Gender							
	Female	6.8	13.5	14.2	0	25.8	1717
	Male	23.8	35.4	30.4	0.2	53.2	1639
Current employment	A Student	6.3	12.4	9	0	22.9	512
	Unemployed	14.4	23.1	20.3	0	37.0	441
	Employed	20.1	32	27.5	0.1	48.6	1738
	Others	9.1	13.5	19.3	0.1	28.7	665
Highest education Level	No formal education	9.6	8.3	24	0	27.7	333
	Primary education	17.3	19.3	25.4	0	38.3	1408
	Secondary Education	14.7	27.9	18.7	0.3	40.0	1248
	Post Secondary Education	13.4	44.7	19.3	0	50.4	367
Religion	Christian	16.2	26	23.1	0.1	41.9	2868
	Muslim	2.5	8.3	8.5	0	14	367
	Others	27.2	30	39.3	0.8	51.8	122
	High	10.5	38.6	16.9	0	45.3	209
	Middle	11.5	29.9	16.4	0.1	38.8	977
Economic Status	Low	15.2	26.4	22.5	0.2	39.7	876
	Very low	18.5	16.1	26.9	0	38.2	1294
	Total	15.1	24.2	22.1	0.1	39.2	3356

The findings in figure 3.6 show that there are rural-urban differentials in ever use of alcohol by men and women age 15-64. For example, men and women in rural areas are more likely to have ever consumed chang'aa (15.9%) than those in urban areas (13%). Furthermore, men and women age 15-64 in urban areas are more likely to have ever consumed packaged/legal alcohol (31.6%) than those in rural areas (21.6%). Traditional liquor was also more likely to have been consumed by rural men and women (24%) than urban men and women (16.6%). The results also show that rural men and women are much more likely to have consumed any other alcohol compared to urban men and women age 15-64.

Figure 3.6 Percentage of men and women aged 15-64 who have ever used alcohol



3.5 Current usage of alcohol among 15-65 year-olds

About 18% of urban dwellers are current users of various types of alcohol compared to 13% in rural areas. Besides North Eastern and Western provinces where current usage of alcoholic drinks is less than seven percent, in all other provinces at least 13 percent of the residents are current alcohol consumers.

Table 3.5 Percentage distribution of respondents aged 15-65 who have taken different types of alcohol in the last one month by background characteristics

		Chang'aa	Legal alcohol	Traditional liquor	Any Alcohol	Total
Setting	Rural	4.3	7	6.3	13.0	2483
	Urban	2.3	15.1	3.1	17.7	873
Province	Nairobi	1.8	16.8	1.3	18.6	397
	Central	0.9	16.3	2.9	17.7	399
	Coast	0.8	7.9	13.2	18.6	248
	Eastern	1.7	11	6.9	14.8	557
	Nyanza	9.8	7.6	7.3	17.0	534
	Rift Valley	5.6	6.4	6.2	12.5	729
	Western	3.7	1.3	3.4	6.8	331
	North Eastern	0	0	0	0	161
Age	15 - 17 years	0.5	1.8	0.6	2.6	392
	18 - 24 years	2.6	8.7	3.6	11.7	824
	25 - 35 years	4.4	10.5	5.2	16.4	1133
	36+ years	5.4	10.7	9.1	18.4	1007
Gender	Female	1.1	3.4	2.2	5.9	1717
	Male	6.6	15	8.9	22.9	1639
Employment status	A Student	0.4	3.7	0.9	4.6	512
	Unemployed	3.5	8.8	3.7	12.7	441
	Employed	5.3	13.1	7.8	19.9	1738
	Others	2.5	2.9	4	7.8	665

Highest Education Level	No formal education	1.5	1.8	7.9	9.4	333
	Primary education	4.8	6.1	6.6	12.5	1408
	Secondary Education	3.8	10	4.2	14.1	1248
	Post Secondary Education	2.1	23.8	3.2	25.5	367
Religion	Christian	3.9	9.7	5.1	14.6	2868
	Muslim	0.3	2.2	4	5.7	367
	Others	11.8	14.3	17.7	30.5	122
Economic status	High	0.6	21.7	2.2	22.1	209
	Middle	2.1	12.6	3	14.4	977
	Low	4.3	8.4	5.6	14.4	876
	Very low	5.2	4.9	7.8	12.7	1294
	Total	**3.8**	**9.1**	**5.5**	**14.2**	**3356**

3.6 Ever use of other substances among children aged 10-14 years

Out of the 932 respondents aged 10-14 years old successfully interviewed, only 13 percent claimed to have ever used any substance (Table 3.6). The rate of use of various drugs and substances is similar across urban and rural setting except tobacco (cigarette) which is lower in rural areas compared with urban settings. Overall, 4 percent of these respondents have used cigarettes at least once. Apart from Miraa which recorded a rate of 1.2 percent, current use of other substances is below 0.5 percent.

Table 3.6 Percent of 10-14 years who have used other substances of abuse other than alcohol across background characteristics

		Cigarette /Pipe	Sniffed/ chewed tobacco	Bhang	Miraa	Hashish	Cocaine	Petroleum products	Ecstasy	None	Number
Setting	Rural	3.7	1.2	0.3	2.6	0.4	0.4	0.5	0.4	86.9	698
	Urban	5.6	0	0.5	2	0	0	0.5	0.5	87.3	234
Gender	Male	7.4	1.6	0.6	3.6	0.6	0.6	0.8	0.8	83.4	480
	Female	0.7	0.2	0	1.3	0	0	0.2	0	90.9	452
School attendance	In school	4.0	0.7	0.4	2.2	0	0	0.2	0.1	87	869
	Not in school	6.1	4.5	0	6.1	4.5	4.5	4.5	4.5	87.9	63
Economic status	High	2	0	0	4	0	0	0	0	90.1	60
	Medium	7.5	1.4	0.8	2.7	0.4	0.4	1.2	0.8	83.4	264
	Low	2.5	0.4	0	3.3	0	0	0	0	90.9	230
	Very low	3.2	1	0.3	1.5	0.5	0.5	0.5	0.5	86.7	378
	Total	4.2	**0.9**	**0.3**	**2.4**	**0.3**	**0.3**	**0.5**	**0.4**	**87**	**932**

Results indicate that 66 percent of the children targeted are not aware of the risk of consuming drugs and substances of abuse without their consent. Thirty three percent (33%) of the children who knew of this risk of drug consumption were further asked to explain some of the possible ways a boy or a girl can consume drugs and substances of abuse without his or her knowledge and their responses are presented in the table below. Over three quarters of the

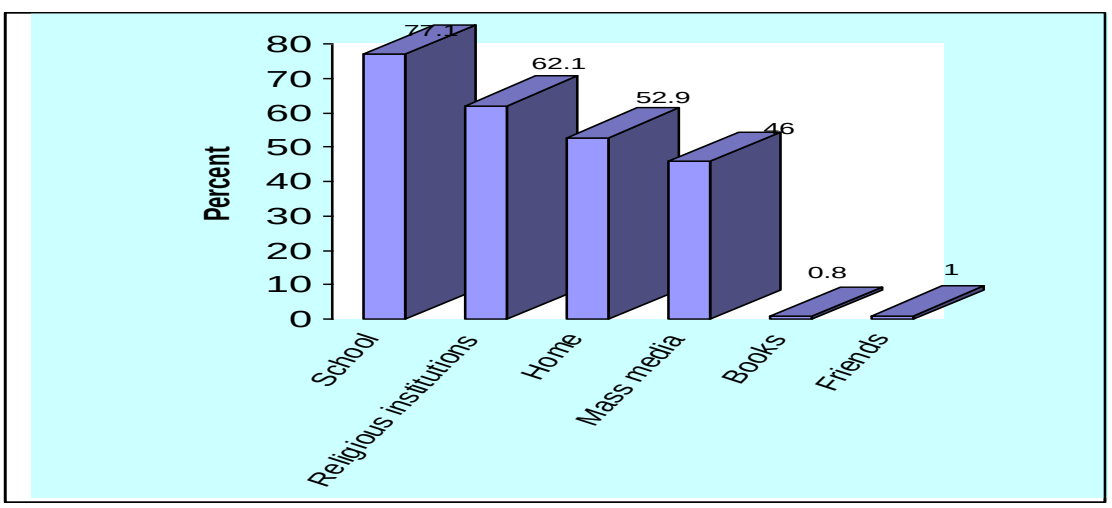
children who are aware of this problem are also aware of how it can occur. Most of them (77%) mentioned mixing of drugs with food or drinks (Table 3.7).

Table 3.7 Awareness of how involuntary drug consumption can occur

	Rural	Urban	Total
Drugs can be mixed with food or drinks	72	87	77
Can be tricked that it not harmful/not a drug	20	8	16
When asleep	2	2	2
Through injection without knowing	2	1	2
The packaging can be deceiving	1	1	1
Old people can give you as medical purpose	1	0	1
Can be mixed with sprays	0	1	0
Don't know	6	4	5
Number of respondents	**196**	**100**	296

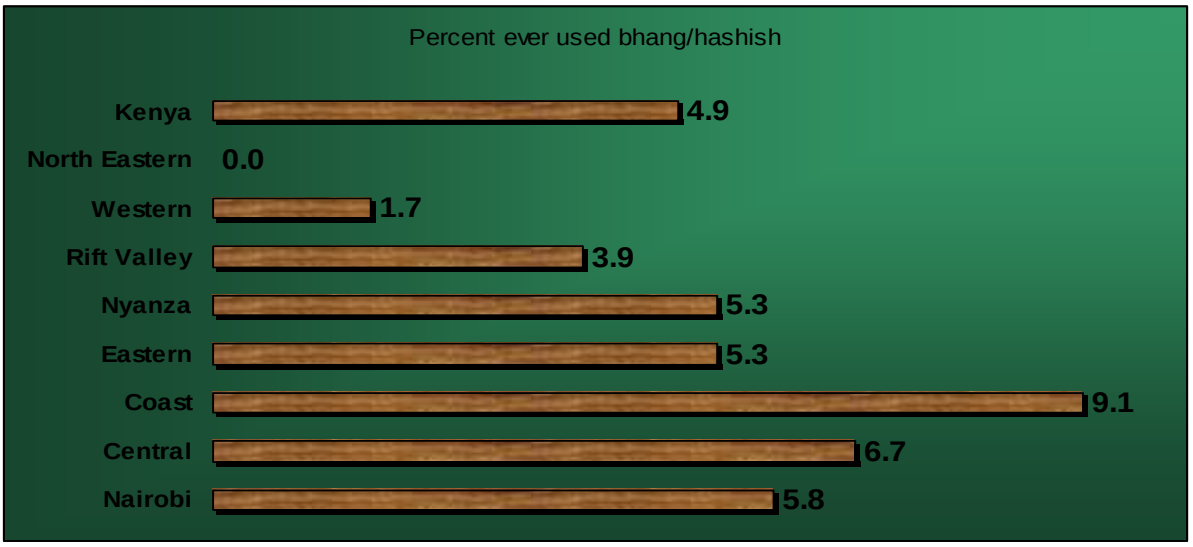
Overall 89% of the children had received information about drugs and other substances of abuse. Schools and religious institutions are the main channels for passing information to children with a reach of 77 percent and 62 percent respectively. Fifty three percent (53%) of the children received information about drugs at home (Figure 3.7).

Figure 3.7 Percent distribution of respondents age 10-14 by sources of information on drug abuse



The results show that overall, 5 % of 10—14 year olds have ever used bhang/hashish in Kenya (Figure 3.8). The results also show regional differentials in the ever use of bhang/hashish. For instance, over 9% of 10-14 year olds in Coast province have ever used bhang/hashish while about 7% have ever used bhang/hashish in Central province. Further the results indicate that at least 5% of 10-14 year olds in Nyanza, Eastern and Nairobi provinces have ever used bhang/hashish. Rift Valley and Western provinces recorded ever use of bhang/hashish of lower than 4% with North Eastern province recording the lowest usage of zero percent.

Figure 3.8 Percent distribution of respondents age 10-14 by ever use of bhang/hashish



3.7 Ever use of other substances among 15-64 year-olds

About half (48%) of all respondents aged 15-65 years have taken at least one of the drugs. Men presented the highest proportion of those who have ever taken any substance of abuse (67%) which is twice the proportion of women (31%). North Eastern province present the lowest ever use of any drug or substance across the provinces.

Results on specific drugs and substances indicate that 22 percent of the respondents have smoked tobacco (cigarettes or pipe) and another 11 percent have chewed miraa in their lifetime. About 7 percent have used bhang while 5 percent have chewed or sniffed tobacco. On the other hand, less than one percent of the respondents said they had taken hard drugs.

Table 3.8 Percentage distribution of people aged 15 to 65 who have ever taken various drugs by background characteristics

		Cigarette/piped tobacco	Sniffed/chewed tobacco	Bhang	Miraa	Heroin	Hashish	Cocaine	Petroleum products	Ecstasy	Other drugs	None	N=
Setting	Rural	20	5.6	5.7	9.9	0.2	0.1	0.2	0.1	0.2	0.4	52.4	2483
	Urban	26.6	2.9	8.9	15.4	0.9	0.9	1.2	0.7	0.7	1.3	49.8	873
Province	Nairobi	29.6	2.8	8	15.3	1.5	1.4	1.4	0.6	1.1	1.2	50	397
	Central	29.5	2.3	9.9	7.4	0.9	0	0.3	0	0	1.1	51.4	399
	Coast	28.4	8.6	11.6	16.6	0.8	1.7	1.8	0.4	0.8	0.5	46	248
	Eastern	24.4	10.5	7.9	25.8	0	0	0.2	0.7	0	0.4	44.8	557
	Nyanza	17.7	2.9	6.4	5.1	0	0	0	0	0.5	0	48.8	534
	Rift Valley	17.6	5.4	3.6	4.7	0.2	0.1	0.3	0.2	0.1	0.3	56.8	729
	Western	9.3	1.4	3.3	1.7	0	0	0	0	0.3	0.6	53.8	331
	North Eastern	21.3	3.2	1.4	23.4	0	0	0	0	0	2.7	72.6	161
Age	15 - 17 years	7.2	1.1	1.1	6.3	0	0	0.2	0	0.6	0.9	73.4	392
	18 - 24 years	16.9	4.2	6.5	11.7	0.4	0.3	0.6	0.3	0.4	0.6	56.1	824
	25 - 35 years	26.9	3.8	8.9	14.4	0.5	0.6	0.7	0.5	0.4	0.7	48.2	1133
	36+ years	25.5	8.3	5.9	9.6	0.3	0.1	0.1	0	0.1	0.5	43.7	1007
Gender	Female	3.9	3.6	1.4	4.5	0.1	0.3	0.2	0.1	0.3	0.2	69.2	1717
	Male	40.4	6.2	11.9	18.5	0.7	0.4	0.7	0.4	0.4	1.1	33.5	1639
	A Student	8.8	1.1	3.2	6.3	0	0.2	0.4	0	0.6	1.4	70.5	512
	Unemployed	19.6	5.2	6.5	12.3	0	0.5	0.6	0	0.3	0.3	52.4	441
	Employed	31	5.4	9.1	15	0.5	0.3	0.5	0.4	0.3	0.7	40.8	1738
	Others	9	6.4	2.3	5	0.4	0.4	0.3	0.1	0.3	0.1	65.4	665
	No formal education	13.6	16.3	3.6	11.7	0.3	0.3	0.3	0.3	0.6	0.3	57.6	333
	Primary education	20.6	4.4	6	11.1	0.2	0.2	0.2	0	0.2	0.6	52.7	1408
	Secondary Education	22.3	2.6	7.2	11.4	0.3	0.2	0.4	0.3	0.3	0.4	52.5	1248
	Post-secondary education	31.3	4.2	8.5	11.8	1.6	1.3	1.3	1	0.7	2.1	40.4	367
Religion	Christian	20.9	4.3	6.2	9.1	0.4	0.3	0.4	0.2	0.3	0.5	51.5	2868
	Muslim	24.2	5.9	6.9	24.7	0.3	0.6	0.6	0.3	0.6	1.5	58.8	367
	Others	34.1	16.7	12.6	22.8	1	0.8	1.8	1	0.8	0	36.8	122
Economic status	High	29.1	2.6	5.9	13.6	1.6	1.2	1.6	1.2	0.6	0	45.3	209
	Middle	22.3	2.7	7.9	12.4	0.8	0.3	0.5	0.2	0.4	1.4	52.2	977
	Low	21.2	3.9	6	10.9	0	0.1	0.4	0.1	0	0.2	54.3	876
	Very low	20.5	7.7	5.9	10.4	0.1	0.3	0.2	0.2	0.4	0.4	50.7	1294
	Total	**21.7**	**4.9**	**6.5**	**11.3**	**0.4**	**0.3**	**0.4**	**0.2**	**0.3**	**0.6**	**51.7**	**3356**

3.8 Current drug use among 15-65 year-olds

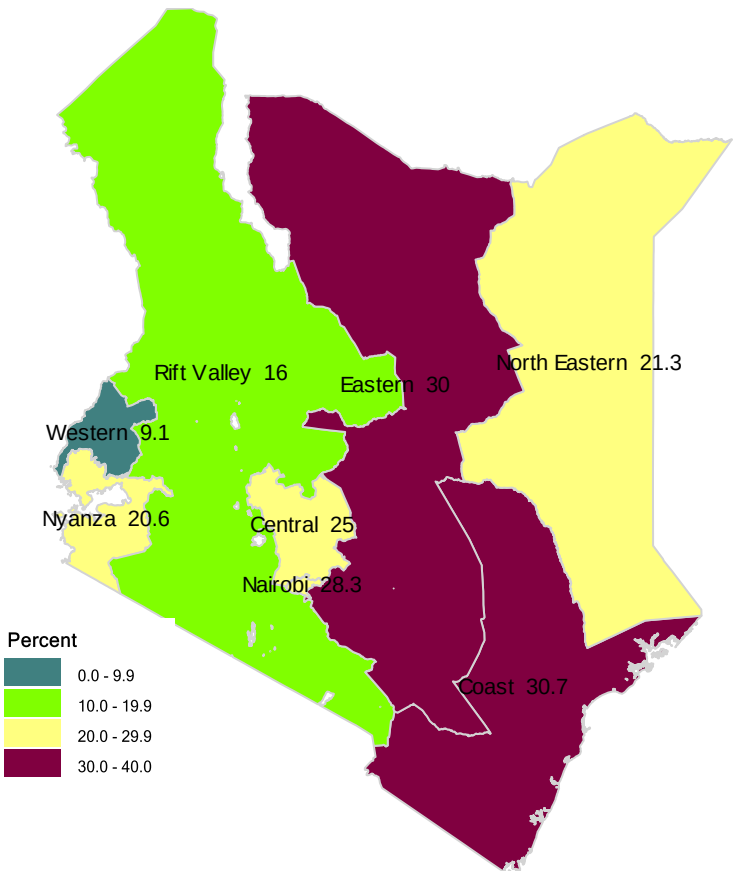
Twenty two percent of all the sampled respondents were current users of at least one substance of abuse. The current users of cigarettes and miraa were 11% and 6% respectively. For sniffed/chewed tobacco products and bhang, the proportions for current use were 2% and 1% respectively. Sixty four percent of men were leading drug-free lives compared with 91 percent of women respondents (Table 3.9).

Table 3.9 Percentage of all male and female age 15-65 by drug they are currently using according to background characteristics

		Cigarette/piped tobacco	Sniffed/chewed tobacco	Bhang	Miraa	Heroin	Hashish	Cocaine	Petroleum products	Ecstasy	Other drugs	None	Total
Setting	Rural	9.9	1.9	0.9	4.7	0.1	0.1	0.1	0	0.1	0	79.5	2483
	Urban	13.4	0.2	1.4	7.7	0.1	0.4	0.5	0.1	0.6	0.4	72.8	873
Province	Nairobi	15.3	0.2	1.1	7.2	0.2	0.8	0.5	0	0.8	0.6	71.7	397
	Central	16.9	0	0.6	2.3	0.2	0	0	0	0	0	75	399
	Coast	14.4	5	2.3	7.8	0.4	0.8	1.3	0.4	0.4	0	69.3	248
	Eastern	12.5	3.8	1.3	13.9	0	0	0	0.2	0	0	70	557
	Nyanza	7.6	0.6	1.4	1.5	0	0	0	0	0.2	0	79.4	534
	Rift Valley	7.4	1.2	0.6	1.4	0	0.1	0.2	0	0.1	0.1	84	729
	Western	3.6	0.3	0.3	0	0	0	0	0	0.3	0	90.9	331
	North Eastern	15.1	1.2	0.8	18.7	0	0	0	0	0	0.8	78.7	161
Age	15 - 17 years	0.6	0	0.9	2.9	0	0	0.2	0	0.6	0	93.7	392
	18 - 24 years	8.4	0.6	1.6	6.3	0.1	0.3	0.3	0.1	0.2	0	80.9	824
	25 - 35 years	14.1	0.5	1.2	7.4	0	0.3	0.3	0.1	0.2	0.2	74.3	1133
	36+ years	13.2	3.9	0.3	3.6	0.2	0	0	0	0.1	0.2	72.9	1007
Gender	Female	1.3	1.3	0.3	1.7	0.1	0.3	0.2	0.1	0.2	0	91.2	1717
	Male	20.9	1.7	1.7	9.4	0.1	0.1	0.2	0.1	0.2	0.3	63.7	1639
Employment	A Student	1.8	0	1.4	3.1	0	0.2	0.2	0	0.6	0	91.3	512
	Unemployed	10.1	1.9	1.5	4.4	0	0.2	0	0	0	0	79.1	441
	Employed	16.5	1.6	1	8.1	0.1	0.1	0.2	0.1	0.2	0.3	69	1738
	Others	3.4	2.1	0.3	1	0.3	0.3	0.3	0.1	0.1	0	89.5	665
Education	No formal education	6.6	8	0.9	7.2	0.3	0.3	0.3	0.3	0.6	0	79.4	333
	Primary education	10.4	1.3	0.8	5.5	0	0.1	0.2	0	0.1	0.1	79.4	1408
	Secondary Education	11.7	0.2	1.5	4.9	0.1	0.2	0.3	0.1	0.2	0	77.9	1248
	Post Secondary Education	13.6	0.9	0.3	5.6	0.3	0.6	0	0	0.3	0.7	69.4	367
Religion	Christian	9.8	1	0.8	3.5	0.1	0.1	0.1	0	0.2	0.1	79.4	2868
	Muslim	15.3	3.5	1.9	18.3	0.3	0.6	0.6	0.3	0.6	0.3	72.2	367
	Other religions	21.8	7.1	2.8	13.6	0	0.8	1.8	1	0	0	57	122
	High	13.5	0.5	0.6	6.5	0.5	0	0	0	0	0	69.2	209
Economic	Middle	10.4	0.1	0.9	5.7	0.1	0.2	0.2	0	0.3	0.2	78.6	977
status	Low	11.2	1.2	0.5	4.8	0	0	0.1	0.1	0	0.1	78.4	876
	Very low	10.5	2.9	1.4	5.6	0.1	0.3	0.2	0.1	0.3	0.1	78.1	1294
Total		**10.9**	**1.5**	**1**	**5.5**	**0.1**	**0.2**	**0.2**	**0.1**	**0.2**	**0.1**	**77.8**	**3356**

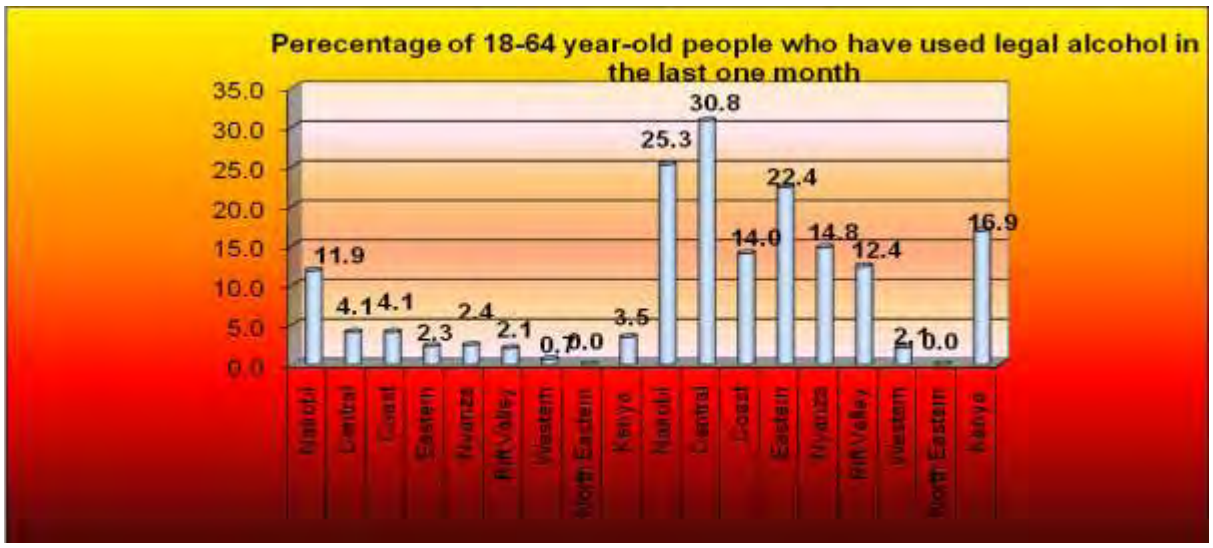
There are also huge variations in the prevalence of use of the various drugs and substances across the eight provinces. Western province has the lowest proportion of people currently using any substance (9%) followed by Rift Valley (16%) and North Eastern and Nyanza provinces (21%) (Figure 3.9).

Figure 3.9 Proportion of respondents' 15-65 currently using drugs/ substance of abuse



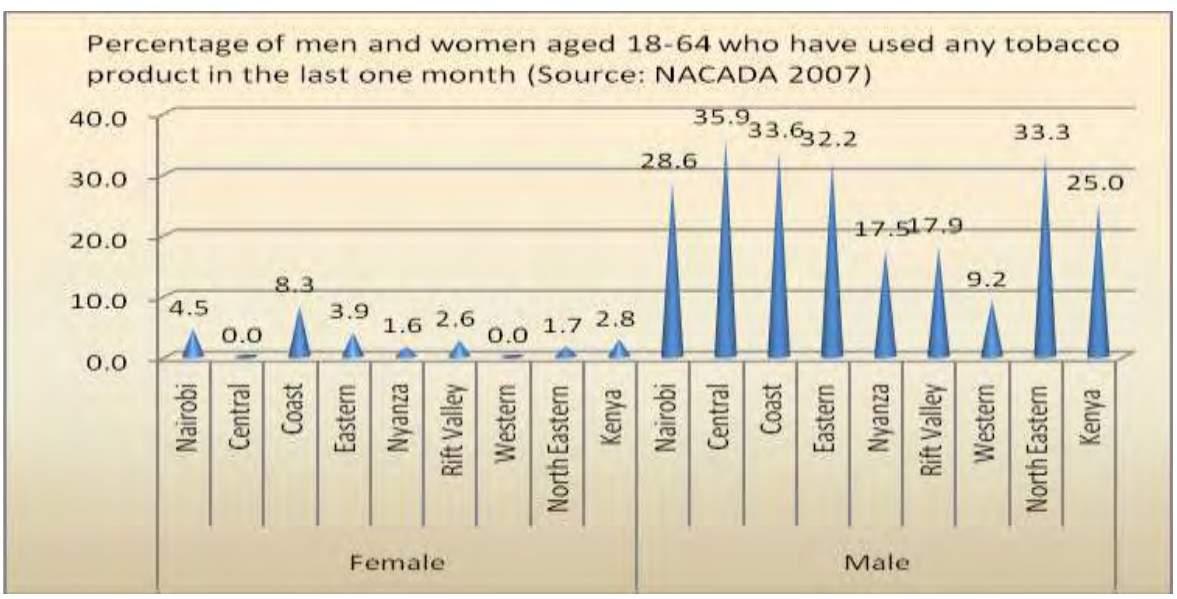
The results further show that, the distribution of current use of all substances of abuse is higher among males than females. For instance, current use of legal alcohol by region and gender indicate that over 31% of males in Central province are current users of legal alcohol compared to over 25% of males in Nairobi province. At least, 14% of males in Eastern, Coast and Nyanza provinces are current users of legal alcohol. For females, the distribution shows that over 11% of females in Nairobi province are current users of legal alcohol while at least 4% are current users of legal alcohol in Central and Coast provinces. For both males and females, Western and North Eastern provinces recorded the lowest rates of current use of legal alcohol (Figure 3.10).

Figure 3.10 Percentage of men and women aged 18-64 currently using legal alcohol



Furthermore, the results show that the distribution of current use of any tobacco product differ by region of residence and gender. For example, over 30% of males in Central, Coast, Eastern and North Eastern provinces are current users of tobacco products. Nairobi province recorded 29% of male current users of tobacco products while Western province recorded the lowest rates of current use of tobacco products at less than 10%. For females, the results show that Coast province recorded the highest proportion of current user of tobacco products (8.3%), followed by Nairobi province at 4.5%. Nyanza and Eastern provinces recorded the lowest rates of current use of tobacco products at less than 2% with North Eastern province recording no current use at all of any tobacco products. (Figure 3.11).

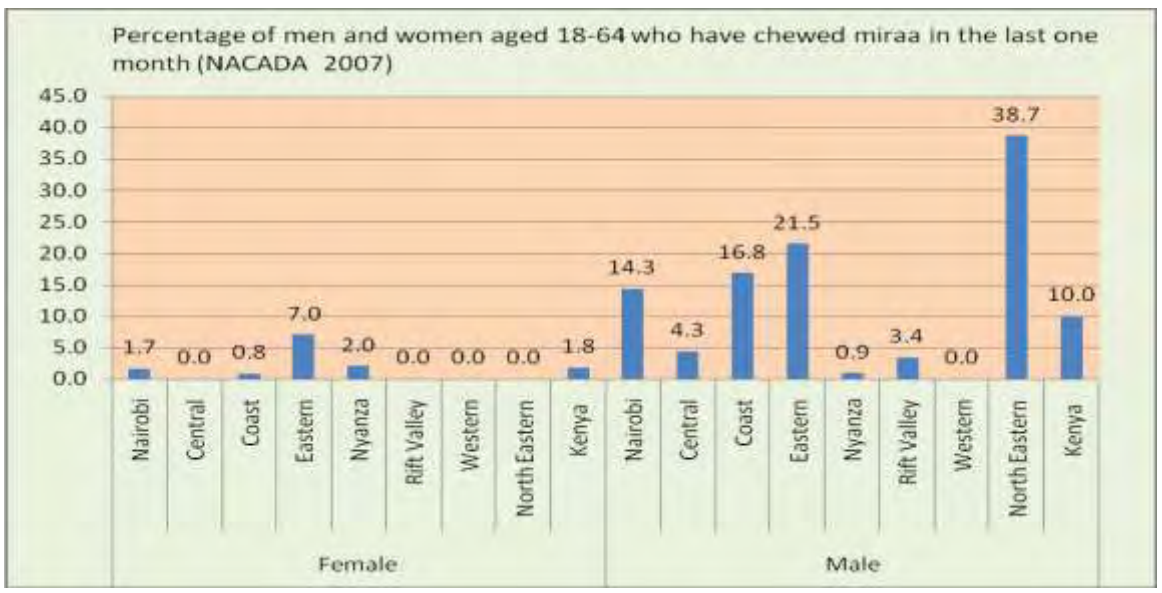
Figure 3.11 Percentage of men and women aged 18-64 currently using any tobacco products



Current use of miraa also varies by region of residence and gender. Over 39% of males in North Eastern province are current users of miraa compared to 22% of males in Eastern province. Current use of miraa stands at 17% and 14% for males in Coast and Nairobi provinces respectively. Males in Nyanza province recorded a current use of miraa of less than one percent while males in Western province were not currently using miraa. For females,

current use of miraa is highest in Eastern province (7%), followed closely by Nyanza province (2%) and Nairobi province (1.7%). There were no current users of miraa among females in Central Rift Valley and North Eastern Provinces (Figure 3.12)

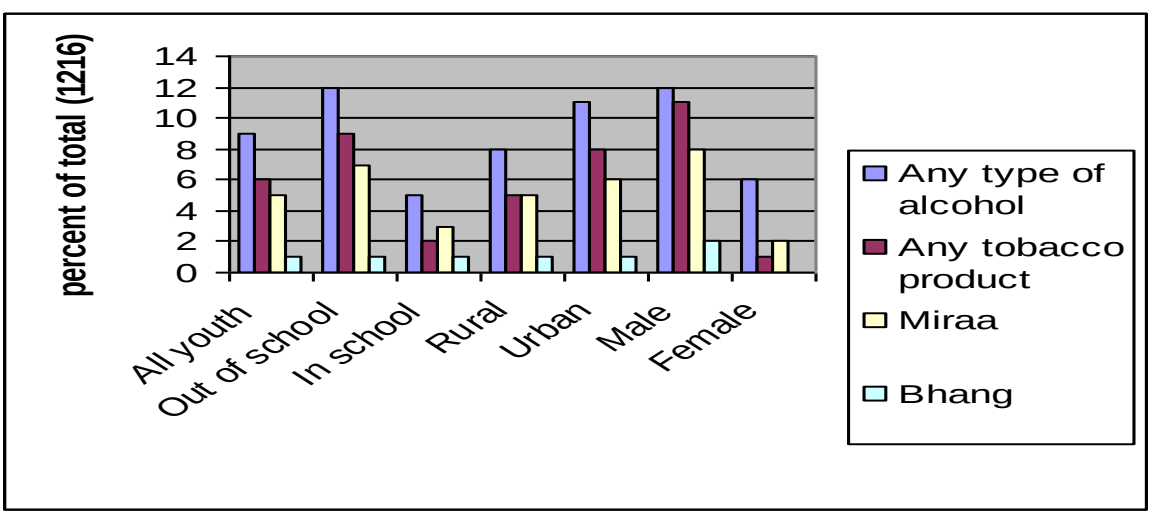
Figure 3.12 Percentage of men and women aged 18-64 currently using miraa



3.9 Current Drug Usage among youth aged 15-24 years

Among all young people aged 15-24, 9 percent are currently using alcohol, 6 percent tobacco, 5 percent miraa, and 1 percent bhang. Male youth are more likely to be current users of alcohol compared with their female counterparts (12% and 6% respectively) (Figure 3.13).

Figure 3.13 Percentage distribution of youth aged 15-24 by current use and background characteristics



3.10 Initiation of use of various drugs and substances

Among the respondents aged 10-14 years, the median age at first use of chang'aa and cigarettes is 9 years, while by age ten; half of them have tried chewing/sniffing tobacco,

traditional liquor and miraa. The median age of use of packaged alcohol is 11 years while that of bhang is 14 years.

In the case of the 15-65 years old, smokers of tobacco smoke everyday (90%). About 70 percent of miraa users and people who sniff or chew tobacco products use the substances daily. It is also evident that proportionately more of chang'aa and traditional liquor drinkers drink everyday compared with those who drink packaged alcohol. When the period is increased to a week, it is clear that the proportions of drinkers who have taken each of the three types of alcohol are quite similar: Over 95 percent of chang'aa and packaged alcohol drinkers and 90 percent of traditional liquor drinkers will have drunk their respective brews at least once.

3.11 Role of immediate social environment in drug and substance abuse

About 27 percent of children who have ever consumed alcohol have friends who take alcohol compared with only 5 percent of those whose friends did not take alcohol. It is also evident that relatively bigger proportions of children who think drugs are readily available in the school are likely to have ever used alcohol. Moreover, those who have ever taken alcohol are likely to report that a close relative was using one drug or the other (Table 3.10).

Table 3.10: Percentage of respondents who have ever taken alcohol by usage of alcohol among their friends and relatives

		Percentage of respondent who have ever consumed any alcohol
Friends take alcohol	No	5.2
	Yes	27.4
Drugs available in school	No	7.1
	Yes	12.5
Lives with both parents	No	7.6
	Yes	8.3
Mother/father/family member takes any drug	No	5.0
	Yes	13.1
Drugs available in the community	No	6.7
	Yes	8.5

In order to assess the role of the immediate social environment in the initiation of drug use, respondents were asked a number of questions related to the time they first used a drug. More of the 15-65 years old respondents who have ever taken alcohol had a father who was taking any drug when they initiated use of alcohol. Further, having siblings and close friends who take any drug is associated with higher odds for having ever taken alcohol. Mother's drug use, however, does not seem to be closely associated with a respondent's having ever taken alcohol.

CHAPTER FOUR -
HEALTH AND SOCIO-ECONOMIC IMPACT OF DRUG ABUSE

This chapter is describes social problems that are commonly associated with drug abuse. They include presentation of the study findings that link drug use and frequent medical attention, work or school absenteeism, violence, crime and risky sexual behaviour.

4.1 Health problems emanating from drug use

Figure 4.1 shows percentage of users of various drugs who have ever sought medical attention following the use of each drug. About one in every 10 users of cigarette, bhang and cocaine have sought medical attention for a problem related to substance use. Note also that the proportion of chang'aa users who have sought medical intervention is the same as that of packaged alcohol users (5%).

Figure 4.1: Percentage of users of various drugs who have ever sought medical attention for problems related to using the drugs

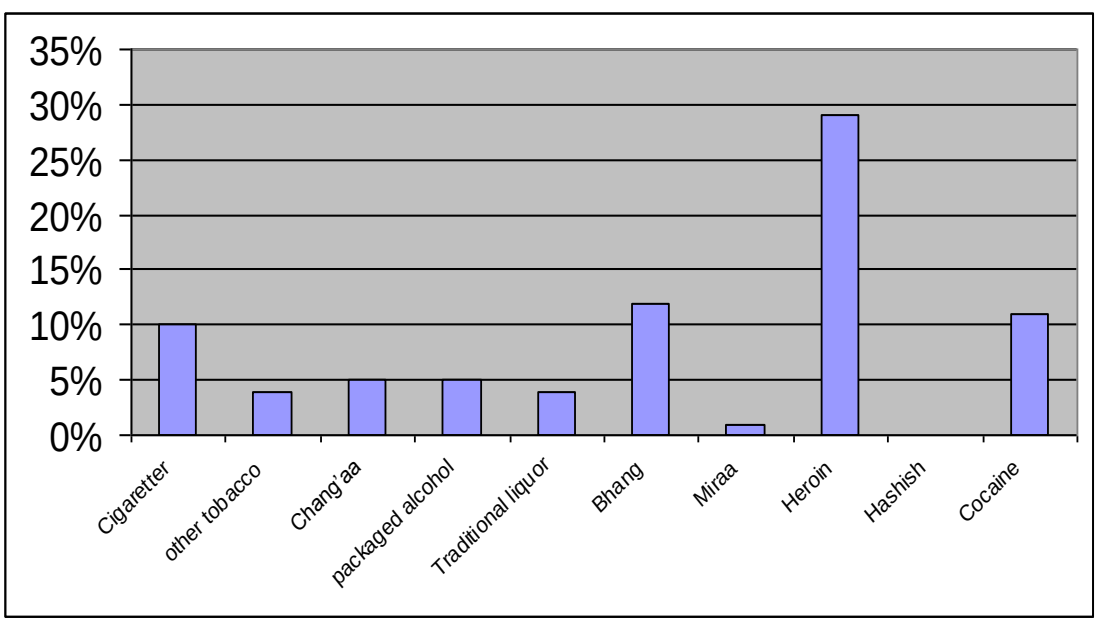
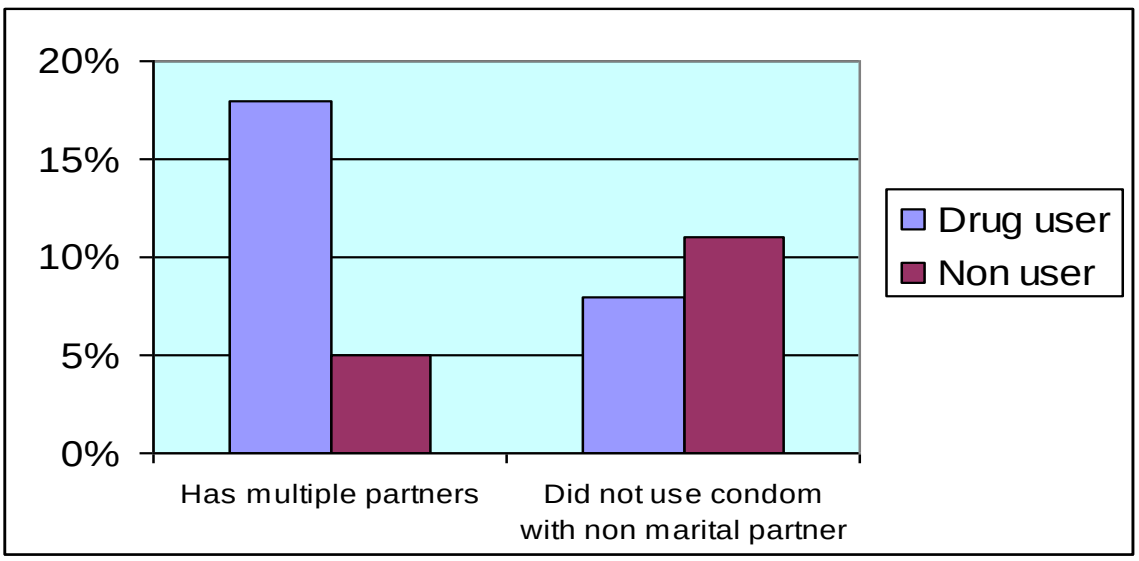


Figure 4.2 shows that drug users are likely to have more than one sexual partner compared to non-users. Seven in every 10 people aged 15-65 with multiple partners are likely to be substance abusers. Users of bhang/hashish, heroin and cocaine are more likely to have multiple partners compared to users of alcohol, tobacco and Miraa.

Figure 4.2 Sexual behaviour of drug users and non drug users



Overall, out of the 932 children in this study 11% have ever engaged in sex (12% of boys and 10% of girls). The median age at sexual debut is 11 years. Nearly all (90%) who have ever had sex had it first with their age mates but 7 percent had sex with a much older person[1]. Only one child (a girl) said she received a fee. It is instructive to note that as many as 23 percent of the children were not willing to have sex at the time of their first sexual encounter (40% of the girls and 13% of the boys).

In addition, 10 percent of these children were given incentives such as sweets and chocolate before engaging in sex (Figure 4.3). About 6 percent had taken one drug or other and 8 percent had sex with people who had taken a drug.

4.2 Socio-economic impact of drug abuse

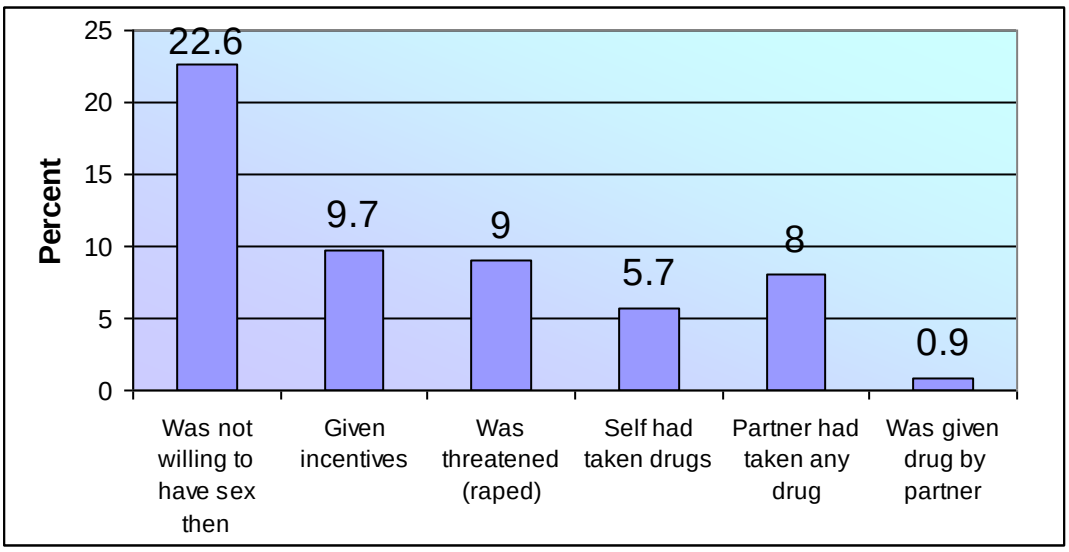
Close to 90 percent of all heron/cocaine users reported that they have diverted resources in order to buy the drugs while 44 percent of bhang users have done so in the 12 months preceding the survey. Close to 40 percent of tobacco and alcohol users too have diverted resources meant for domestic use to buying alcohol. Miraa has the least proportion of people reporting to have diverted domestic resources to finance drug taking. Nearly 1 in every 5 miraa users reported work or school absenteeism as a result of taking the substance.

Alcohol, bhang and cocaine users are more likely to report having been violent towards their family members compared with users of tobacco and miraa. Considering that as many as 14% of all men and women aged 15-65 are currently using alcohol in the country (23% of all men in that age band are using alcohol) this drug is the commonest cause of domestic violence a rate higher than even hard drugs (heroin, cocaine etc).

The percent of people ever arrested in the last 12 months as a proportion of all respondents is 4.3% .While only 3 percent of none users of tobacco have been arrested or charged, 15 percent of users of tobacco reported that they had been arrested. It is also evident that users of bhang and hashish have particularly high odds for being arrested/charged compared with non-users of the two drugs.

[1] Note that all these children are girls. On the other hand all the boys said they had sex with girls of their age.

Figure 4.3 Percentage of respondents age 10-14 by context of first sexual encounter



CHAPTER FIVE -
EXTENT OF CHEMICAL DEPENDENCE AND PERCEPTIONS RELATING TO COUNSELLING, TREATMENT AND REHABILITATION

Chapter Five brings together findings on addiction and desire to stop drug and substance abuse. Findings on attitudes towards drugs as well as the relationship between drugs and traditional practices are also included in the study. Respondents' suggestions on how to contain drug abuse form the last part of the chapter.

5.1 Extent of chemical dependence

Addiction to substances of abuse was assessed using a number of indicators namely: craving for the substance, needing the substance first thing in the morning; concern by someone close to the respondent or a doctor about the person's drug consumption habits. Tobacco is the most addictive substance with more that 90 percent of users reporting craving for it always and a similar percentage saying that they always needed the substance first thing in the morning. About 50 percent of users of any type of alcohol also reported craving for alcohol always and 25 percent said they needed alcohol first thing in the morning.

Overall addiction to tobacco smoking is the main concern mentioned by 34% of the respondents. Specifically, tobacco smoking as a problem was noted more frequently in Central (54%), Nairobi (52%) and Coast (51%) while chang'aa was the main drug of concern in Nyanza (38%) and Western (22%) provinces. Traditional liquor was considered the main drug of concern in households in Coast province (22%). Moreover, one in every 10 respondents from a household with addiction problem in Rift Valley, Western and Nyanza attributed it to traditional liquor. Cocaine, despite its addictive nature, was hardly mentioned anywhere: only 3% of the respondents in Coast and 1% in Eastern province mentioned it as problem in their households. Miraa is a concern in North Eastern province (56%) and Eastern province (11%). Higher proportions of respondents mentioned bhang as a source of drug related problems in households in Coast (6%), Nyanza (6%) and Western (4%) provinces.

Further analysis demonstrates that heads of households constitute the majority of people with addiction problems (60%), and followed by sons (17%), other relatives (15%), and daughters (1%). The heads of household are normally the main decision makers in the homes. The survey was able to quantify that other household members are probably affected by the head of the household's substance addiction condition. The effects of addition are both financial and psychological. The main financial impact is diversion of resources (41%) while the main psychological impact is domestic violence (38%).

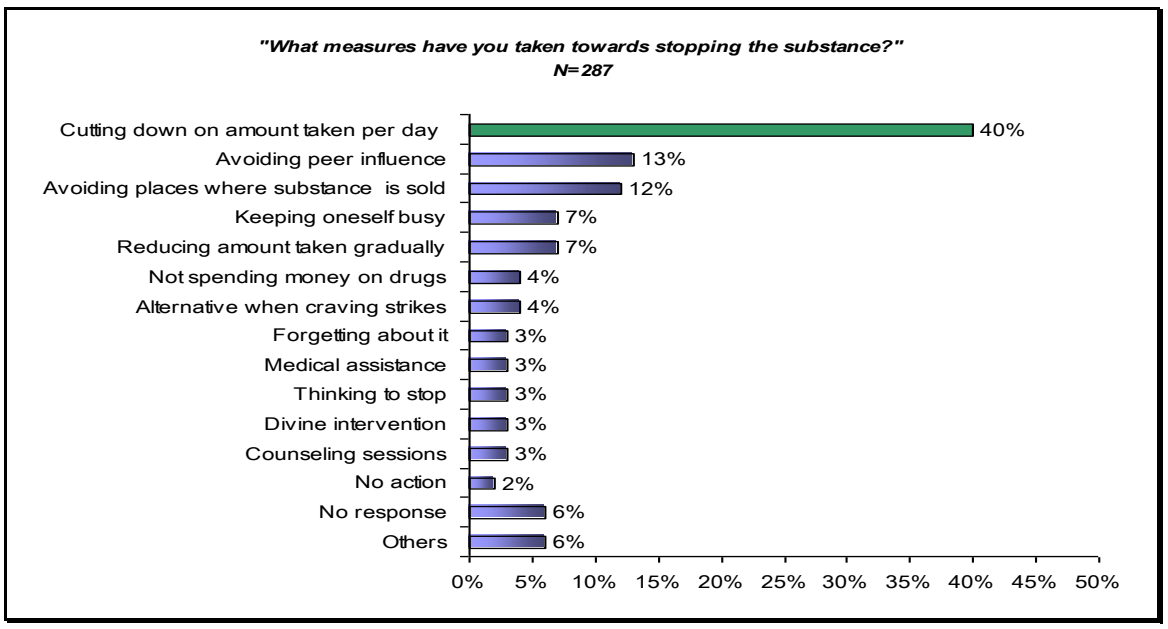
5.2 Desire to stop drug use and knowledge and attitudes towards rehabilitation facilities

At least one in every 5 users of any substance is willing to stop taking the substance. Desire to discontinue is higher among cigarette, cocaine and bhang users compared with other drugs.

It can be seen in the figure below that out of the 287 substance abusers who are trying to discontinue, only 6 percent have sought professional help including counselling and medical

attention. Majority are trying to discontinue by cutting down on the amount of substance used and avoiding environments which may lead them to use the substance.

Figure 5.1: Percent distribution of respondents by measures taken to end addiction



Indeed, 64 percent of all the respondents are not aware of any drug treatment centre with rural areas having lower awareness levels (68%) compared to urban ones (55%). Eastern province recorded the lowest awareness levels of such facilities at only 27%. Consequently, a significant number did not give much information on such facilities. Of those who responded, most of the facilities mentioned are government hospitals. Over one half of the respondents perceived drug treatment facilities as "not easy to reach" (57%) in terms of cost and distance. They also viewed them as facilities for people with serious addiction problems (53%).

Quality of the staff at the facilities was perceived to be good; however the effectiveness to treat drug addiction was doubted by 25%. Affordability of the services is not clear to the communities as indicated by a 39% non-response rate.

Without prompting, only 9 percent of the respondents are aware of Mathari hospital as a treatment centre for drug abusers with urban areas and Nairobi in particular recording high awareness levels (16% and 23% respectively). When prompted 75% of the respondents acknowledge awareness of Mathari hospital with majority in urban areas (85%) as compared to rural areas (71%). Nairobi, Central and Eastern provinces recorded a prompted awareness of 85 percent and above.

Of the 2508 respondents who said they are aware of Mathari, a substantial proportion of them (59%) perceive the facility to be capable of counselling, treating and rehabilitating drug abusers. The rating amongst different age groups and gender are similar at over 60% and over 55% respectively.

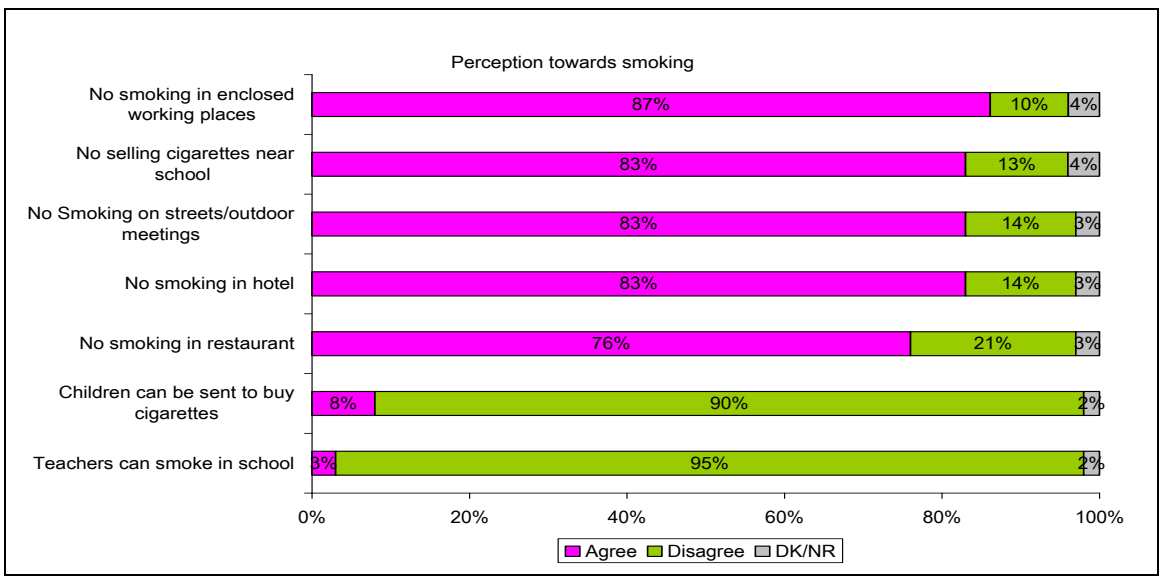
5.3 Attitudes towards drugs

Results suggest that majority of Kenyans hold positive attitudes towards consumption of licit drugs such as cigarettes (73%), packaged liquor (72%), traditional brew (69%), other tobacco products (68%) and miraa (54%). In contrast, illicit drugs have particularly low acceptability rating: cocaine and heroin have a rating of 5 percent and 4 percent respectively. Other drugs in this category are chang'aa (34%) and bhang (12%).

Acceptability of the various drugs covered in this survey varies also by region. Acceptability of cigarettes is over 65 percent in all the regions except North Eastern province. Bhang, chang'aa, heroin and cocaine have particularly high acceptability ratings in Nairobi. Packaged alcohol has the highest rating in Central while miraa has the highest rating in Eastern province[2].

Over 90 percent of the respondents agree that children should not be sent to buy cigarettes and teachers should not smoke around the school area. There is also a general feeling against smoking in enclosed work places (87%), selling of cigarettes near schools (83%), smoking in street or outdoor meetings (83%), smoking in hotels (83%) and smoking in restaurant (76%).

Figure 5.2 Community attitudes towards smoking



The perceived negative effects of all drugs on self is similar both in urban and rural areas except for hard drugs like cocaine and heroin. These drugs were rated high (cocaine 80%; heroin 79%) in urban areas as compare to rural areas ratings of cocaine 61% and heroin 58%. The perceived harm of drugs on self is similar amongst women and men with exception to the hard drugs which most men rated higher (cocaine 73%; heroin 69%) as compare to women (cocaine 60%; heroin 57%).

A perceived harmful effect of substance use to other people was found to be similar to the individual user. Use of cigarettes, bhang and chang'aa were rated higher in terms of their harmful effects to other people by users (90%, 90% and 82% respectively). Other substances which are perceived to cause harm to other people besides the users are packaged liquor

[2] Miraa is produced in the Meru region of Eastern province while people in Moyale, the farthest district in the northern part of the province, can access miraa from Ethiopia.

(72%), traditional brew (72%) and tobacco sniffing/chewing (70%). Miraa, heroin and cocaine received lower rating of causing harm to others at 55%, 52% and 55% respectively.

The perception of harmful effects does not differ significantly between the substance user and non user except for chewed or sniffed tobacco. Users of chewed tobacco rated the harmful effects much lower compared with non users. However, the difference may not be significant given the small number of chewed or sniffed tobacco users.

CHAPTER SIX -
TRENDS IN DRUG ABUSE AND TRADITIONAL PRACTICES REGULATING DRUG ABUSE IN THE COMMUNITY

Close to 90% of the respondents felt that there was an increase in the number of drug users. In addition, over one half of the respondents (57%) had noticed a change in the users of drugs. The main changes in drug users reported are increased use of drugs by the youth (31%) and use of drugs by children (15%)

Kenyan ethnic communities had elaborate moral systems that guided drug consumption particularly by stipulating who consumed the substance, where it was consumed and when it was consumed. Below is a shared set of code of conduct that guided use of substances across the Kenyan ethnic communities.

Some traditional practices used to control drug and substance of abuse

- Although women were brewers in some communities it was a taboo for women and under age children to take alcohol. Any woman who indulged in alcohol lost the respect and status in the community.
- A young man had to pass some rite of passage to be allowed to use alcohol
- Consumption of alcohol was mainly done in ceremonies and special functions. Traditional liquor had a higher value than intoxicating the mind. This ensured that addiction was controlled.
- Some members of the community were allowed to prepare the drink using stipulated ingredients.
- Traditional liquor was taken in a group, which helped in regulating usage
- Excessive drinkers were disrespected by the community. In some communities punishments and expulsion were used for excessive drinkers
- Each member of the community had been assigned responsibility which kept all the people busy

Table 5.1 gives a summary of respondents' recommendations on regulating drug abuse. Most people identify the government as the main player in drug control. The key role of the government is in enactment of strict laws on drug abuse that places heavy penalties on drug offenders. In addition there should be education campaigns on drug abuse, dismantling of drug markets, and establishment of treatment centres. The table below is a summary of the main suggestions.

Table 5.1: Suggestions on how to contain drug abuse

What would you recommend as ways of regulating drug abuse? N=3356	**Percent**
Parliament should enact strict laws on drug abuse	32
Education on dangers of drug abuse; guidance and counselling	31
Ban drug dealers and harmful substances in black market	20
Provide youth with source of income active activities	7
Introduction of huge fines for those found guilty	4
Seek divine intervention	4
Be strict on underage policies & rules	4
Establish hospitals and drug rehabilitations	3
Companies which process the substances to be closed	3
Others (13 suggestions put together, each less 3%)	13

CHAPTER SEVEN - DISCUSSIONS

This chapter presents a discussion of the results of the study on rapid situation assessment of drug and substance abuse in Kenya.

In general, the study findings reveal that drugs and substance abuse is a major social problem in Kenya. The finding is in line with similar observations made in the UNODC report of 2004. In addition, to its' public health manifestations that are often easily noted, drug and substance abuse has many other social facets.

The study findings confirm that drug and substance abuse in Kenya has a complex cause and effect relationship. One of the most important direct causes of DSA is easy availability of cheap drugs and other substances. The study revealed a high level of awareness of cigarettes and bhang among respondents. This is the case since cigarettes and bhang were also shown to be the most available and accessible drugs. Since accessibility also implies cost, hard drugs such as cocaine and heroin which are more costly are less accessible. They are also least known by the respondents with some variations among the different social economic groups.

Provincial variations in access to drugs were revealed by the study. Cocaine was most easily accessed in Nairobi, Coast and North Eastern Provinces. The entry of North Eastern province is surprising since it has low awareness levels of drugs in general. The province also has low prevalence of drug use. For targeted intervention purposes, the realisation of the relationship between awareness, availability and accessibility is important. This is even more critical since the study has also revealed wide provincial disparities among the three factors.

Young adults have the highest drug and substance abuse prevalence. According to the study findings, immediate social environment has an important role in influencing drug and substance abuse. The environment acts as both the source of peer pressure, money and the drugs. In most of these situations, parents and other guardians lack the capacity to intervene.

As shown by the study, nearly half of the children interviewed had never received any information about drugs at home. Schools and religious institutions are the main channels for passing information to children with a reach of 77 percent and 62 percent respectively. The findings show that experimentation with drug use starts at a very young age. This experimentation takes place within the immediate social environment. The role of friends or peers in discouraging drug use among the 10-14 years old respondents is minimal. In fact, this is consistent with the finding that friends and peers are some of the main sources of influence in initiation to drug use.

A majority of the 10-14 years old respondents were school going. Even in North Eastern province, the school going proportion was 84%. On the other hand children who are out of school were disproportionately more likely to report having ever taken chang'aa (6%) compared to those who are currently attending school. The school going populations can easily be targeted with information through schools. Reaching the out of school populations however presents with some programmatic challenges.

However, there are huge variations in the proportion of children who have ever used the various substances covered in the study. For instance, male children are more than seven times as likely to have ever smoked cigarettes as their female counterparts while those out of school are three times as likely to have taken cigarettes as their in-school counterparts.

Smoking of tobacco is also more prevalent among children from medium economic status (7.5%) compared with other economic status (e.g. 2% among children in high economic status). Apart from cigarettes and miraa which have been used by 4 percent and 2 percent of the respondents respectively, less than one percent of the same group claimed to have used any of the other drugs.

The general rate of ever use of all types alcohol is comparably similar in both rural and urban settings at 39% and 40% respectively. However, there are huge variations in the types and the rate of consumption of alcohol across regions, rural-urban residence, age, gender, educational level, religious affiliation and economic status. For instance, the proportion of respondents who reported having ever drunk chang'aa is highest in Nyanza province while Central, Nairobi, and Eastern provinces display the highest incidences of ever-use of packaged or legal alcohol. In addition, ever-use of traditional liquor is highest in Western and Coast provinces (31% and 30% respectively). It is clear that the use of alcohol is almost non-existent in North Eastern province. This may be attributable to the fact that majority of people in the province profess the Islamic faith, which proscribes consumption of alcohol. Proportionately more people in rural areas have ever taken chang'aa and traditional brews compared with their urban counterparts.

Consistent with the consumption of alcohol, ever-use of other drugs and substances of abuse exhibits marked variations across rural-urban setting, region, age and gender. Compared with rural areas, urban centres have consistently larger proportions of respondents reporting to having ever used all the drugs covered in this survey except sniffed or chewed tobacco. Gender is also a critical determinant of drug use. For instance, while only 4 percent of women said they had ever smoked tobacco, as many as 40 percent of the men in the sample reported having ever smoked tobacco. The likelihood of having ever smoked tobacco increases sharply with age: while only 7 percent of the respondents aged 15-17 said they had ever used cigarettes, the proportion rises to 25 percent among those aged at least 36 years. It also increases with the level of education but sniffing and/or chewing of tobacco products declines as education level rises. Further, Nairobi and Central provinces have the highest rates of smoking tobacco (30%) while Eastern province leads in chewing or sniffing tobacco and in the use of miraa (11% and 26% respectively).

Smoking is highest in Central and North Eastern provinces (15%), urban areas (13%), and among the 25-35 year-olds (14 percent). The results further reveal that, men are relatively more likely to be tobacco smokers compared with women (21% and 1% respectively), only 2% of students are smokers and that sniffing or chewing of tobacco is concentrated in rural areas, Eastern province, and among people who are neither Christians nor Muslims. On the other hand, current use of miraa is highest in North Eastern province (19%) and lowest in Western province (0 percent) while bhang consumption is concentrated in Coast province (2%) and among people professing religions other than Christianity and Islam (3%).

Several negative effects of drug and substance abuse in Kenya can be derived from the study findings. Heroin users had a high rate of seeking medical attention. This means that resources for use elsewhere will be used in seeking health care. It is also known that drug users easily divert resources to buy the substances. Drugs damage one's ability to act as free and conscious beings, capable of taking action to fulfil their needs, care for others and contribute positively to society. Hence drug and substance abuse drains the economy. The findings are similar to those documented in the UNODC report of 2004. According to the report, the most commonly abused drugs in Kenya were alcohol, bhang, glue, miraa and psychotropic drugs.

The study findings also suggest an increase in violence as a result of drug and substance abuse. Alcohol, bhang and cocaine use had a higher likelihood of being associated with violence. On the other hand, bhang and hashish users were more likely to be arrested. In both these instances, the destructive social impacts of substance abuse are felt. Women and children suffer most from these effects.

The prevalence of HIV/AIDS among injection drug users is estimated at 68-88 percent (UNODC 2004). The UNODC report documents a relationship between injecting drug use and HIV/AIDS. Nairobi and Coast provinces were most affected with an estimated 10,000 heroin users in Nairobi and 8,000 in Coast province. The study findings indicate that drug and substance abuse is associated with multiple sexual partners. However, the study could not link HIV/AIDS sero-status and drug use since there were only 15 respondents who were using hard drugs and only 3 of them claimed to have injected themselves in the last 12 months. None of the Injecting Drug Users (IDUs) was willing to disclose the drugs they are injecting.

The study findings indicate that about 20% of current drug users are willing to stop the habit. High level of perceived harmful effects on self and others as a result of drug use was also revealed by the study. The two revelations provide a window of opportunity for effective interventions. But two critical and related challenges are also demonstrated by the study. Except for North Eastern province, a significant proportion of respondents (65%) do not condone cigarette smoking. They see nothing wrong with use of licit drugs. Changaa, heroin and cocaine have high acceptability ratings in Nairobi. It will therefore be a daunting programme task to positively influence and change these high acceptance levels. The second challenge is the observation that majority of respondents are not aware of the available drug and substance abuse treatment facilities.

As part of Kenya's heritage, various communities had some traditional practices that were used to control drug and substance abuse. Due to the changing times, it is not clear whether these strategies have any value. This is therefore an area that may be explored through a more detailed study.

CHAPTER EIGHT - STUDY LIMITATIONS

This chapter discusses the limitations of the study on rapid assessment of drug and substance abuse in Kenya.

It should be noted that from the outset the sample was representative only at the national level due to financial limitations. Thus, sub-national (regional) figures are only indicative and all interpretations of the findings should take that caveat into consideration.

This study solely employed quantitative techniques. By so doing, the study findings lost out on the added complimentary value from qualitative studies. Some of the social impacts of drugs and substance abuse can only come out through qualitative study. Thus future studies should endeavour to capture this aspect.

One of the key limitations of the survey was underreporting of usage of hard drugs because of the criminal nature of such drugs and the fact that there was a campaign in the mass media on the dangers of hard drugs at the time of data collection. There may have been an element of underreporting on hard drugs, because of their sensitive nature that attracts huge penalties for traders and those in possession of them.

There was also a lot of reluctance among most respondents to disclose their HIV/AIDS sero-status hence findings on this variable are unreliable and could not be linked to other study variables. Only 8 respondents said they were HIV positive, which is a gross underreporting given that HIV prevalence in Kenya is about 5 percent

The number of children who have ever used the various drugs is rather low hence these findings are only indicative. At the same time, the number of children aged 10 to 14 who are current users of any drugs is too small to allow robust analysis.

CHAPTER NINE -
CONCLUSIONS AND RECOMMENDATIONS

This chapter presents conclusions of the rapid situation assessment of drug and substance abuse in Kenya.

9.1 Conclusions

This study has the potential of informing policy as it is related to drug and substance abuse. We have more and up to date evidence that drug and substance abuse is a major social problem in Kenya with far reaching negative implications. To effectively address the problems of drug and substance abuse, there is need for greater prioritization in both funding and capacity development.

The programmes are also supported by weak institutional framework in which roles; partnerships and human rights perspectives of DSA are not strongly articulated. We lack appropriate and up to date data and information on DSA in Kenya. Hence, evidence based practice and programmes to address specific DSA problems are not always possible.

Since use of specific drugs and substance of abuse constitute a crime in Kenyan law, poor enforcement of the law may actually contribute to increased prevalence of the vice. Related to that, weak policies and intervention programmes may also be contributory as well as limited skills and personnel capacity of the law enforcers; unemployment and low prioritization of DSA. The implementation of effective awareness programmes is often affected by limited facilities and personnel skills. Since these programmes may be accorded low priority, they are often underfunded. Lack of intervention at home may be complicated by the stigma to drugs and substance abuse.

This study has shown huge variations in most important aspects of drug and substance abuse. It simply means "one size fit all" strategies wouldn't work. There is therefore need for tailor made specific interventions and strategies to address drug and substance abuse. Whereas there are clear opportunities for intervention through schools for the school going children, there is no clear cut strategy to address out of school youths. There may also be a need for operational research to inform evidence based practice on "what works, where and how".

The findings from the study showing the wide ramifications of drug and substance abuse effects calls for wide multi-sectoral involvement and action to address DSA. There is therefore need to develop and strengthen partnerships and collaborative arrangements.

A significant proportion of drug users in Kenya appreciate the harmful effects posed by drug use to self and others. They are also willing to change and many have made some attempts. However, many relapses do occur. It is therefore imperative that access to preventive, promotive and treatment services is increased and sustained.

The data collected as part of this study in the area of HIV/AIDS could not support any meaningful conclusions. HIV/AIDS and its relationship with drugs and substance abuse is an important issue. Similarly the study findings are not clear on the potential role of traditional approaches in the control of drugs. There is therefore need to design specific studies to address and generate information on the subjects.

9.2 Recommendations

The following policy recommendations are made:

1. There is need to review and update policies that address the regulation of drugs and substance abuse. In particular, the commercialization of traditional brews needs to be reviewed. There is need for a policy that will ensure that children do not frequent places where alcohol is consumed.
2. Advocate for increased funding to drugs and substance abuse programmes. A Sector Wide Approach (SWAp) similar to Governance Justice Law and Order Services (GJLOS) is proposed.

The following programmatic recommendations are made:

1. Develop the capacity of families, communities, learning and faith based institutions to sustainably address drugs and substance abuse.
2. Support the establishment and strengthening of promotive, preventive, treatment and rehabilitation services for drug and substance abuse. The recommendation will involve: drug and substance abuse service mapping, capacity gap analysis for stakeholders, promotion of available services, standardization and regulation.
3. Develop a national Information, Education and Communication strategy for drugs and substance abuse. The strategy should be specific and sensitive to the disparities in drugs and substance abuse.

The following areas are recommended for further research:

1. The relationship between drugs and substance abuse and HIV/AIDS in Kenya.
2. Potential role of traditional practices in the control of drug and substance abuse.
3. The dynamics of drugs and substance abuse among vulnerable segments of the population such as users of hard drugs, commercial sex workers, prisoners e.t.c.
4. Compliment quantitative study methods with qualitative research.

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