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A qualitative study exploring the views on tobacco use and cessation support among patients in Kenya

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Abstract

Tobacco use adversely affects the health of users, making hospitals a good place to introduce tobacco cessation efforts. However, most healthcare providers do not offer cessation support. This study sought to explore the views on tobacco use and cessation support among patients in Kenya. A qualitative approach was used. 19 patients were selected from various health facilities in Nairobi and Kisumu using purposive and snowball sampling. Semi-structured in-depth interviews were conducted by staff trained in qualitative interviewing between May 2017 and October 2017. The interviews were recorded and transcribed in their respective languages. Data management was done using Vivo version 10 software and analysed using content analysis method. Findings from this study revealed the following: Awareness regarding harmful effects: Participants were of view that tobacco use causes cancer, respiratory problems, impotence, lack of sleep and appetite and discoloration of the teeth. Lack of awareness regarding tobacco cessation clinics and lack of tobacco cessation interventions: Participants mentioned lack of awareness about any institutions which provide tobacco cessation services. Others mentioned that they had not been offered any support to quit; very few had been asked about their tobacco use status. Quitting tobacco use challenges: Respiratory problems, headache, lack of sleep and appetite, urge to smoke and the smell of smoke were the key challenges. Motivating factors to quit: Religion, support from family and friends, poor health condition, less availability of tobacco products and financial problems were the factors cited. Need for enhanced tobacco control: need for more awareness campaigns about harmful effects of tobacco use, provision of more tobacco cessation services, and implementing policies such as banning tobacco and increasing tax.

There is need for multi-disciplinary efforts in Kenya to enhance tobacco control through

awareness campaigns and integrating accessible and affordable tobacco cessation services within healthcare facilities.

Keywords: *Tobacco use, cessation barriers, healthcare workers, qualitative study, Kenya*

Introduction:

Tobacco has been shown to kill up to half of its users; with more than 7 million people dying each year as a result of direct tobacco use, while around 1.2 million deaths are the result of exposure to second-hand smoke. Over 80% of these deaths occur in low- and middle-income countries.[1, 2] Kenya has the highest recorded smoking prevalence in Sub-Saharan Africa,[3] with 11.6% of the adult population using tobacco products (19.1% men, 4.5% women) according to the Global Adults Tobacco Survey-Kenya (GATS) of 2014.[4] Similarly, 9.9% of school going children aged 13-15 years were using tobacco products (12.8% boys, 6.7% girls) according to the Kenya Global Youth Tobacco Survey (GYTS) of 2013.[5] Reports from Kenya have shown that 69 per 100,000 deaths for individuals aged 30 years and older are as a result of tobacco use related conditions, and 20% of all non-communicable disease-related deaths result from tobacco use.[6] According to the GATS-Kenya 2014 survey, 92.8% of the adults believed that smoking causes serious illness. Among adults who used tobacco, 52.4% had attempted to quit smoking in the past 12 months, while 55.9% had thought of quitting because of health warning labels on cigarette packages. Only about one in three persons (30%) who visited a health care provider in the past year were advised to quit smoking, whereas 70% had tried to quit without any assistance. The survey also showed that more than three fourths (77.4%) of current smokers planned to or were thinking about quitting, which is similar to the worldwide report that shows that approximately 70% of smokers report that they want to quit. Health care facilities have been identified as very important contact points to offer cessation support. This is because a great percentage of people will visit their physician at least once a year, offering the best opportunity for healthcare providers (HCPs) to provide cessation support. However, according to Ratschen et al., both patients and HCPs have limited knowledge and practice on how to treat tobacco dependence, although affordable and effective treatments for nicotine dependence exist.[8] A study by Olando et.al., exploring barriers and facilitators to successful cessation among tobacco using patients on outpatient follow up in Kenya with mental illness found results that were similar to experiences among the general population. The barriers experienced included: peer influence, withdrawal symptoms, fear of complete cessation, other substance use, and end-of-month disputes (difficulty meeting financial obligations). The facilitators that participants found worked for them in promoting successful cessation besides behavioral therapy were oral stimulation (eating or chewing things), and spousal and friend support.[9]

Most LMICs lack good quality qualitative data which provide an in-depth understanding of how the health systems in LMICs work, particularly with respect to tobacco cessation in terms of care pathways, referral, and coordination of services between health and social care professionals at different levels of care. Patients are important stakeholders in cessation support and their active participation in cessation support can only be achieved by understanding their views and bring in behavioural change interventions. This study thus sought to understand among adults visiting various health facilities of Kenya, the awareness regarding harmful effects of tobacco use, their perceptions, beliefs and suggestions related to tobacco use and its cessation, the challenges faced by patients in receiving cessation support,

their experiences during cessation attempts as well as the support they require in order to quit successfully.

Methodology

Study design

The study used a qualitative approach consisting of semi-structured in-depth interviews.

Study settings

Two study sites from Kenya were selected. The two sites in Kenya were Nairobi County (Capital city) and Nyanza County. Nairobi is the capital centre with the major base for policy makers and diverse health facility settings, while Kisumu is a growing city with the major referral hospital serving three regions (Nyanza, Western and North Rift Kenya), with a population in excess of five million. Hospitals in Kenya, apart from the main referral hospital (run by the national government), are run by the county government.

In both Nairobi and Kisumu, the study sampled participants from different hospitals within the cities i.e. both public and private. This ensured a good representation of the different socio-demographic characteristics of the patients. The main hospital in Nairobi was the Kenyatta National Hospital, which is a public, tertiary, referral hospital having over 6000 staff and has a bed capacity of 1800. This hospital served as the urban site for the present study. In Kisumu, Jaramogi Oginga Odinga referral hospital was the major referral hospital in Nyanza, serving a population in excess of 5 million; average annual out-patients' visits are 197,200 and in-patient admissions of about 21,000, with a bed capacity of 467. This hospital served as the main rural site for the study.

Study population: The study recruited patients who were seeking care from the two main hospitals and neighboring private hospitals.

The inclusion criteria for the study participation were: current or past tobacco user, receiving routine clinical care from at least one of the health care facilities in the selected study areas during the previous six months, and was willing to provide written informed consent for the study.

Sampling, recruitment and consenting process

Nineteen (19) participants were recruited from the different healthcare facilities in Nairobi and Kisumu between May 2017 and October 2017 using purposive sampling and snow balling (done particularly within Tuberculosis clinics). This number was arrived at after reaching data saturation. Purposive sampling for patients was done based on characteristics such as age, gender, residence [urban/rural with varying levels of socioeconomic status(SES)], the level and type of healthcare facility the patient usually receives care from, tobacco use status (current tobacco user/ past tobacco user and smoker/smokeless tobacco user), tobacco intervention status (those currently under pharmacological or non-pharmacological intervention / those who received and successfully completed interventions previously / those who started pharmacological or non-pharmacological interventions and did not complete them). After the initial eligibility assessment and obtaining the informed consent, participants were interviewed with the help of semi-structured interview guides. Face-to-face interviews were conducted by staff (YO, JK and JWM) trained in conducting qualitative interviews. The interviews explored the awareness of patients regarding harmful effects of tobacco use, their perceptions, beliefs, and suggestions related to tobacco

use and its cessation, along with the challenges faced by patients in receiving cessation support, their experiences during cessation attempts as well as the support they require to quit successfully. The interview guides were originally developed in English and translated to Swahili (national) language. All the interviews were audio-recorded using an audio voice recorder. Additional notes and non-verbal cues were recorded by the interviewers. The interviews lasted 40-45 minutes. Efforts were made to conduct the interviews in a private and comfortable space that was deemed suitable for the respondent. Consolidated criteria for reporting qualitative research (COREQ) guidelines were followed.

Ethical considerations

Written informed consent was taken, before enrolling the participants into the study. Ethical clearance was obtained from the KNH/ERC committee (P22/01/2017). This study was a part of a broader study on barriers and facilitators of tobacco cessation conducted in Kenya and India.

Qualitative data analysis

The interviews were recorded and transcribed in full. Following verbatim transcription in the local language, the transcriptions were translated to English. Nvivo v 10 qualitative data analysis software (QSR International, Melbourne, VIC, Australia) was used for qualitative data management. Content analysis method was used, where the content of text was analyzed in both inductive and deductive manner to generate codes and sub codes. Appropriate themes and subthemes were generated by grouping appropriate codes and sub codes. Coding was done by AM and RPK (Research Assistant). AM has experience of conducting qualitative analysis and had trained RPK. Any discrepancies were finalized in discussion with YO.

Results

Table 1 outlines the characteristics of the participants.

Characteristic		N=19
Age, mean (in years)		**40.2**
Gender		
	Male	14
	Female	5
Residence		
	Urban	10
	Rural	9
Socioeconomic status		
	High	5
	Low	14

Findings

Awareness regarding harmful effects of tobacco use

Most patients responded that tobacco has harmful effects on lungs, oral cavity (yellowing/browning of teeth, tooth cavity, tooth loss and affects the gums as well), skin and causes loss of appetite. With respect to lung problems, most mentioned cough, chest infections, and shortness of breath. Some of them mentioned cancer, and a few specifically mentioned lung cancer. Similarly, a few said that it can cause tuberculosis. Many of the participants also mentioned that it can lead to impotence. Some of them mentioned its effect on mental health because of its addictive nature and hallucinations. Other less common responses were that it makes the blood thin, causes throat cancer, deformity in babies, yellow fingers, and affects the work of other medications which are being taken for other conditions.

"lung cancer, impotence, mmm, it ruins your teeth, actually, mmm... I don't know what to call it, yellow fingers, mmm yeah, it ruins your fingers. Yeah." (22 yr old, Female, Urban, Current smoker, Low SES).

Lack of awareness regarding tobacco cessation clinics and lack of tobacco cessation interventions

Almost all participants mentioned that they are not aware about any institutions which provide tobacco cessation services outside the health system. They also mentioned that nobody had given them particular quitting skills, but they were just told to stop smoking. None of the participants was aware of nicotine replacement therapies.

"I have tried stopping smoking and it did not work.....the doctors just tell you to stop because it will hurt you. But they don't tell you how. Yeah...they just say stop. I have tried..... even gone to church, but I can't. I can't. They need to give us something to help us stop." (36 yr old, Male, Urban, Current smoker, High SES).

Unpleasant experiences among current and past tobacco users

The participants had varied experiences in terms of how it had affected their bodies, and their daily life, including societal dimension. Most of them had experienced chest related problems, mainly cough, cold and breathlessness. Some reported that they experienced easy tiredness on doing strenuous jobs like running and jogging, and some others reported headaches. Other less common responses were stomach aches, feeling uncomfortable, lack of appetite, bad smell, chest pains, hoarse voice, loose tooth and tooth loss, diarrhea, made them bored and lethargic with morale going down, that it made one thinner, and brought family problems.

"For all that time I have smoked, you can see that I am even coughing, I feel some chest pains. When I cough, there's sputum.....yeah, thick and heavy one, but I can't stop; it has a really bad taste.....I can't sleep without cigarette. When I just sleep in my bed, tiaah!, I will smoke, when I finish, I throw it away, and there I sleep! But sleeping just like that, I can't, those are some of the effects of tobacco." (43 yr old, Male, Rural, Current smoker, Low SES)

Motivation for quitting tobacco

More than half of the participants believed that self-talk and self-motivation is the key. Some participants also believed that religious places and institutions help provide the necessary motivation. However, one of them was of view that religious places cannot help those addicted to tobacco. A few participants got motivated to quit since their bodies had got affected by it or there was fear of being sick. Similarly, a few also

reported that non-availability of tobacco products also played a role in decreasing the urge and thus increased the motivation in them to quit. Some also pointed out that wastage of money was also a motivating factor.

"First I decided by myself, I was like I need to quit this. And then, like you should keep yourself away from an environment where people are smoking or people are doing Kuber. Yeah, just away from such people and yeah." (22 yr old, Female, Urban, Current smoker, Low SES)

Perceived social effects of tobacco use

In many cases, close family members were affected by tobacco use by the participants and this caused some issues in the family. Some even were fed up with the tobacco user.

"Yeah. And also my immediate family members. They didn't approve bad odor from my mouth. And it was also, okay, it was also affecting them." (33 yr old, Male, Urban, Current Smoker, High SES)

Participants experiences regarding help received from family and society in quitting tobacco use

Families played an important role and helped tobacco users in quitting tobacco. In one case, neighbors and relatives had helped.

"That's obvious like now your family should help also. To encourage you don't smoke, to remind you, don't forget to take this gum..... Family wise, people, neighbors you know..... try to organize. We don't need smoking area zone, they (family and neighbors) can do it, and we can do it. They should help, everybody should intervene about tobacco....." (65 yr old, Male, Rural, Current smoker, Low SES)

Challenges to quitting tobacco

Craving for tobacco by the users

"Apart from having the urge to smoke, for some, if they do not smoke, they cannot sleep, others, if they do not smoke, they get headaches, for others if they do not smoke, they cannot think clearly. So those are the major challenges smokers are facing here." (29 yr old, Male, Rural, Current tobacco user, Low SES)

Professional obligation and pressure to use tobacco was the reason in one case

"You know, a person like me, I am a sex worker and you might go with a client who wants you to smoke while he smokes. So it makes you smoke even when you have decided not to use today. Sometimes, you go with a client, let's say a European, and he tells you to do what he is doing." (40 yr old, Female, Urban, Current smoker, High SES)

Seeing others smoke was a challenge to control the urge in one case

"Mostly it's triggers. Yeah. When you see someone smoking, when you smell, like when you are outside, you smell the smoke, you feel like smoking. That's the main problem that we face." (26 yr old, Female, Urban, Current smoker, low SES)

Triggers for initiation and facilitators for continuation of tobacco use

Almost half of the participants agreed on the fact that peer pressure was the main trigger for initiation and continued use of tobacco.

"To me, myself, I would like to quit but in the society, see, in the society where I live, most of my friends are smokers, I have seen some of my friends who had quit cigarettes for may be two years, one year, three months, but when they come back to us, they find themselves back to.....to cigarettes."(42 yr old, Male, Urban, Current tobacco user, Low SES)

Participants' suggestions regarding what should be the steps towards tobacco control

Government Regulation

Completely banning tobacco products was one of the common suggestions given by the participants. Many of those who were in favor of banning considered the tobacco companies to be the main culprits and thought that they should be shut down, even if they were a source of employment to many. The reasons they gave were that if tobacco products were not available, people would not use them. A few also highlighted that prices of tobacco products should be increased so that people cannot use it, but a few others also were of the opinion that even if prices are increased (in form of added taxes or otherwise), tobacco users will continue to smoke. One participant was very negative regarding government regulation and was very sure that government won't be able to put complete ban since government collects taxes through tobacco products. One of them also suggested that nicotine gums should be more affordable as these are currently very pricey.

"Let the companies close, the people will get other work.....I do not know what else the government can do other than closing the companies..... they should ban it like changaa [local illicit alcohol]." (55 yr old, Male, Rural, Past smoker, Low SES)

"In my opinion on cigarettes, they should hike the price so that people cannot afford." (40 yr old, Female, Urban, Current smoker, Low SES)

Creating more awareness among people

Participants were of the view that it is important to spread awareness, and make people understand, especially the negative effects of tobacco use, else it is not going to be effective. Some also mentioned that in addition to health effects, teaching about financial costs of tobacco use and giving examples of people who have suffered should be done.

"I would love to see people being taught about tobacco, being counseled on tobacco because it is the cause of everything.....I would like the government to be told that cigarette is a bad disease it should look for something." (49 yr old, Male, Rural, Current smoker, Low SES)

Discussion:

Findings from this study revealed the following:

1) Awareness regarding harmful effects: Participants were of view that tobacco use causes cancer, respiratory problems, impotence, lack of sleep and appetite and discoloration of the teeth. '

2) Lack of awareness regarding tobacco cessation clinics and lack of tobacco cessation interventions: Participants mentioned that they are not aware about any institutions which provide tobacco cessation services. Others mentioned that they had not been offered any support to quit; very few had been asked about their tobacco use status.

3) Quitting tobacco use challenges: Respiratory problems, headache, lack of sleep and appetite, urge to smoke and the smell of smoke were the key challenges.

4) Motivating factors to quit: Religion, support from family and friends, poor health condition, less availability of tobacco products and financial problems were the factors cited.

5) Need for enhanced tobacco control: Participants perceived the need for more awareness campaigns about harmful effects of tobacco use, provision of more tobacco cessation services, and implementing policies

such as banning tobacco and increasing tax. Tobacco cessation interventions are already known to be among the most cost-effective interventions available in reducing the risk of mortality among tobacco users. To our knowledge, this is the first qualitative study from Kenya reporting the perceptions, experiences and challenges of patients with cessation interventions while seeking healthcare services. The current study highlighted that most of the participants know the impact of tobacco use on their lives and to their families, but they still struggle to quit successfully. This is not surprising as nicotine is very addictive, and quitting smoking has been compared to being as difficult or even more than quitting heroin use. In the present study, some participants had reported withdrawal symptoms as a challenge. Twyman et. al., also found that enjoyment (79%); cravings (75%); and stress management (36–63%) are the most frequently reported barriers. Irritability (39–42%); habit (39%); withdrawal symptoms (28–48%); fear of failure (17–32%); and concern about weight gain (27–34%) were also identified as barriers to cessation. Weight gain was however not identified as barrier to cessation among the study participants; this could be because, particularly in Nyanza region- culturally, big bodied women are seen as a sign of good health and found to be attractive. A study by Kim S-J et al; found an association between unsuccessful smoking cessation and higher stress levels [odds ratio (OR) 1.11, 95% confidence interval (CI) 1.09–1.14, $p < 0.001$]. These challenges reported by the participants are usually anticipated in those making tobacco cessation attempts, and therefore the tobacco cessation programs are able to address them. Healthcare facilities should be well equipped to attend to patients experiencing withdrawals and support their cessation efforts. Tobacco cessation pharmacotherapy and behavioral support have been identified to be evidence-based strategies. Another challenge highlighted was peer pressure. This is similar to other studies that have shown that smokers who reduced their number of smoking friends were more likely to quit smoking as compared to smokers who had no change in smoking friends. A smoker's perception of strong social support for quitting from family and friends is also associated with greater success in quitting. Some of the motivating factors reported by the participants included religious beliefs, family and friends support, poor health and financial problems. Similar to our findings, a study by Rosenthal et al; found that social support (from doctors, friends, and family), social norms, one's own health, and children/grandchildren's health were highly endorsed as motivators to cessation attempts. Echer IC and Barreto also found spirituality as a motivator to cessation. Their study reported the need for professional, family, social and spiritual support, conditions that worked as factors that motivated tobacco cessation. Unfortunately, almost all the participants mentioned that they were unaware of places where they could access tobacco cessation services. Most of the participants reported lack of access to smoking cessation support. One study had reported lack of training of healthcare providers in cessation interventions, they were not enquiring about history of smoking in the patients, along with pharmacotherapy like nicotine patches and nicotine gums not being readily available; and where available, not affordable, were the major challenges for cessation. Kenya ratified the framework convention tobacco control (FCTC) in 2004, after which it enacted the Tobacco control act 2007 as well as the tobacco control regulations 2008, which have guidelines on tobacco control and provision for tobacco cessation support. Unfortunately, these policies have not been effectively implemented. In 2018, the national tobacco cessation guidelines were launched and were expected to address this gap raised by the participants on access to

cessation support, and particularly provide accessible cessation support to patients as they attend healthcare facilities. Participants mentioned that creating more awareness about harmful effects of tobacco use, banning tobacco, increasing tax and availing services for tobacco cessation might increase tobacco cessation positive outcomes. Smoke-free laws and policies have been associated with a lower smoking prevalence by youth and young adults. Living in an area with 100% smoke-free laws in workplaces has been associated with lower odds of smoking initiation among adolescents and young adults (OR 0.66, 95% CI 0.44–0.99). Substantial evidence base supports the effectiveness of public policies to reduce tobacco use. Most tobacco control policies act by reducing the demand for tobacco products. Such measures include increasing the price of cigarettes by raising tobacco excise taxes, adopting smoke-free policies for indoor areas, mandating health warning labels on tobacco packages, and supporting mass media campaigns to educate the public and promote cessation. These policy restrictions are outlined in the Tobacco control act; but their implementation has been poor. Lack of resources and government funding gets in the way of implementing effective smoking cessation interventions. Lack of availability, accessibility and affordability of pharmacotherapy products puts them beyond the reach of the smokers.

Strengths and limitations

The study has key strengths, including focusing on identifying perceptions and experiences of the participants towards tobacco use in their local healthcare facilities using qualitative methods. Secondly, the study was performed in a novel setting, while attending to those in the urban, rural, low social economic status as well as high social economic status. However, our study also has a limitation. We targeted patients visiting healthcare facilities, thus, might have missed out on the view of tobacco users who did not suffer from any physical illness.

Conclusions

Healthcare workers need appropriate training in tobacco use screening; assessment and in providing evidence based interventions. Pharmacotherapy to provide support during the withdrawal period and to help sustain successful cessation should also be readily available in healthcare facilities. There are missed opportunities to promote smoking cessation for example whilst patients are in outpatient waiting areas and accident and emergency departments; as well as providing brief interventions during their clinical consultations. We found that most participants in our study did know that tobacco was harmful for their health. Most of the tobacco users had experienced unpleasant symptoms during tobacco use. The main challenges to quitting were addiction to nicotine and peer pressure. Self-talk and self-motivation were perceived as main source of motivation to quit. Religion, support from family and friends, poor health, low availability of tobacco products and financial problems were also the factors cited as motivating factors to quit. Creating more awareness, increased taxation and policies like banning tobacco products were the main suggestions. Health worker training, availability of cessation medications, health education and increased government support to enhance cessation support are the key steps towards success.

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Authors contributions:

All the authors designed the implementation, reviewed the manuscript, data collection tools and procedures. YO took part in the data collection. AM participated in data analysis. This manuscript was written by YO, with input of all co-authors who provided critical revisions. All authors have read and approved the final manuscript.

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Abstract

Drugs and alcohol abuse impairs an individual's ability to live a normal life. These problems relate to all spheres of life; physical and mental health, social and economic. With rehabilitation it is expected that these aspects of quality of life will improve. However, majority of the studies have largely focused on abstinence as the rehabilitation outcome. This study aimed at establishing the perceptions of quality of life among persons recovering from alcoholism after presidential crackdown and subsequent rehabilitation in Kirinyaga County. The study utilized a descriptive survey. The study population was drawn from persons attending community support groups established after presidential crackdown on illicit brew and subsequent rehabilitation. A multi-stage purposive sampling method was utilized to get eleven (11) support groups and one hundred and forty-one (141) respondents. A Questionnaire and a focus group discussions were utilized to collect data. Abstinence was measured using Recovering Addicts Adherence Scale (RAAS) which was adapted from Alcoholics Anonymous Affiliation Scale. Perceptions of quality of life outcomes were measured using Recovering Addict's Quality of Life Scale (RAQOLS) which was adapted from the World Health Organization Quality of Life instrument (WHOQOL-BREF). Data collected was coded and analysed using Statistical Package for Social Sciences (SPSS) version 23 and analysed using descriptive statistics. The study findings revealed favourable perceptions of quality of life in all the four domains. Physical health was rated moderate while social health was rated highly. This can be attributed to the support groups which emphasized on empowerment of the recovering persons and abstinence. Favourable rates of abstinence can also be attributed to improved quality of life. The implication to treatment is that domains of quality of life need to be emphasized during treatment process for the ultimate goal of rehabilitation to be achieved.

Keywords: *Community support groups, quality of life, abstinence, rehabilitation, recovering persons and alcoholism.*

Introduction

Many rehabilitation centres, government and private, inpatient and outpatient and after- care support groups have been set up in Kenya to assist persons recovering from drugs and alcohol addiction change their addictive behaviours. This is aimed at helping them achieve a lasting abstinence and improve the quality of their current life. In essence they return to their normal life functioning. However, majority of studies have mainly focused on abstinence and rates of relapse

Although over the years the goal of substance use treatment and rehabilitation has been achievement of abstinence and prevention of relapse, a key question that arises is whether abstinence is the only expected rehabilitation outcome and predictor of successful treatment. Substance use affects individual's physical and mental

social functioning. Apparently these are the domains of quality of life emphasized by World Health Organization (World Health Organization ,1997). Substance use affects these domains of quality of life and dissatisfaction experienced can lead to more indulgence in substances to avoid the unpleasant impacts and emotions.

According to Borges, Ketsela, Munodawafa & Alisalad, (2013) alcohol use results in permanent health damage, neuropsychiatric disorders, and social problems such as unemployment, violence, trauma and death. This results in poor perceptions of quality of life of the affected persons. American Psychiatric Association (2013) also correlates drugs and alcohol use with deterioration of quality of life. They associate use of drugs and alcohol with impairment on an individual's functioning. The normal functioning is thus replaced with a persistent need which results to recurrent use of drugs and alcohol. This calls for demand for more money and time to satisfy the cravings. Less time is left for attending to family, occupational duties, responsibilities, to nurture meaningful relationships and attend to leisure activities.

Studies have shown that persons with substance use disorders experience poor quality of life. Muller, Skurtyet and Clausen (2016) studied quality of life indicators amongst drugs and alcohol addicts on admission to a Norwegian treatment program. They discovered that among both males and females, majority of them (75 percent) reported either poor or very poor quality of life on admission. Further, the author's states that persons with drugs and alcohol addiction report substantial poor quality of life comparable to those suffering from serious psychiatric disorders. Majority of respondents (75%) reported low levels of quality of life ranging between poor and very poor for both genders.

Vederhus, Prip and Clausen (2016) also observed that patients with drugs and alcohol in a detoxification general hospital in Norway had significant low quality of life on physical, psychological, social and existential domains. Abdu-Raheen (2013) studied sociological factors and effects of drug abuse in Nigeria and reported that health, social, psychological, physical, cultural and moral consequences of alcohol use result in poverty, disability, maladjustment, death and poor academic performance among students. These studies have shown that persons dependent on drugs and alcohol have poor quality of life on various domains. Treatment and rehabilitation should aim at improving these domains of quality of life affected by alcohol addiction. Improvement on these areas then reflect an effective rehabilitation process. Assessment of perceptions of quality of life domains is therefore important at all stages of substance use treatment and rehabilitation to discern the progress of the effort and programs.

Improvement in quality of life outcomes is depicted in the reduction of the major drug used and improvement on an individual's life functioning domains. The concept of quality of life embraces the central notion that health is not restricted to the absence of a disease (to Faller, da Rocha, Benzano, Lima & Stolf ,2015). It also includes a state of social, mental, and physical well-being (Office of Disease Prevention and Health Promotion,2020). This signifies that an assessment of quality of life domains captures the full impact of addiction on the individual. Quality of life involve assessment of how drug-dependent individuals experience their daily lives (Zubaran, Emerson, Sud, Zolfaghari & Forest, 2012). Assessment after rehabilitation captures how an individual experiences life functioning after treatment. This permits a holistic focus on the far-reaching objective of rehabilitation which is achievement of abstinence and prevention of relapse as well

as improving the addict's quality of life.

Qualitative studies have shown that the desire to amend the negative effects of substance abuse on a patient's life and improve the domains of quality of life is a more explicit goal of treatment among patients than reducing substance use itself. Muller Skurtveit & Clausen (2016) adds that poor quality of life may also be a predictor of treatment readiness. Persons using substances seek help in quitting drugs and alcohol as a way of escaping destructive impacts of addiction and to acquire better life (Laudet, 2011).

Improvement in quality of life outcomes is depicted in the reduction of the drug of choice and improvement on an individual's life functioning domains. Domains of quality of life improve with abstinence then deteriorates with relapse. It also improves with both short term and long term abstinence among individuals' dependent on alcohol following treatment. (Srivastava, Bhatia, Rajender & Angad ,2009). Abstinence therefore is a contributing factor to quality of life. Quality of life also help in sustaining abstinence. In Norway, Vederhus, Prip & Clausen (2016) observed modest improvements in various domains of quality of life after six months follow-up. Reduction in alcoholism increased prosocial behaviour which were inferred from decreased number of arrests, improvements in quality of life and community involvement. Srivastava & Bhatia (2013) observed that quality of life improved significantly through the three months of treatment in four domains of quality of life in India. These were, physical, psychological, social and environmental domains. Laudet (2011) found that higher quality of life at treatment discharge predicted abstinence better than traditional substance use disorder characteristics. Therefore, quality of life plays an important role in recovery from substance use disorders.

However, despite their importance as rehabilitation outcomes and in promoting abstinence, quality of life indicators has scarcely been included in the studies of drugs and alcohol addiction. (Dawson, Li,Chou, & Grant, 2009; Preau et.al.2007 as cited in Laudet, 2011). Laudet, (2011) add that quality of life in relation to addiction is an emerging issue. Muller, Skurtyet & Clausen (2016) emphasized that the immediate goal of reducing alcohol and drug use is necessary but rarely sufficient for the achievement of the longer-term goals of improved personal health and social function and reduced threats to public health and safety—i.e., recovery. This implies that improvement in the domains of quality of life after treatment and rehabilitation reflect effective rehabilitation. A focus on these aspects of life functioning gives an all-inclusive picture of the success of rehabilitation process. Therefore, quality of life is critical to the goal of recovery.

Quality of life require to be incorporated in assessment, treatment and in after care programs. According to Muller, Skurtyet & Clausen (2016) quality of life measures help in determining factors that could lead to relapse after treatment. Determining whether their employment status, health, and family contact, for example, are satisfactory or not help clinicians recognize problems other than the specifics of the disorder hence make better treatment decisions and priorities and help determine where to focus treatment services. Knowing the variables that influence recovering person's' well-being can help focus treatment toward person-centred needs and goals. This can result in improvement on treatment engagement, retention and success.

Improvements in key domains of quality of life should be included among the goals of treatment. Assessing quality of life at intake can be an opportunity to learn about patient vulnerabilities. Continued measurement of

assessment can help guide further treatment plans. It is also an outcome measure of treatment, which for a chronic condition must be monitored and addressed during the course of the disorder at various phases during treatment. If treatment's goal of recovery and improved well-being is to be achieved, services must be offered on multiple levels and empower patients to improve numerous areas of their lives without focusing only on abstinence outcomes. Majority of studies however in alcohol use have mainly focused on abstinence. This study therefore focused on domains of quality of life as an important outcome of rehabilitation which eventually enhances abstinence.

The study was done in Kirinyaga County as one of the counties which previously formed Central Province of Kenya. These counties had experienced serious impacts of alcohol use including illicit liquor which necessitated a crackdown order by the President in 2016 (War on Illicit Brew is still on, 2015). A Baseline Survey on Alcohol and Drug Abuse in Central Province, carried out by NACADA in 2010 indicated that Kirinyaga County scored a high of 75.4%. Following the crackdown was subsequent establishment of community rehabilitation centres. Kirinyaga County further established support groups immediately for continuum of care under the Department of Social Services. In Kirinyaga County, the support groups were an extension of the rehabilitation programs geared towards sustaining abstinence and empowerment through various economic projects such as poultry, farming and table banking. Due to scarcity of documented studies on support groups and domains of quality of life, this study purposed to establish the perceptions of quality of life among persons recovering from alcoholism in Kirinyaga County.

Theoretical Framework

The study was based on Marllat's Cognitive-Behavioral Model of Relapse proposed by Marllat and Gordon in 1985. Basic assumption is that relapse is preceded by a high risk situation, outcome expectancies and covert antecedents such as lifestyles, urges and cravings. It is based on cognitive behavioural models which attribute relapse to contextual factors and cognitive processes (Handershot, Witkiewitz, George & Marlatt, 2011). In this study, this model is used to explain how relapse occurrence is related to perceptions of quality of life domains.

The model proposes that a person feels in control when he or she maintains abstinence or complies with the rules that govern a given behaviour. The perceived control persists until the person encounters a situation that has a high potential for relapse. The danger of relapse threatens the sense of control achieved and eventually increases potential of relapse. The situations that poses the highest risk of relapse are undesirable emotional statuses, relational skirmishes and social influence. Apparently these are some of the aspects of quality of life that are affected by addiction and are expected to improve with achievement of abstinence. This theory informs this study that the risk of relapse will increase if domains of quality of life do not improve. Initial lapse is precipitated by an inability to deal effectively with these situations (undesirable emotional statuses, relational skirmishes and social influence). These then exposes the recovering persons to the greatest risk of relapse.

Objectives of the study

The specific objective was to establish the perceptions of quality of life among persons recovering from alcohol addiction in Kirinyaga County.

Research Methodology

The study used a descriptive research design to describe the perceptions of quality of

life and generate both quantitative and qualitative data. The design was utilized to Hence confining the study to the nature of perceptions of quality of life. The study was conducted in Kirinyaga County among persons attending community based support groups. The target population included both males and females recovering from alcohol addiction. The support groups were chosen to enable the study perceptions of quality of life as reflected in the experiences of recovering person's daily lives outside the confinements of a rehabilitation centre.

The study used multi-stage sampling technique in order to get a representative sample. The sample size of support groups was determined by adopting a formula by Kathuri and Pals (1993) for estimating sample size (n) from a known population size (N).

$$n = \frac{\chi^2 NP\ (1-P)}{\chi^2\ (N-1) + \chi^2 P\ (1-P)}$$

Where n= required sample size
N= the given population size of potential adults 12 support groups and 439 members.

P= population proportion assumed to be 0.50
χ^2= degree of accuracy whose value is 0.05
χ^2= table value of chi-square for one degree of freedom which is 3.841

Substituting these values in the equation, estimated sample size (n) for support groups would be

$$n = \frac{3.841 \times 12 \times 0.50\ (1-0.5)}{(0.05)^2\ (12-1) + 3.841 \times 0.5\ (1-0.5)}$$

verbose

n= 11

The eleven groups were randomly selected by eliminating the group picked from a pool of folded papers with the group names. Purposive sampling based on the willingness of the participants present at the period of study to participate enabled recruitment of 141 participants. Dattalo (2008) states that purposive sampling can be applied to select participants based on their willingness to participate. Two focus groups comprised of 16 participants who were randomly selected from the research participants.

Table 1

Distribution of Participants among Community Based Support Groups

Support Group	Sample Size
Kiamwenja	11
Kakanga	15
Kagumo	12
Kaitheri	18
Kerugoya	20
Sunrise	8
Difsthas	7
Wamumu	10
Mumbui	15
Kiamuthambi	16
Jitegemee	9
Total	**141**

A pilot study was carried out at the Clinic of Substance Abuse Treatment (CSAT) in Mathari hospital centre in Nairobi County. The pilot study utilized clients who had gone through rehabilitation, inpatient or outpatient. Results of the pilot study were used to improve on the validity and reliability of the instruments. Results of Cronbach's Coefficient Alpha analysis implied a reliability of the instrument with a reliability coefficient of 0.968.

This study was undertaken between November and December 2017. A questionnaire and a focus group discussion guide were utilized in data collection. The first section of the

questionnaire was used to collect data on demographics characteristics while Recovering Addicts Quality of life Scale was utilized to collect data on perceptions on quality of life. Recovering Addicts Quality of Life Scale (RAQOLS) was adapted from the World Health Organization Quality of Life instrument (WHOQOL-BREF).

According to WHO (2018), WHOQOL-BREF has good discriminant validity, content validity and test-retest reliability. Domain scores produced by the WHOQOL-BREF correlate at around 0.9 with the WHOQOL-100 domain scores. It was used to assess patient's perception of how they were functioning on four domains: physical health, Psychological health, Social relationships and environment. Physical health comprised of 7 items: Psychological health 6 items, Social relationships 3 items and environmental had 8 items. The responses in all the four domains were rated using a Likert scale of 1 to 5 (1-Not at all, 2-A little, 3-Moderate amount, 4-Very much, and 5-An extreme amount). The last section was used to collect data on the respondents' perceptions on interventions that can be applied to enhance various domains of quality of life.

Data Analysis Procedures

Data from the questionnaire was analysed descriptively while data from the focus group discussions was analysed using content analysis by deriving themes based on respondent's perceptions of their quality of life. The scores from Recovering Addicts Quality of Life Scale (RAQOLS) were analysed based on the four domains of quality of life as follows: Physical Health, Psychological Health, Social Relationships and Environment Quality of Life. The scores were then divided into three levels representing low perceptions, moderate perceptions and high perceptions on various domains quality of life.

Demographic Characteristics of the Respondents

A total of 141 respondents participated in the study. Sixteen of them participated in the focus group discussion. Majority of the respondents were males (57.4%), compared to 41.8% females. Respondents that were aged between 26 to 35 years were 27.0% while 36.2% ranged between 36 to 50 years. The respondents that were married were 56.7% while 31.9% indicated that they had been divorced. Forty-one percent (41.1%) of the respondents had been able to abstain from alcohol for a period of 1 to 3 years, while 17% had abstained for about 6 months. Since majority of the respondents were a cohort thus left rehabilitation during the same period, this indicates that the rate of abstinence in relation to the period of abstinence increased with time.

The total number of 67.4% respondents indicated that they were in a community rehabilitation program before joining the support groups while 14.2% had not gone through rehabilitation program at all. Those who had been in rehabilitation for the first time were 85.8%. This could be attributed to the fact that majority of respondents were rehabilitated after the President ordered a crackdown on illicit brew in the counties that formerly formed the Central Province of Kenya. Scarcity of public rehabilitation centres in the rural areas and high cost of private in-patient rehabilitation centres could have prevented many persons struggling with addiction from seeking treatment before the crackdown.

On the type of addiction, 57.8% were addicted to alcohol, while 26.7% used both alcohol and other drugs. The type of alcohol mostly abused was second generation alcohol and beer indicated by 61.1% and 38.9% respectively. This correlate with findings observed in other areas for example, alcohol was also found to be more prevalent in Rwanda with 34%

followed by tobacco with 8.5% and cannabis with 2.7% (Kanyoni, Gishoma & Ndahindwa, 2015). Second generation types of alcohol may be the most abused due to the fact that they are cheaper and affordable than other types of alcohol for low income earners in the rural areas.

On attendance to support groups, 70.9% of respondents in Kirinyaga County began attending support group meetings immediately, 36.9% of the respondents indicated that they attended support group meetings very often while 26.2 % attended often and 26.2% sometimes respectively. The favourable attendance could be due to the unique nature of support programs, the support groups were an extension of the rehabilitation programs geared towards sustaining abstinence and empowerment through various economic projects such as poultry, farming and table banking.

The empowerment programs may have been the motivation behind the attendance of the meetings. This is by improving their lives and enhancing their quality of life positively. This was supported by the focus group discussions. "We save kshs. 50 per person, then share where I get about a thousand and I'm able to buy food for my cows, and improve my life." Another respondent said "I'm able to invest in chicken project where I get money for my family after selling the eggs." The reason may due to their social status since majority of them depend on casual labour to earn a living and thus when such an opportunity arises they give it the first priority. This was noted also during the focus group discussions 'One respondent reported "Sometimes I do not come for meetings because I have to go to work at the construction or else I lose the opportunity to someone else, that is where I also get money for table banking"

Though economic activities are important in improving quality of life, involvement and participation in the activities is equally important. Active involvement provides more opportunities to members to learn from peers during and after the meetings. Tracy and Wallace (2016), suggest that active engagement in peer support groups is a key predictor of recovery and also sustain recovery. Findings from focus group discussions support this view where respondents said that from the support group meetings they were able to support each other, get advice from others, get new ideas and continue to be sober.

The implications is that there is need to provide information on recovery resources after treatment to ensure the respondents attend support groups after rehabilitation for continuum of care. According to Donovan, Ingalsbe, Benbow and Daley (2013) although early and frequent attendance / involvement (e.g., three or more meetings per week) is associated with better substance use outcomes, even small amounts of participation are helpful in increasing abstinence. However, higher amounts of adherence are needed to increase abstinence and reduce the risk of relapse. The support groups need to incorporate activities that are geared towards improving quality of life in addition to sustaining sobriety. These activities are a motivation in themselves to continue attending support group and also help in improving quality of life.

Results of the Study

Perceptions on Quality of Life domains among Persons Recovering from Alcohol Addiction

Quality of life was assessed in terms of satisfaction with their physical health, psychological health, social relationships and their living environment. The findings are as shown in the following sub-sections.

Physical Health

Results on perceptions of physical health are presented in table 2 and table 3

Table 2

Frequencies of Perceptions on Physical Health

Quality of Life	Frequency	Percent
Low quality of life	15	10.6
Moderate quality of life	68	48.2
High quality of life	58	41.1
Total	**141**	**100.0**

From table 2 majority of the respondents (48.2%) had a moderate perception on quality of life. Descriptive statistics of the same are presented in Table 3.

Table 3

Descriptive Statistics of Perceptions on Physical Health

County		N	Minimum	Maximum	Mean	Std. Deviation
Kirinyaga	Physical health	141	11	35	23.18	3.752
	Valid N (listwise)	141				

Table 3, indicates that the lowest score attained by the respondents was 11 while the highest score attained was 35. The mean score was 23.18 (SD=3.752) which indicates that the perceptions on quality of life in terms of physical health was on the moderate level (19-24). Favourable perceptions on physical quality of life in the current study were further supported by the reports in the focus group discussions. A respondents reported that "I am able to eat well, sleep and even maintain hygiene after rehabilitation."

Psychological Health

Respondents were required to assess their satisfaction on the quality of their psychological health in a Likert scale of 1 to 5 Summary of the findings were presented in Tables 4 and 5

Table 4

Frequencies of Perceptions on Psychological Health

Psychological health	Frequency	Percent
Low quality of life	9	6.4
Moderate quality of life	33	23.4
High quality of life	99	70.2
Total	**141**	**100.0**

From Table 4, majority of the respondents (70.2%) had a high perception on psychological health. The data was further computed descriptively and presented in Table 5

Table 5

Descriptive Statistics of Perceptions on Psychological Health

	N	Minimum	Maximum	Mean	Std. Deviation
Psychological	141	7	30	22.80	4.213
Valid N (listwise)	141				

From Table 5 results indicate that the lowest score attained by the respondents was 7 while the highest score was 30. The mean score was 22.80 (SD=4.213) which indicates that the perceptions on quality of life in terms of psychological health was on the high level.

Social Relationships

Respondents were required to assess quality of their social relationships. Summary of the findings are presented in Table 6 and 7.

Table 6

Frequencies on Social Relationships Quality of Life

	Frequency	Percent
Low quality of life	9	6.4
Moderate quality of life	27	19.1
High quality of life	105	74.5
Total	**141**	**100.0**

As shown in Table 6, majority of the respondents (74.5%) had a high perception on social relationships quality of life. This indicate that many respondents had better social relationships. Further analysis was done on this and the descriptive results are presented in the Table 7 below.

Table 7

Descriptive Statistics of Perception on Social Relationships

	N	Minimum	Maximum	Mean	Std. Deviation
Social	141	4	15	11.52	2.238
Valid N (listwise)	141				

From Table 7, results indicate that the lowest score attained by the respondents was 4 while the highest score was 15. The mean score was 11.52 (SD=2.238) which indicate that the average quality of life in terms of social relationships was on the high level.

Environment

Respondents were required to assess quality of their life in terms of their satisfaction with their environment. The findings are presented in Table 8 and 9.

Table 8

Frequencies on Perceptions of Environment Quality of Life

Environment	Frequency	Percent
Low quality of life	15	10.6
Moderate quality of life	61	43.3
High quality of life	65	46.1
Total	**141**	**100.0**

As shown in Table 8, majority of the respondents (46.1 %%) had a high perception of quality of life followed by 43.3% who had moderate quality of life. The data was then analyzed descriptively and the findings are presented in the Table 9 below.

Table 9

Descriptive Statistics of Perceptions on Environment

	N	Minimum	Maximum	Mean	Std. Deviation
Environment	141	14	40	27.45	5.133
Valid N (listwise)	141				

From Table 9, results indicate that the lowest score attained by the respondents was 14 while the highest score was 40. The mean score was 27.45 (SD=5.133) which indicate that the average quality of life in terms of environment was on the moderate level.

Overall Perception on their Quality of Life and Health

Respondents were further asked to rate the quality of their life generally and the satisfaction with their health in a Likert scale of 1 to 5. The findings are shown in figure 1 and 2.

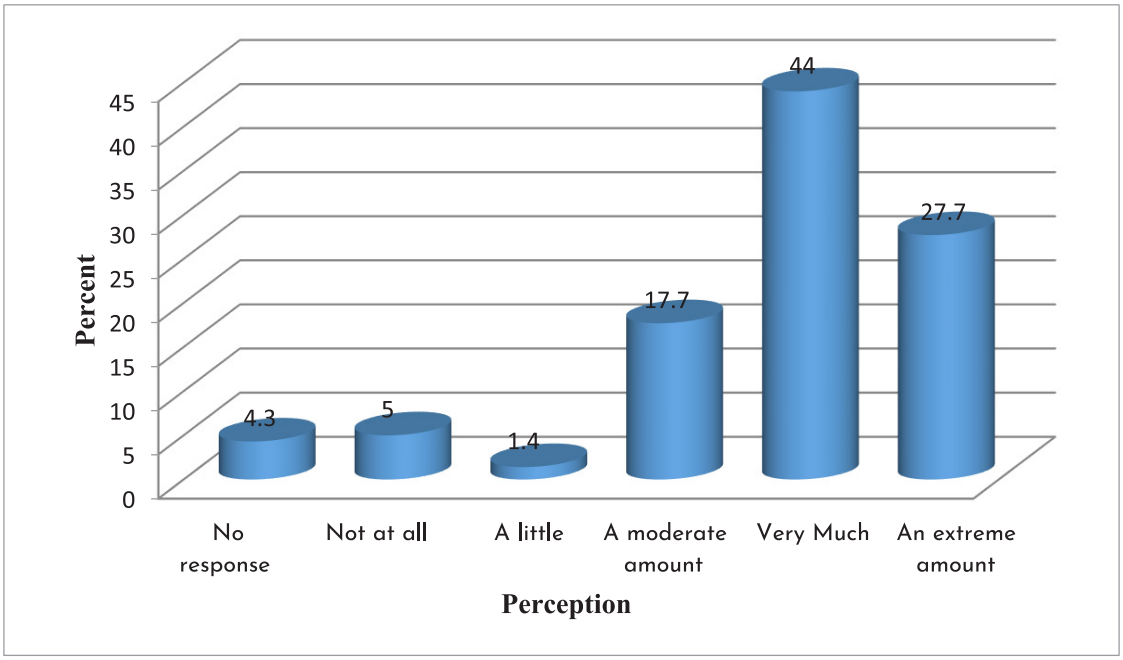
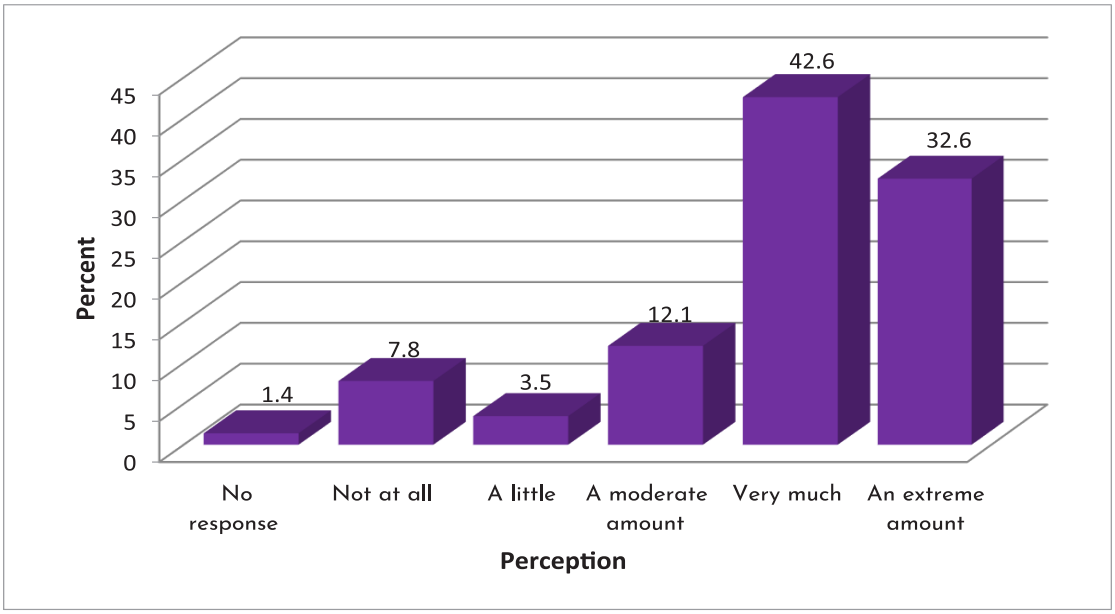


Figure 1 Perceptions of Respondents on the Quality of their Life.

As shown in figure 1, 44% of the respondents were very much satisfied with the quality of their life.

Overall Perception on their Quality of Health.

The overall perception on quality of health is presented in figure 2 belows



As shown in figure 2, majority of the respondents were very much satisfied with the quality of their health representing 42.6%.

The results were supported by data from focus group discussions. The respondents reported satisfaction with changes in their life as follows. They reported satisfaction with their ability to carry out their daily activities such as farming and feeding their cows, bodily appearance and on their physical strength, being able to eat, take a bath ,work, get home early and have time for my family, family members were happy and showed more love. A respondent said "I am even expecting a new born with my wife". Another one said "People have now started respecting me". These results agree with the goal of treatment according to NIDA (2012) which is to return people to productive function in the family, workplace and community.

Discussions of the Results

Better perceptions on physical health observed in the study could be attributed to two factors. First one is abstinence. These results compare with those in the literature. For instance, Srivastava and Bhatia (2013) found that physical health among other domains of quality of life improved significantly among 56 patients of alcohol dependence aged 18-45 years over a three months' study period in India. This was associated with complete abstinence and effective control of withdrawal symptoms. The second one is empowerment through community support groups.

Favorable satisfaction was expressed on psychological health among the respondents in this study. This can be associated with activities related to attendance to the community programs hence reducing chances of relapse. According to Faller, da Rocha, Benzano, Lima & Stolf (2015) the presence and absence of alcohol use disorders are strongly associated with changes in mental and psychological functioning. Srivastava and Bhatia (2013) associated improved psychological functioning to complete abstinence and effective control of withdrawal symptoms. The reductions in drugs and alcohol use result in decrease in problems associated with the abuse which eventually affects positively the psychological functioning.

The results also showed that respondents had good social relationship outcomes. An inconsistency is evident in existing literature. For instance, past primary studies searched in Web of Knowledge and analyzed by Poudel, Sharma, Gautam and Poudel (2016) found that social and family functioning improved over time while others found no differences at all. Current results can be explained by attendance to support groups which gives them empowerment economically and socially. Relationships are usually affected by alcohol abuse which makes a person unproductive and unreliable to support their families. Conflicts arising as a result of this make them indulge more into drinking and eventually severing more the social relationships. Findings on abstinence in this study indicated a notable decrease in alcohol and drug use. This can also be attributed to improved social relationships.

The respondents also seem to have favorable perceptions of their environment. Favorable perception can result to favorable psychological health which can prevent relapse. Negative mental state is one of the high risk factors of relapse in the Marllat's Cognitive-Behavioral Model of Relapse.

Overall perception of quality of life compares with those of prior studies. Parsareanu, Opsal and Vederhus, (2015) found significant improvements in quality of life among persons recovering from addiction in Norway. However, it was considered to be modest. Better perceptions in the current study can be attributed to community support groups. Improvement in quality of life is a predictor of treatment success.

Overall perception on quality of health can be attributed to better abstinence outcomes and adherence to support groups resulting

to improved health. Faller, da Rocha, Benzano, Lima & Stolf (2015) indicates that the problems observed in alcoholics such as medical issues are associated with the decrease in health quality of life more than with alcohol use itself. This implies that it's important to measure the problems associated with drugs and alcohol abuse in order to establish the status of health quality of life.

Conclusions of the Study and Implications to Treatment

The results indicate favorable perceptions on quality of life among respondents in Kirinyaga County in all the four domains. This can be attributed to achievement of abstinence and benefits reaped from participating in support groups.

After crackdown and subsequent rehabilitation, there is need for establishment of support groups. These can be either community based or those inclined to the 12 steps for continuum of care and to follow-up on the progress.

There is need for managers and rehabilitators in the rehabilitation centres and support groups to view the persons addicted to drugs and alcohol and recovering from addiction holistically and invest into the domains affected by poor quality of life. This would facilitate recovery.

Assessment for perceptions of quality of life on admission and throughout the treatment stages is necessary. This would help determine the effectiveness of the rehabilitation programs. Assessment after rehabilitation period should also be done as they transit to the support groups. This can be done during the termination of the residential program. Continuous assessment as well, may help determine the success of support group programs in sustaining the achieved quality of life.

Recommendation for further study

The current study used descriptive survey research method to establish perceptions of quality of life. There is need to conduct an experimental study to establish a causal relationship of attendance to support groups and perceptions of quality of life.

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Public Health in Urban Spaces; Vulnerability of Youth to Drug Abuse in Nairobi's Mukuru Kwa Njenga Informal Settlements, Kenya

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ABSTRACT

Rising urban population, deprivation, Poverty, shifting family practices and lack of opportunities for young people are widely recognized as key factors influencing the increasing indulgence of young people in crime and drug abuse (UN Habitat, 2007). The study sought to assess the vulnerability of youth in slums to drugs; specifically, Mukuru Kwa Njenga in Nairobi. The study is based on Vested Interest Theory (VIT). The interests of the individual postulate that an attitude toward objects allows for a number of responses and courses of action, in order to balance motivation and decision to behave in an efficient fashion. This research is a cross-sectional descriptive design to assess the vulnerability of youth in slums to drugs and more specifically Mukuru Kwa Njenga in Nairobi The study population was the youth both in and out of school in Mukuru kwa Njenga informal settlements. For this study purposive sampling, snowballing and simple random sampling approach were adopted. The sample size was 210 respondents derived following Krejcie and Morgan formula (1970) from a target population of 460. Thirty key informants from the study area were recruited. Interviews were used to collect data from key informants and questionnaires from youth and their leaders. Qualitatively, data was given in form of text whereas quantitatively, descriptive statistics including standard deviation and frequency distribution were used to describe given samples. ANOVA and Chi square were used to analyze data quantitatively. Cannabis (Bhang) is the most abused substance with 50% of the youth in the slums smoking it.

Keywords: *Drug abuse, slums, vulnerability, vested interest theory, youth*

Introduction

The United Nations Habitat (2007) states that over 50% of urban population is under the age of 19.8 years in many African cities. Rising urban deprivation, high employment rates, shifting family practices and deteriorating environmental and health conditions are negatively affected. Furthermore, poverty and lack of opportunities for young people are widely recognized as key factors influencing the increasing indulgence of young people in crime and drug abuse (UN Habitat, 2007). In slum areas and certain rural areas, with low income opportunities and a loss of trust, the high incidence of crime and drug abuse concentrate (UN Habitat, 2007).

The drugs issue, in conjunction with a high level of poverty, increases Africa's vulnerability in the face of social concerns, like crime, HIV and AIDS, according to Mashele in Geyer et al. (2015) "has become a serious

developmental challenge, and continues to undermine African government collective, personal, and individual efforts." Africa is a vulnerable transit region for both cocaine and heroin; while in recent years West and Central Africa have experienced increased cocaine trafficking. East Africa is increasingly emerging as a transit route for Afghan opiates bound for the European market. West Africa is also becoming a center for the manufacture of methamphetamine (UN, 2013).

Groups of young people classified as vulnerable may be susceptible to earlier, more severe, or more harmful substance use like children in care facilities or homeless young people (EMCDDA, 2008). KNDRP, 2009 states that about 60% of Kenya's urban population live in informal settlements such as slums. This leads to overcrowding in the slum areas and inability to live a decent lifestyle due to the absence of the social amenities. Of concern to this study are the types of drugs and substance and their potential impacts on youth located within environments such as Mukuru Kwa Njenga. The study sought to assess the vulnerability of youth in slums to drugs and more specifically Mukuru Kwa Njenga in Nairobi. Mukuru Kwa Njenga informal settlements is among the many informal settlements within Nairobi County which is characterized by improper infrastructural planning and the lack of basic social amenities. According to 2019 Kenya Population and Housing Census Report, the population of Mukuru Kwa Njenga is 242,941 living in an area of 2.8 kilometre squared and a population density of 87,538 which indicates there is congestion (2019 Kenya National Census Report). It had 49,198 households with a density of 16,720 persons per square kilometer. 75 percent of them youth. The increasing cases of unemployment amongst the youth has compelled majority of them to move to the urban slums and engage in activities that are considered socially unacceptable.

In a study by Wacuka (2018), the respondents were asked to indicate which drugs and substances of abuse most people use in Mukuru kwa Njenga slums. From the findings, 94.4% of the respondents indicated that cigarettes were the most abused drugs followed by Miraa (79.6%), beer(Keg) (75.0%), Busaa (68.5%), Spirits (65.7%), Changaa (47.2%), bhang (44.4%), kumikumi (38.0%), glue (19.4%), cocaine (4.6%), kuber (2.8%) and heroine (1. 9%).This implies that cigarettes, miraa, beer, busaa, spirits, changaa, bhang and kumikumi were commonly used in mukuru kwa Njenga.

Identifying vulnerable groups is becoming an important tool for directing and channeling drug policy responses at those groups or geographical areas where problem drug use is more likely to develop.

Vested Interest Theory and Susceptibility of Youth to Drug Abuse in Nairobi's Informal Settlements

Enhanced person disaster preparedness enhances the rates of survival of those involved and helps alleviate burdens on rescue and aid personnel, thus increasing the general resilience of the society (Landau, 2007; Norris, Stevens, Pfefferbaum, Wyche, & Pfefferbaum, 2008). The Kenya National Policy for Disaster Management-KNPDM (2009) views a hazard as something which negatively alters the life, environment, society or the physical wellbeing of individuals. Susceptibility to a drug refers to an individual's risk of developing an addiction to it during his or her lifetime (Wikipedia, 2015). And extreme poverty, inadequate social service, insecurity, crime, high level of unemployment, drug abuse are characteristics which interact in urban informal settlements and predispose the adolescents to risks in life. It is for this

reason that Sustainable Development Goal 3 aspires to strengthen the prevention and treatment of substance abuse including narcotic drug abuse and harmful use of alcohol (UN, 2015)

Research on disaster preparedness also shows that some population factors have a major impact on preparedness. It is time to raise awareness about increased resilience against the use of drugs and substances among vulnerable groups, especially young people in informal communities. Since the living and working conditions in informal settlements are extremely stressful, there is high risk in stress and psychological disorders. Many psychosocial health issues arise in cities such as depression, substance misuse, addiction, suicide, and interpersonal violence. Shauri (2007) says that vulnerability has worsened by the quick rise in population, urban poor, increased disagreements over resources, disease outbreaks and poor planning further highlights this.

Hazards are ever present in the slum areas and many of them, especially the natural hazards are interrelated since one hazard often leads to another as noted by Nomdo (2002). Slums are the largest markets to narcotics such as heroin. Despite the effort by the Kenya government to address inequalities within slums in Kenya, there it is still a big challenge (UN, 2006). Implicitly, Kenya has been a trafficking country but of late, reports indicate it is increasingly becoming an end-user. NACADA says 0.1% of Kenyans consume heroin (NACADA, 2017). The poor within Mukuru kwa Njenga informal settlements are not able to come up with proper designs and plans of the structures like houses which they use leading to their increased vulnerability. The poverty levels in urban areas especially in the informal settlements cannot allow the inhabitants to get proper employment, save, acquire assets which they have tenures and plan their livelihoods due to their stable incomes. This leads to them occupying disaster prone areas in informal settlements where they are exposed to hazards continually (Okello, 2016).

The teenagers and the youth in such an environment are pre-disposed to Drug and Substance abuse because aspects of the physical design of the environment can also harm young people's overall development and social relations and lead to the commission of crime and to substance use.

Methodology

Research Design

The researcher used mixed methods in this analysis. In recent years, research in mixed methods has become increasingly popular to mitigate the limitations and draw on the power of both methods (Bryman, 2006). The quantitative and qualitative data were collected concurrently, the priority between the two methods is equal and the results of the two methods were integrated during the interpretation phase as advocated by Creswell (2009).

Sampling Procedures

The target population is 460 youth distributed among 32 youth groups in the three locations of Mukuru kwa Njenga, Embakasi and Imara Daima. The following formula by Krejcie and Morgan (1970) was used to select the sample size for the study:

Table 1 Determining Sample Size from a Given Population

N	S	N	S	N	S
10	10	220	140	1200	291
15	14	230	144	1300	297
20	19	240	148	1400	302
25	24	250	152	1500	306
30	28	260	155	1600	310
35	32	270	159	1700	313
40	36	280	162	1800	317
45	40	290	165	1900	320
50	44	300	169	2000	322
55	48	320	175	2200	327
60	52	340	181	2400	331
65	56	360	186	2600	335
70	59	380	191	2800	338
75	63	400	196	3000	341
80	66	420	201	3500	346
85	70	440	205	4000	351
90	73	460	210	4500	354
95	76	480	214	5000	357
100	80	500	217	6000	361
110	86	550	226	7000	364
120	92	600	234	8000	367
130	97	650	242	9000	368
140	103	700	248	10000	370
150	108	750	254	15000	375
160	113	800	260	20000	377
170	118	850	265	30000	379
180	123	900	269	40000	380

190	127	950	274	50000	381
200	132	1000	278	75000	382
210	136	1100	285	1000000	384

Note. _ N is popultion size.

S is sample size

Source: Krejcie and Morgan, 1970

Using Miller and Brewer formula (2003), 210 youth were sampled from the 32 youth groups as shown below

Embakasi 11/32*210=72 youths

Mukuru kwa Njenga 13/32*210=85 youths

Imara Daima 8/32*210=53 youths

Data collection

Though the questionnaires could have made subjects to respond artificially, it assisted as a means of collecting information from a wider sample than can be reached by personal interview. Orally presented questionnaires created a rapport between the researcher and the respondents. The researcher clarified the purpose of the study thus motivating the respondent to respond to the questions.

Interviewing served well in Mukuru kwa Njenga as it fostered 'low pressure' interactions and allowed respondents to speak more freely and openly. It allowed the interviewee to delve more on the issues thus generating more information for the interviewer. Through the focus group discussion, the researcher explored more on issues of drug and substance abuse at Mukuru kwa Njenga informal settlements in Nairobi County. It assisted in determining the reason for their attitudes and beliefs.

The researcher also utilized both disguised and uncontrolled methods of observation. The choice of disguised and uncontrolled method of observation ensured that the researcher did not raise any suspicion among the inhabitants due to the sensitivity of the issue of Drug and Substance abuse. The use of disguised and uncontrolled methods of observation meant that the subjects would be observed in their natural settings without any alteration to their behavior whatsoever.

Most demographic information was obtained from census data and population statistics as well as other related databases. Literature on nature of drug and substance abuse in the selected informal settlements as well as use of social media among the youth was collected from written sources. It provided insight into how much work had already been done on the same topic and formed part of literature review. Journals and newspapers were also important as far as data collection was concerned. Published Electronic Sources also ensured that availability of secondary data is easier.

RESULTS

The data collected from the research field on the influence of social media in prevention of Drug Abuse among the youth in the selected informal settlements was analyzed by the chi-square, ANOVA and Multiple Regression. Qualitatively, data was given in form of text whereas quantitatively, descriptive statistics including standard deviation and frequency distribution were used to describe given samples. Multiple Regression, ANOVA and Chi square were used to analyze data quantitatively.

About half of Nairobi's population that is about 59% reside in informal settlements. Known informal settlements within Nairobi include Kibera, Mathare, Korogocho and Mukuru within which are various social concerns namely poor drainage, Drug and substance abuse, crime and lawlessness and as a result youth living in such environments are therefore prone to these hazards. This implies that the inhabitants of such environments are constantly faced with a series of social economic problems. Of concern to this study are the types of drugs and substance and their potential impacts on youth located within environments such as Mukuru Kwa Njenga.

Discussion of Key Findings Gender distribution of the Respondents

The study sought to establish the gender distribution of the youth in Mukuru kwa Njenga informal settlements of Embakasi Sub-County, Nairobi County. The findings were analyzed and presented as shown in Table 2

Table 2 Gender of the Respondents

	Frequency	Percent	Valid Percent	Cumulative Percent
Male	120	60.0		
Female	80	40.0		
Total	**200**	**100.0**		

Source: Researcher, 2019

Age distribution of the Respondents

The respondents were requested to indicate what age bracket they fall in relation to the research topic. The findings were analyzed and presented as shown in the Table 3.

Table 3 Age distribution of the Respondents

	Frequency	Percent	Valid Percent	Cumulative Percent
18-24 yrs.	148	73.6	74.0	74.0
25-29yrs.	26	12.9	13.0	87.0
30-34yrs.	20	10.0	10.0	97.0
Above 35yrs.	6	3.0	3.0	100.0
Total	**200**	**99.5**	**100.0**	

Source: Researcher, 2019

Household types of the Respondents

The study sought to establish the existence of the different types of households. The respondents were asked to indicate on the questionnaire which type of households existed in the informal settlements by ticking against their choice(s).The findings were recorded in Table 4

Table 4 Types of households in Embakasi Sub-County, Nairobi County, Kenya

	Frequency	Percent	Valid Percent	Cumulative Percent
Single Parent	82	40.8	41.0	41.0
Nuclear	50	24.9	25.0	66.0
Extended	32	15.9	16.0	82.0
Child Headed	20	10.0	10.0	92.0
Step Parent	16	8.0	8.0	100.0
Total	**200**	**99.5**	**100.0**	

Source: Researcher, 2019

The findings indicate that 82(40.8%) of families in Embakasi Sub-County are headed by single parents. The other family types are nuclear 50(24.9%), extended 32(15.9%), child headed 20(10%) and step parent 16(8%).Those who identified single households as the most common within the informal settlements said a number of homesteads do not have a father figure or do not take care of them thereby viewing them as absentee fathers. Nuclear families are also prominent as indicated by 50(24.9%) of the respondents. Such families consisting of a father, a mother and children is easier to take care of in an environment characterized by deprivation such that of slums. This is in contrast with an extended family which comprises of members from a nucleur famly and other relatives expanding it even further. This type of households were identified by 32 (15.9%) of respondents suggesting that they were not a common feature. Also not popular but a greater risk factor to substance abuse are the child headed families and step parent families. Though child headed families were noted by 20(10%), they are a risk factor for substance abuse because such adolescents are lonely and rely on their peers for support. They do not have anyone to guide them or provide moral support during this challenging stage of development. Thus, the family structure of the participants in this study proved to be a risk factor for their use of substances. The adolescents become vulnerable as they grow; they need the care of parents, other family members, as well as other elders in the community. Step parent families are often full of parent-child conflicts which lead to poor communication and strained relationship between the two parties. Children who are in conflicts with their parents end up not being able to communicate with their parents. That puts them at risk of abusing substances because they will then spend most of their time with friends who will give them love and support that they lack at home (National Institute on Drug Abuse, 2003).

Substance abuse in slum areas is perceived as a learned behavior. Adolescents learn either from adults, role models or friends that substance abuse is something that one has to do to relieve stress and to be happy. As social learning theory postulates, these children in such families learn this behavior both at their homes and from other people in their communities (Oketch, 2008).

A walk through the expansive Mukuru kwa Njenga slums shows that the community is permissive. As the researcher walked through the paths that meandered along the slum area, he noted individuals who were visibly drunk and inebriated as early as mid-morning suggesting that drinking took place all the times. There is rampant abuse

of varied kind of drugs and substance abuse and total disregard of laid down acts. The premises are adjacent to people's houses due to lack of space. Young people and minors are not cushioned from risks of getting influenced into alcohol and drug abuse. Children born in such environment learn to use substances because no one corrects such behavior or even guides them.

Socio-economic status of households in Mukuru kwa Njenga informal settlements in Nairobi County

This study examined the socio-economic preferences of the inhabitants of the informal settlements. Data was analyzed by means of Chi square test and results presented in Table 5.

Table 5 Chi square Test Statistics

	Income	Payment of rent	Accessibility to toilet	Water connection	Connection to electricity
Chi-Square	38.440[a]	36.000[a]	.160[a]	88.360[a]	81.500[b]
Df	1	1	1	1	2
Asymp. Sig.	.000	.000	.689	.000	.000

Source: Researcher, 2020

The results in Table 5 show that income was a concern to the slum dwellers with a significant level of 0.000. Eighty-one percent of the residents earn less than a dollar per day. This confirms that incidence of economic poverty is very high in Nairobi's slums. About 73 percent of the slum dwellers are poor, that is, they fall below the poverty line and live on less than US$ 42 per adult equivalent per month as confirmed by a study by AMT (2012). This is in contrast with average household costs in Mukuru kwa Njenga which is US$ 66. The high rate of economic poverty is accompanied by horrible living conditions and other forms of non-economic poverty. Slum dwellers have poor access to gainful employment. Unemployment rates are highest among youth (age 15-24) and women 46 percent of the youth and 49 percent of the women report that they are unemployed. This is problematic not least because the presence of an unemployed member in a household is strongly correlated with poverty (World Bank Report, 2006).

Drugs commonly abused among the Youth in the selected informal settlements in Nairobi County, Kenya

The study sought to establish commonly abused drugs. The respondents were asked to indicate on the questionnaire the drugs and substances commonly abused in the selected informal settlements in Embakasi Sub-County, Nairobi county and the findings were recorded in Figure 1

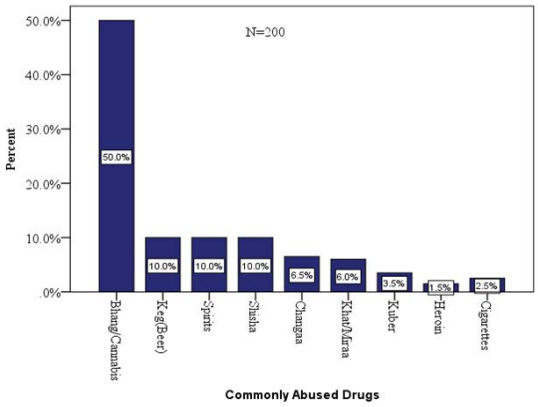

Figure 1: Drugs commonly abused among the youth in the selected informal settlements in Nairobi County

Source: Researcher, 2019

The findings in Figure 1 showed that Bhang was consumed more than any other drug as indicated by 100 (50%) of the youth. This was followed by Keg beer, spirits and Shisha all consumed at a rate of 20 (10%) each. Changaa and Khat were consumed at 13 (6.5%) and 12 (6%) respectively. Other drugs abused in informal settlements include Kuber at 7 (3.5%), Heroine at 3 (1.5%) and also Cigarettes at 5 (2.5%). Cocaine however was not consumed or the youth had no knowledge of anyone consuming it at all. Unlike in rural settings where alcohol was rampant, in informal settlements, use of Marijuana is widespread. This is majorly attributed to the fact that it is easier to conceal Marijuana than it is for alcohol. Majority of the responses from the questionnaire indicated that young people smoked Marijuana (Cannabis) in large numbers followed by those who drink. Cannabis is a drug commonly abused by the young people as indicated in World Drug Report 2018. This is attributed to the availability and accessibility of cannabis, coupled with perceptions of a low risk of harm, making the drug among the most common substances whose use is initiated in adolescence. Cannabis is often used in conjunction with other substances and the use of other drugs is typically preceded by cannabis use (UNODC, 2018).

From the researcher's own observation, drinking of alcohol was evident among adults in Mukuru kwa Njenga informal settlement. This could be attributed to its availability as the households were congested and in proximity to alcohol joints which were also quite numerous. Social conditions in neighborhoods have major implications for risk of substance use as they shape social norms, enforce patterns of social control, influence perception of the risk of substance use and affect psychological and physiological stress responses. The extent to which the neighborhood is perceived as disorganized or disordered or is an area characterized by vandalism, abandoned buildings and lots, graffiti, noise and dirt may also influence levels of substance use among adolescents. The neighborhood context has been found to be particularly influential for young people living in low-income urban areas owing to the high level of exposure to drug activity, disorder and violence in their neighborhoods, all of which may influence substance use among young people. Many aspects of the physical design of the environment can also harm young people's overall development and social relations and lead to the commission of crime and to substance use. Peers appear to influence one another through the idea of "pluralistic ignorance", whereby the general belief that more individuals are engaging in substance use than actually are may contribute to their own use of substance (UNODC, 2018). In Mukuru kwa Njenga which is one of the Known informal settlements within Nairobi, there are various environmental concerns namely poor drainage, poor sanitation, dumping of both biodegradable and non-biodegradable domestic and industrial waste, flooding and fire outbreaks, crime, drug abuse and lawlessness and as a result young people in such environments are therefore prone to hazards (Okello, 2016).

Though alcohol was ranked as the second most abused drug in the slums, the researcher made a different kind of observation as he walked through the alleys in the slums. As observed by the researcher, it was clear that there was presence of quite a number of premises that operated joints dispensing "Keg" beer. Beer Kegs are made of stainless steel and commonly used to store, transport and serve beer. Senator keg answered an unmet need: a safe, affordable beer to lure users away from illicit brews, since it is significantly cheap than more alcohol drinks, senator keg is famous with young people. A glass is sold

for 15 to 20 shillings and this presented an opportunity for a safe ultra-low cost beer to compete with illegal supplies (Wilewska et al., 2012). The Keg joints however operated as early as 11.00 A.M against the official time of 5.00 P.M on weekdays and 2. 00 p.m on weekends as indicated in Alcoholic Drinks Control Act, 2010. The Alcoholic Drinks Control Act, 2010, provides for various policy measures to curb alcohol abuse in Kenya. The Alcoholic Drinks Control Act, 2010, seeks to control and regulate the manufacture and production, sale, consumption, distribution and promotion of alcoholic drinks. There are various factors that contribute to alcohol abuse which Alcoholic Drinks Act seeks to address and mitigate. The main factors are: drinking context; drinking patterns; underage drinking; product standards and safety; health impact; and promotion and advertisements (NACADA, 2010).

The disparity is attributed to the fact that drinking of alcohol by adults is deemed a normal thing especially if the same happens in premises sanctioned by NACADA. The few young people indulging in drinking may therefore have gone unnoticed given the expansive nature of Mukuru kwa Njenga informal settlements. It is however important to note that Mukuru kwa Njenga is an expansive and combing through the settlements may be impossible. With the crowded nature of the slums, it is easy to miss out on acts that amount to breaking of the law as is the case above.

Structural vulnerability in Mukuru kwa Njenga informal settlement in Nairobi County, Kenya

Plate 1 and 2 show the location of Mukuru kwa Njenga's chief's camp and a path in the slums. Though not situated right at the heart of the slums, the chief's camp is constructed using semi-permanent materials thus fitting into the structures in the slums. Plate 2 which is a reflection of the nature of structures in the informal settlements represents the kind of lifestyle adopted by the inhabitants. The paths are narrow and poorly lit because of lack of planning which makes construction of feeder roads and power lines a nightmare. Also noted is the lack of space hence congestion among the residents of the slums. Narrow pathways, lack of security lights and congestion in Mukuru kwa Njenga slums heighten the problems of crime and drug abuse among the residents. Policing and patrolling the slum area is often difficult because illicit activities can easily be concealed because of the factors discussed above. Since the living and working conditions in informal settlements are extremely stressful, there is high risk in stress and psychological disorders. Many psychosocial health issues arise in cities such as depression, substance misuse, addiction, suicide, and interpersonal violence.

Plate 1 shows the Administrative unit in Mukuru *kwa* Njenga. Plate 2 shows an alley in the slums

Source: Researcher, 2019

Outside nightlife settings, stimulants such as methamphetamine are also quite commonly used among young people in most parts of the world (UNODC, 2018). The use of club drugs is also gaining prominence in informal settlements according to one key informer. Young people who go clubbing in recreational places dotting the nearby Pipeline Estate encounter use of new forms of drugs, which is quickly gaining prominence amongst them. The majority of those who had started using methamphetamine, known locally as Shisha, learnt the habit in clubs and other recreational settings where they go clubbing with their peers. Globally, those who use it, do so as a way of coping with their current opioid use, either to self-treat opioid dependence or to manage its adverse events. In the case of informal settlements such as Mukuru

kwa Njenga in Nairobi, the young people used Shisha during their first substance use as novelty seeking and to experience a new "high" (UNODC,2018).

The local administration has difficulties taming the problem of Drug and Substance Abuse among the young people in the informal settlements including Mukuru kwa Njenga. As noted by the researcher, administrative units in Mukuru kwa Njenga are located on the peripheries of the slums. In fact, all the administrative units ranging from the Assistance Chief's office, the chief's office, the police station and the Assistant county commissioner's office are all located in Imara Daima, which is home to middle level and high-class dwellers. As indicated, space in informal settlements is a challenge. Poor planning results in congestion leaving no space for public amenities such as hospitals, administrative units and social welfare facilities. Even churches and hospitals such as Mukuru kwa Njenga health centre are all located in Imara Daima area. On the contrary, facilities such as schools are located next to the slum area. Topline group of schools, Embakasi secondary school and Kwa Njenga primary school are adjacent to the slums. They serve the children from the slum area but on the other hand, expose them to social ills emanating from there. Drug and Substance abuse, crime and insecurity, poverty and stressful environment face such children living in informal settlements with overpopulation and congestion; the young people living in informal settlements are at risk of contracting communicable diseases. Mukuru kwa Njenga is populous and thus overwhelms the administrative arms of government mandated to arrest the issues of Drug and Substance abuse.

Plate 1

Plate 2

The use of psychoactive substances among teenagers and youth in the informal settings is often part of their coping mechanism in the face of adverse experiences, such as the physical and sexual abuse and exploitation they experience being in the slums. Therefore, many young perceive inhalants as a form of comfort and relief in a harsh environment, as they numb feelings. In their own words during a focus group discussion, "wanting to forget or escape problems" was reported as the main reason for substance use among the youth. For many, peer pressure and the nature of hard life in informal settlements has influenced use of inhalants youth among their peers.

Conclusion

The major cause of vulnerability is low income resulting from poor access to gainful employment. In slum areas with low income opportunities and a loss of trust, high incidence of crime and drug abuse concentrate. Patrolling the informal settlements poses a challenge due to its expansive as well as congested nature. Policing and securing of the informal settlements occurs on the outskirts of Pipeline Estate, which has assumed the lifestyle of the slums. Though 50 percent of the youth in Mukuru kwa Njenga indicated that cannabis is the most common substance, drinking of illicit brews and cheap Keg beer goes on uncontrollably. Consumption of brews is accompanied with smoking of Cigarettes and Bhang, chewing of Khat and Kuber as well as injection of harder drugs such as heroin and cocaine.

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Relationship Between Substance Use and Victimization to Intimate Partner Violence Among Men in Nyeri County, Kenya.

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Abstract

Substance use and intimate partner violence (IPV) are significant public health concerns. There is research evidence on co-existence of the two. Most efforts addressing this co-existence have focused on substance use among male perpetrators of IPV. Not much focus has been given to the correlation between substance use and female perpetrated IPV. This paper seeks to explain the relationship between substance use and victimization to IPV among men in Nyeri County, Kenya. Based on social cognitive and attachment theories, the study utilized an Ex post facto correlational design. The sample consisted of 412 male participants who were selected through multi-stage sampling. A 4-questions, validated substance use screening tool, CAGE was used to screen for substance use while IPV scale measured prevalence and forms of IPV. Correlations between substance use and victimization to IPV was established using Pearson's Product Moment Correlation Coefficient and regression analysis. 87.9% of the participants reported experiencing some form of IPV in their intimate relationships. Psychological IPV was most prevalent compared to physical and sexual IPV. 42% reported substance use while 32% indicated having clinical drug use problem. There was a moderate positive correlation (r=.288) between the substance use and IPV. Regression analysis indicated IPV (Est 0, 01, p-value<0.01) to be associated with substance use. Both IPV and substance use are prevalent among men in Nyeri county. Majority of substance users have a clinical drug problem. There was association between substance use and sexual IPV. The study recommends that interventions to address substance use and IPV amongst men should be put in place. Such interventions include counseling, awareness creation about the negative consequences of substance use and IPV as well as economic empowerment among men.

Keywords: *Substance Use, Intimate Partner Violence, Male Victimization*

Introduction

Substance use and Intimate partner violence (IPV) are significant public health concerns that have attracted research efforts over time albeit independently. IPV has been suggested to be the most prevalent form of domestic violence (Tjaden & Theonnes 2006). WHO (2012) defines IPV as any action by an intimate partner that is harmful physically, psychologically or sexually. IPV may be perpetrated by either gender however, most literature addresses male perpetrated IPV. Female perpetrated IPV has not received as much attention as male perpetrated IPV. Although women are the most commonly reported victims of IPV, a significant number of men has also reported being victims (Grama and Magalhaes, 2011; Dutton & White 2013; Hines & Douglas 2012).

Regardless of the gender of the perpetrator, IPV leads to traumatizing short-term and long-term consequences. These consequences affect the health and well-being of the victim, their family and the community at large. The consequences include physical injury,

relationship conflicts, divorce and separation, murder and psychological problems among them depression, posttraumatic stress disorders (PTSD), substance use and suicide (Hines, 2001; Cook, 2009; Black, Basile, Breiding et al 2011). According Rivera, Phillips, Lyon, Bland & Kaewken (2015), many survivors of IPV resort to use of substances to manage the traumatic effects of abuse. In other cases, the abusive partners coerce them into using substances.

Substance use has been reported to be a risk factor for IPV perpetration according to WHO, (2013). Among the drugs associated with IPV perpetration include but not limited to; alcohol, Cocaine, marijuana (Leornard & Quigley (2017). Global estimates suggest that 23–63% of IPV incidents involve alcohol as a contributing factor (WHO, 2012). On the other hand, perpetrators under the influence of alcohol are reported to cause more severe physical harm (Choenni, Hammink, & van de Mheen D., 2017). There is evidence supporting the co-existence of IPV and substance use/substance use disorders. The data on prevalence rates is conflicting. Some studies indicate that substance abuse co-occur in 40-60% of IPV (White & Chen, 2002; Stuart, Hellmuth, Gordon & Moore, 2013, Breiding, Basile, Chen & Merrick 2014). Others indicate that the prevalence rates of IPV among people using substances however, range from 31% - 90%. Studies of people who use or are dependent on substances such as Burke, Thiemen, Gielen, O'Campo & McDonnell (2005), Cohen, CraigField, Campbell & Hien. (2013), consistently found high rates of lifetime IPV. Most of these prevalence studies however have been conducted among people entering substance abuse treatment centers and not the general population. On the other hand, the prevalence rates of substance use or abuse among IPV survivors vary from 18% -72%. Literature shows that there is a high likelihood of those experiencing IPV to report increased alcohol use, abuse, heavy drinking or even dependence (Stuart et al., 2013; White & Chen, 2002).

Some of the studies indicate that substance abuse plays a facilitative role in IPV in precipitating violence such as El-Bassel, Gilbert, Go & Hill (2005). Others indicate that IPV is a predictor of substance abuse problem or addiction (Stuart et al. 2013, White and Chen, 2002). Other authors suggest a bidirectional relationship between the use of alcohol and/or other drugs IPV (Cohen et al., 2013 Kilpatrick, Acierno, Resnick, Saunders & Best 1997). The direction of the relationship between the two variables is therefore not clear; whether IPV precedes substance use, or vice versa. The need to untangle this temporal continues. The current study investigates the association between substance use and victimization to IPV in a Kenyan population and in female perpetrated IPV as compared to majority of the previous studies that address male perpetrated IPV.

Studies have shown that female survivors of IPV are more likely to use or become dependent on substances compared to those who have not experience IPV (Anderson 2002, Schneider & Burnett, 2009). On the other hand, male perpetrators of IPV have been reported to use alcohol or illicit drugs prior to committing assault. Literature is deficient on whether male victims of IPV also use or abuse substances and if the relationship exists between the two as it does for male perpetrators. The current study sought to establish the association substance use and female perpetrated IPV among men in Nyeri County, Kenya The specific objectives of the study included to;

(i) establish the prevalence of substance use
(ii) assess the prevalence of victimization to IPV among men
(iii) to determine if there is a significant relationship between substance use and victimization to IPV among Men in Nyeri County, Kenya.

Methodology

The study was conducted in Nyeri County in Kenya. The County was purposively chosen because of the repeated media reports of incidents of male victimization to IPV which justified the need for a scientific investigation. A sample of 412 male participants was selected from the general target population of men. The inclusion criteria included being a male aged between 18 and 65 who was married or had ever been married by the time of the study. The study utilized an ex post facto correlational design. Multi-stage sampling was used in selection of participants comprising of random sampling to select the three sub-counties namely Mukurwe-ini, Mathira West and Mathira East; stratified random sampling of 9 locations and 19 sub-locations and systematic sampling of 412 households from which one man who met the inclusion criteria was randomly selected. A formula recommended by Yamane (1967) was used to determine the number of households and hence the number of men to be included in the study.

$n=N/1+N(e)$

Where N= total number of households, e=the acceptable precision error and n=the sample size.

The target households were 15058 (KNBS, 2009). The sample size was distributed proportionately across the selected sub-locations. The sampling frame in table 1 below summarizes the information on how the sample was selected.

Table 1

The Sampling Frame

	Districts (2009 Census)	Sub-counties	Locations	Sub-Locations	Households
Target Population	2	8	14	36	15058
Sample-Size	2	3	9	19	412

The study comprised both quantitative and qualitative methods. Data collection instruments comprised of a demographic questionnaire, Intimate Partner Violence (IPV) Scale and CAGE.

Substance use among the participants was screened using CAGE, a four questions validated substance use screening tool. The responses in each question were either Yes (scored as 1) or No (scored as 0). A total score of 0 indicated no drug / alcohol use. A score of 1 indicated rare use of drugs / alcohol which was below clinical drug problem level. A score between 2 and 4 indicated drug / alcohol consumption that had reached clinical drug problem level.

The IPV scale on the other hand comprised of adapted items borrowed from the compendium of assessment tools for IPV by Thompson, Basile, Hertz & Sitterle (2006). The tool comprised of 30 items which assessed the type of IPV whether physical, sexual or psychological IPV. Physical violence was assessed by items 2, 3, 4, 13, 14, 15, 16, 17, 18 and 19. Sexual violence was determined by items 7, 8, 18 and 21. Psychological IPV was measured by items 5, 6, 9, 19, 22, 23, 25, 27, 28 and 30. All the items for each type of IPV were summed up with a total below 30 indicating absence of IPV and above 30 indicating presence of IPV.

Qualitative data was collected in three focus group discussions, one from each sub-county selected. Men who met the inclusion criteria were involved in the FGDs and were randomly selected from the sub-counties through the help of the area chiefs and community leaders. Each FGD comprised of 6-10 participants.

Data was analyzed using both descriptive and inferential statistics. Computation of frequencies and percentages was done and the data presented in tabular form. The relationship between substance use and victimization to IPV was established using Pearson Product Moment Correlation Coefficient. Regression analysis was also conducted to determine the associations between substance use and IPV. Socio-demographic data on age, education, marital status, duration of marital relationship, number of children and employment status of the participants was also collected. Qualitative data was on the other hand analyzed thematically.

Results

Social-Demographic characteristics of the respondents

There was a 100% return rate of the questionnaires because they were administered directly to the respondents by research assistants. Majority of the respondents (37.4%) were in the 36-50 age category, (83.5%) were living with their spouses and (33.3%) had been married for 0-7 years by the time of the study. The mean number of children per participants was 3. Only 22.6% of the respondents had post-secondary school Education. A notable majority (67%) were self-employed compared to 21.8% in formal employment. Data collected on the respondents' demographic characteristics is presented in Table 2.

Table 2

General Characteristics of Respondents

Characteristic	Description	F	%	Characteristic	Description	F	%
Age	No response	3	.7	**Level of Education**	No Response	7	1.7
	18-25 years	20	4.9		No formal Education	9	2.2
	26-35 years	122	29.6		Primary Level	121	29.4
	36-50 years	154	37.4		Secondary level	182	44.1
	51-65years	113	27.4		Post-Secondary Level	93	22.6
	Total	**412**	**100**		**Total**	**412**	**100**
Marital Status	No response	2	0.5	**Duration of Marital relationship**	No Response	6	1.5
	Living with the partner	344	83.5		0-7 years	137	33.3
	Divorced	2	0.5		8-15years	101	24.5
	Separated	45	10.9		16-25 years	80	19.4
	Widowed	16	3.9		26-50 years	80	19.4
	Cohabiting	3	0.7		Above 50 years	8	1.9
	Total	**412**	**100**		**Total**	**412**	**100**

Employment	No response	**8**	**1.9**	**No. of Children**	No Response	4	1
	In Formal Employment	**90**	**21.8**		None	20	4.9
	Self-employed	**276**	**67.0**		1-2	164	39.8
	Unemployed	**38**	**9.2**		3-4	138	33.5
	Total	**412**	**100**		5-7	76	18.4
					Above 7	10	2.4
					Total	**412**	**100**

Prevalence and Types of IPV Experienced by respondents

Most of the respondents (87.9%) reported to have experienced some of form of intimate partner violence. The most frequent type of IPV was psychological at 84.2% and the least was sexual at 21.8% as presented in Table 3.

Table 3

Prevalence and Forms of IPV

	General IPV Prevalence	Physical IPV	Sexual IPV	Psychological IPV
Exposed	87.9%	25%	21.8%	84.2%
Not Exposed	12.1%	75%	78.2%	15.8%

Substance Use Status

57. 8% of the participants reported no current use of alcohol or any other substances while 31.8 % and a vast majority of those using substances had reached dependence level as shown in table 4.

Table 4

Substance Use Status of Respondents

Drug/Alcohol Consumption	Frequency	Percent
No Consumption	238	57.8
Consumption but no Clinical Drug problem	43	10.4
Consumption with a Clinical Drug Problem	131	31.8
Total	**412**	**100**

Relationship between Substance use and IPV

Correlations were done between substance use and IPV using Pearson's correlation Coefficient. Findings provided evidence of a significant low positive correlation ($r=0.298$, $p<0.01$). Partial correlations while controlling for potential confounders of age, marital status, level of education and employment status provided evidence of a significant, low positive correlation between substance use and IPV ($r=0.287$, $p<0.01$). The findings are presented in table 5.

Table 5

Correlation between Substance Use and IPV

		Substance use	Victimization to IPV
Substance use	Pearson Correlation	1	.298**
	Sig. (2-tailed)		.000
	N	412	412
Substance use while controlling for Age, Marital status, Education &Employment	Pearson Correlation	.278**	1
	Sig. (2-tailed)	.000	
	N	412	412

**. Correlation is significant at the 0.01 level (2-tailed)

Logistic regression analysis was conducted and findings indicated that IPV was significantly and positively associated with Substance use. Substance use was treated as the independent variable and IPV as the dependent variable in these analyses. In binary regression logistics for each of the three types of IPV, only sexual IPV was significant. Results are presented in table 6.

Table 6

Characteristic	Estimate	p-value
Age	0.009	.963
Marital Status	.115	.460
Education level	.125	.298
Employment Status	.178	
IPV	.010	.000
Sexual IPV	.252	.014
Physical IPV	.108	.091
Psychological IPV	.033	.059

Qualitative findings

Qualitative findings supported quantitative findings on high prevalence of substance abuse and IPV among men in the County. The FGD participants reiterated that only few men who did not take their responsibilities seriously were beaten. However, majority experienced psychological abuse such as being denied food and sex. Some reported that their wives engaged in extra marital affairs with men who could buy tem expensive gifts. This resulted to fights at home while other husbands sought consolation in substance abuse. There was a feeling that women were more advantaged in the society than the men. The women were given government funding just as the youth while men are left out and that women were also entitled to inheritance from their fathers as well as from their husbands. This made the women more economically powerful than the men and hence increasing the potential for victimization.

Some excerpts are cited below;

"Yes men in Nyeri are beaten it is not a lie. Some men go home very late because they fear to be beaten." *(Mukurweini respondent 1)*

"Many more men are denied food by their spouses na hapo tu ndio wananyimwa ile mambo ingine.... (And in the same way they are denied conjugal rights)" *(Mukurweini respondent 2)*

"Only very few men are beaten physically and in most cases such are the men who do not take their responsibilities seriously and do not have family virtues or those who have already been beaten up by life" *(Mathira East respondent 1)*

"The woman wants may be an expensive shoe I cannot afford. Finally, she is bought by another man out there. The first time I ask her there is a fight at home in fact she does not see as if I am a human being. So next time even if she comes with a more expensive shoe I will not ask her. Instead I go to the club and drink and I will find "KaMary" there who I can touch and she won't ask me." *(Mathira West respondent 1)*

"Some women are able to get some odd jobs that give them money at the end of the day. She then buys food cooks for herself and the children and they leave none for the man of the house." *(Mathira East respondent 2)*

"The law favours the women. The woman nowadays can inherit from two homes, her parents' home and the husband's. Because of this some do not take their marriages seriously, they do not own their marital homes. Most such women do not respect their husbands. Some women just get married to get children. In fact, most marriages are' come-we stay marriages'. The constitution should be amended to ensure that those are married do not inherit from their families of origin. *(Mathira west respondent 4)*

"There should empowerment programmes for men just as there are for the women. Kwa nini hakuna 'inua kijana' ni 'inua dada' peke yake? (Why is there not a programme like support the boy only the girl?) Women can access loans that men cannot. Such money cause conflicts at home because the husbands have no say about it." *(Mathira East respondent)* "Law enforcers should exercise fairness. When women go to report when they are beaten by their husbands, the husbands are apprehended. However, when a man goes to report victimization by the wife, the police says.... siunaona hii dume inapigwa na mwanamke. Si umuondokee kwa nyumba... (Look at this bull (man) he is beaten by the wife, can't you move away from her) Finally, they the law enforcers do nothing about it. This makes most men not report such incidents." *(Mathira west respondent 9)*

Discussion

The demographic characteristics indicate that men in the region marry mostly after the age of 25 years and majority married at an even older age since majority of the respondents were in the age category of 35-50 years and yet most marriages had lasted for only 0-7 years. Majority (40%) had 1-2 children which is lower than expected being a rural population. The mean number of children was 3. This supported the Kenya Demographic and Health Survey (KDHS) by KNBS (2014) which indicated that Nyeri County had a fertility rate of 2.7 and was one of the counties with the lowest fertility rates in Kenya at the time. The findings that only 22% of the male population had post-secondary school Education was a worrying state and explains why most of them were not in formal jobs. There is a possibility that men married women who were more educated than them and who may also have formal jobs. This is likely to have been one of the factors predisposing them to

psychological IPV due to inability to fend for their families as indicated by the qualitative findings. Besides, Education is key to any form of development and is a key indicator of poverty levels. There is need for attention to be given to this to establish the explanations for such low Education levels despite the free education program in Kenya.

Findings of the study indicated Majority of the men had experienced some form of IPV with most of them acknowledging being victims of Psychological abuse. This shows that men had higher chances of being experiencing verbal abuse, threats, being denied food and conjugal rights, stalked or emotionally violated more than they were likely to be beaten physically or sexually abused. This was ascertained by the qualitative findings and is consistent with prior studies which reported that men are subjected mostly to psychological IPV and least to physical and sexual IPV and that women are more likely to use controlling acts (Hines & Douglas 2011, Straus 2004). However, it appears a fraction of the men who experienced psychological IPV also experienced sexual and physical IPV. Psychological abuse may lead men to suffer silently because it is least notable compared to physical harm also referred to as husband battering and which attracts a lot of attention. Given the socio-cultural expectations of men coupled by their poor help-seeking behavior, men are less likely to report IPV meted by their wives. According to Stith et al (2012) the most harmful form of IPV is Psychological and has long lasting effects on mental health. In this case, the men are likely to suffer psychological consequences such as substance use, self-harm and depression and hence the need for psychological interventions.

On the other hand, men who used substances were more likely to have a clinical drug problem. This implies that there were higher chances of addiction among those who reported to use substances. There is therefore need to address the substance use problem. Interventions to address the substance use problem need to be identified and put in place and hence the need for intervention studies in this area.

The study provided evidence of a significant positive relationship between substance use and IPV among male victims of female perpetrated IPV. Specifically, sexual IPV was significantly associated with substance abuse. This implies that those who abused alcohol or other substances were more likely to be victims of IPV perpetrated by their intimate partners and especially sexually. The relationships being positive in both cases indicated that an increase in use of substances was likely to lead to an increase in victimization to IPV. This is in support of previous studies such as Gilchrist et al, (2019). This implies that if the problem of substance use was addressed, it would also lead to a decrease in IPV. The qualitative findings support the fact that most of the participants did not receive parental involvement of their fathers. The parental involvement was combined for both parents and this may have had implications on the findings.

The study being ex post-facto correlation in nature did not investigate the causal effect of the Substance use on victimization to IPV. This is a potential area of further investigation especially in longitudinal or intervention studies. However, the study established a significant correlation between substance use and IPV and established that substance use was likely to predict victimization to IPV. The need to address both problems; IPV and substance use was highlighted by the findings of this study.

Conclusion

Almost half of the men were substance users with more than half of the users having a clinical drug problem. This implies that substance use is a prevalent problem in the area and needs to be addressed. IPV was prevalent among majority of the participants with psychological IPV being the most prevalent form of IPV compared to sexual and physical. This is least likely to be reported since it has no physical evidence but may lead to other psychological or relationship problems and hence needs to be curbed. The study provided evidence of significant positive association between substance use and victimization to IPV in general (all the three types of IPV combined) and to sexual IPV when tested separately. None of the social demographic factors tested in the study was significantly associated with substance use. Pearson correlation findings indicated the correlation with IPV existed despite controlling for any potential confounding. This asserts that there is a strong association between substance use and victimization to IPV. Therefore, men who use substances are more likely to be victims of IPV.

Recommendations

The study recommends evidence based interventions to be put in place to address both substance use and IPV. Although the article does not establish the relevant interventions, the fact that psychological IPV was most prevalent provides basis for the need of counseling and other psychological interventions to address IPV. Banning of cheap local brews may also help to make alcohol inaccessible and less affordable given it was reported to be the most abused compared to other drugs. On the other hand, intervention and longitudinal studies need to be conducted to guide development of relevant evidence based interventions for substance use and for IPV. There is also need to create awareness about the two problems and their negative consequences in the region.

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Theatre as a Campaign Tool against Drug and Substance Abuse in Selected Kenyan Schools Plays.

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Abstract
The Kenya National Drama Festival Committee, the organizers of the National Schools, Colleges and Universities Drama Festival usually enters into a sponsorship agreement with other institutions to help in disseminating certain messages through drama. One of these institutions is the National Agency for the Campaign Against Drug and Substance and Alcohol Abuse (NACADA). NACADA has sponsored a number of editions of the Festival in the hope that participants will be sensitized through the performances on the need for demand reduction and supply suppression of alcohol and drugs use. The event targets mostly the youth in Kenya who are said to be at the highest risk of becoming victims of drug and substance abuse. The youth are mostly in schools. This article interrogates some of the plays presented at this festival and their agency at advocating the NACADA course. Specifically, it seeks to respond to the following questions; how are the plays structured to communicate supply suppression and demand reduction? What qualities are assigned to characters so that they act as campaign agents and how are the plays designed to signpost the dangers of drugs and substance abuse? How have they been used for supply suppression and demand reduction of consumption of drug and substances? What are the challenges that this sensitization campaign faced and how can they be overcomed?

Keywords: *Drugs and substance Use, Youth, Theatre arts, Plays, Demand Reduction*

Introduction
There are four areas that put theatre at a great advantage as an agent for the campaign against drug and substance abuse can be established. These are its power to influence attitude change, its vibrancy and gregariousness, the thrill and lastly its participatory nature. These four do not work each in its individual stead but rather as a combination and in symbiosis. While theatre targets attitude change as the major area of intervention, it is also vibrant in nature as it attracts the youth to participate. It encourages the idea of collaboration between peers and students in the plays and their audience. The vivancy that it is executed with and the fact of standing out and confidently delivering the many lines and dialogues that the youth engage in makes theatre a preferred art of choice. Furthermore it acts as a form of peer advocacy. Underlying all this is the thrill; the sudden feeling of excitement and fear that builds out of adrenaline as the youth tell the story on stage before an audience.

Theatre requires stepping in ones shoe and empathizing with another person and living a make-believe life that convinces others. By participating or by seeing their colleagues participate, theatre allows them to introspect their lives hence is a perfect ground for intervening in attitude change. Demand reduction of alcohol and drug abuse is

highly dependent on attitude change rather than supply suppression particularly among youths who are already engaged.

Different plays embed certain qualities in their productions to express the matter of advocacy. These qualities constitute the theatre style of the plays that manifests in different areas of production. This article takes the Kenya National Drama Festival and Film Festival (KNDFF) as its launch pad to interrogate the theme of the campaign against drug and substance abuse among the plays presented at the Festival as sponsored by NACADA between 2013 and 2015. Three plays that were awarded the best in terms of the theme of NACADA in 2013, 2014, and 2015 were selected and subjected to content analysis. These plays had gone through several levels of competition i.e. sub-county, county and regional levels of competition. An attempt is made to unlock the potency of the plays as campaign agents by interrogating the three areas of play production and how they were used in highlighting to the audience the fight against drug and substance abuse. Secondly, it identifies how three areas of production in three school plays were embedded with qualities of advocacy. These three areas are characterization, production design and structure/form. Thirdly, it appraised some of the challenges of using drama as a campaign tool and how such challenges can be overcome.

2.0 Theoretical Framework

The article takes theatre semiotics as the lenses with which to analyse the three plays selected. This theory lays a foundation to argue that the festival is an activity involving performance embedded in systems of signs and significations that help pass the message for campaigning against drug and substance abuse. Propounded by Elam (1980) in his text Semiotics, Theatre and Drama, this theory defines semiotics as a science that is dedicated to the study of the production of meaning in the society using the different sign systems and codes that are at work in society and the actual messages and texts produced there by'(p.1). While Elam credits Ferdinand de Saussure as the father of semiotics in the linguistics area, he argues that theatre and performing arts in general have simply appropriated what the linguists developed to explain the processes of generation of meaning in linguistic communication. He further argues that the transaction between the audience and the performer warrants and amounts to what can be termed as 'theatrical communication' which is just but a variation of communication (p.2). This theatrical communication is embedded in theatrical systems which are equivalent to the Sausurian linguistic systems. The linguistic sign in semiotics is made of a vehicle or signifier and a mental concept; signified. This sign in theatre is radically transformed by the stage (Elam, 2002).

Bogatyrev (1938) writes that all objects and bodies defined within the stage are metamorphosed, bestowing upon them an overriding signifying power which they lack- or which at least is less evident- in their normal social functions (pp. 35-6). Thus there is a primary signifying function of all those performance elements on a stage. In fact as Veltrusky (1940) declares, "All that is on the stage is a sign" (p.84). The very appearance of objects and subjects on a stage means that they leave the present world to enter the realm of the symbolic or signifying world. Thus the stage transforms the sign into a signifier. For example, an actor's body acquires what Elam (2002) calls "its mimetic and representational powers by becoming something other than itself, more and less than individual" (p, 5). A seat on the stage is a theatre seat. Set, costumes, props, characters, happenstances, entries, exits, spoken words, unspoken words, gestures, expressions, sounds, (both diegetic and non-diegetic), lighting and others are

signs that point towards something (Elam, 2002). They all conspire as signs towards a concept.

This chapter looked out for all these signs in the plays that were selected and interrogated how they were realigned to bear the weight of telling the story of the campaign against drug and substance abuse.

Methodology

An analysis of performance text must take a qualitative design in the sense that Silverman (2000) looks at it as a soft, subjective and speculative approach of inquiry (p.2). This is because it aims at interrogating plays presented at a festival which is a very subjective social activity. The analysis used close reading as well as content analysis which are critical techniques of a qualitative design. This is a performance analysis since it sought to analyse certain aspects of several performances and how they motivated the theme of campaign against drug and substance abuse. The temporal location was fixed and closed as the study interrogated plays presented between 2013 and 2015. This study analysed only three (3) plays presented at the Kenya schools and colleges drama festival between 2013 and 2015. Each edition of the festival usually has competitions in six genres divided into stage and screen productions. This study took the stage productions which usually have the play, the narrative, the cultural creative dance, the choral and solo verses and lately the stand-up comedy and the modern dance. This study selected the play genre only since the play genre takes a longer duration to develop the structure and plot; all of which were points of concern for this study. Each year about two hundred (200) plays are presented by institutions of learning in Kenya. These institutions include primary schools, secondary schools, teacher training colleges, technical training colleges, institutions with special needs learners, and universities. From the whole population of over six hundred (600) plays that were presented in 2013, 2014 and 2015, the study first selected any item that had the theme of the campaign against drug and substance abuse, or popularly known in the Festival as the NACADA trophy winners. In picking the items with the theme on the campaign against drug and substance abuse, the study extracted winners from the awards lists that are usually generated by adjudicators and appended on the festival programme of the subsequent years. On the awards lists are usually a section of awards given to those who have excelled in scripting and presenting plays with the theme 'Campaign against drug and substance abuse'. There are usually four levels of reward for items with the theme. These are;

i. Overall Item with the theme
ii. Play with the theme
iii. Dance with the theme
iv. Verse with the themes

The study used recorded plays at the Kenya Institute of Curriculum Development (KICD). This is the official body charged by the Ministry of Education to record and archive performances presented at festivals organized under the auspices of the state department of education of Kenya. To acquire the video tapes and DVDs of the plays, the researcher went to the Kenya Institute of Curriculum Development (KICD) marketing division and ordered for all of them. The first previewing of the video recorded material led to a selection of only three (3) plays which had strongly brought out the theme of drug and substance abuse. These were The Docker by Menengai High School- Nakuru, Friendly Fire by Lions Primary School- Nakuru, and The Village Gauge by Kenya Aeronautical College.

In selecting the three plays as the sample for the study, the research was guided by Charmaz (2006) who recommends that

qualitative research ought to only use a sample beyond which no new property of the whole population is achieved. In the case of this study, the research estimated that beyond the third play, there would be no new material or ideas relevant to the theme of campaign against drug and substance abuse. The selection of these three editions of the Festival was purposeful since the study was interested in the editions that were heavily sponsored by NACADA as title sponsor. A title sponsor is considered a key ally to the KNDFF in the organization and execution of the festival in a particular year. Such a sponsor is given a latitude of privileges including advertising its functions and products as well as branding most of the material and venues of the Festival.

In selecting the plays presented in the years that NACADA sponsored the KNDF, the study assumed that those plays presented profited from NACADA directly or indirectly since NACADA officials made presentations on how plays with themes on the campaign against drug and substance abuse should be done. These presentations benefited scriptwriters, directors and producers during workshops held at the Kenya School of Government-Mombasa, at Kenya School of Government-Embu and at Kenya School of Government-Baringo in 2013, 2014 and 2015 respectively.

Data collected from the recorded plays was analysed using content analysis approach. Baker (1999) suggests that content analysis can use a scheme in which the frequency of occurrence and recurrence of patterns in content, amount of that pattern of content, absence or presence of certain qualities within the content, type of content, source and degree of intensity of that content is used to analyse it. Using the above parameters, the study categorized content in the plays in regard to the research questions on characterisation, production design as well as structure and plot. In discussing characterisation, the portrayal of figures and elements as signs and symbols of the fight against drugs and substance abuse were investigated. The structure of the performances in allowing for a cathartic flow of events was also subjected to inquiry. Techniques that helped the directors and playwrights impact positively on the audience through the structuring of the plays were interrogated. Lastly, the analysis endeavoured to appraise the production design and how they act as landmarks and beacons of the message of the fight against drug and substance abuse.

Findings

Below are three tables showing the findings of the study in the three areas of production in the selected plays.

Area of production: Structure

Play/ Unit of measure	Exposition that relates to drug issue	Complication that is related to drug demand or supply	Climax confronting in a drug related issue	Youth centred denouement that emerges from the foregoing and is related to drug issue
Friendly Fire	Present	Present	Present	-Not youth centred -Emerges from Narrative -Related to drug issue

The Docker	Present	Present	Present	- Not youth centred - Emerges from Narrative - Related to drug issue
The Village Gauge	Present	Present	Present	- Not youth centred - Does not emerge from Narrative - Related to drug issue

Area of Production: Characterization

Play/ Unit of measure	*Protagonist and antagonists involved in Drugs as signs*	*Rehabilitation of addicted characters as symbols*	*Portrayal of child characters as signs of optimism*
Friendly Fire	Positive	Positive	Positive
The Docker	Positive	Positive	Negative
The Village Gauge	Positive	Negative	Negative

Area of production: Production Design

Play / Unit of measure	*Purposeful and symbolic use of sets, backdrops and props*	*Purposeful use of sound*	*Relation of design elements to drug and substance abuse*
Friendly Fire	Positive	Positive	Positive
The Docker	Positive	Positive	Positive
The Village Gauge	Positive	Positive	Positive

Findings on Theatre content as a campaign tool

Here, the study was interested to primarily establish the kind of content that the plays presented to the audience. The play Friendly Fire by Lions Primary School Nakuru seeks to address how children may inadvertently abuse drugs in the quotidian life at home and in school. The play also alludes to unintentional abuse of drugs by children through consumption of substances like Kuber, dextrosal and other sachets of substances bought innocently from Kiosks around schools. Parental role in minimizing access to drug consumption is tackled here. In the play The Docker, the allure of the Kenyan coast and poverty are seen causes that lead to peddling of drugs by children. This leads to child prostitution and unwanted pregnancies. The influence of foreigners at the Kenyan coastal region is also indicted as one of the causes of drug peddling and consumption by minors in Kenya. Lastly in the play The Village Gauge greed and get rich quick by merchants of death and entrepreneurs of illicity are seen as the cause of the rise in adulterated and cheap killer liquor that causes blindness, death and family strains.

Theatre Style as agent for the campaign Findings on the structure

Ideally, a play production that advocates for demand reduction and supply suppression would have the elements of structure reveal an issue that relates to the drug problem. Right from the exposition through the complication to climax and to

the dénouement, the narrative ought to be arranged in such a way that punishes offenders, offers optimism and rehabilitates the addicted. The plays start by introducing a problem at the beginning in what is called exposition. The problem is made worse as characters, especially the protagonist, try to make it better by trying to run away from drug use or drug business (complication). Forces that are bent on supplying drugs to children or making dirty money in drug business fight the protagonist and are about to win at the climax. In a reversal of fortunes, these forces are defeated (in the Village Gauge), unmasked (In Friendly Fire), and decimated (in The Docker). The forces are arrested and taken to court or made to account for their deeds. The end restores the normal order.

In all the plays, the plots tend to be prescriptive and preachy and in this event, the audience do not relate to the pain, anguish, joys and sufferings of the lead characters. As a result, the impact of association between the spectator and the character; the identification that spurs soul searching in the audience and the need to purge the burdensome emotions of imagining that they can engage in drug or substance abuse is almost lost. It is therefore concluded that although the productions attempted to present plays relating to drug and substance abuse, they fall short in as far as constructing a plausible message of the same. However, this in itself cannot bind the productions as total failures. It is possible to have a production weak on plot but strong on production design and characterization.

Findings on Characterization

While interrogating the role characters in the construction of the theme of campaign against drug and substance abuse, attention has to be paid to the role of characters as semiotic signs in the play production and their Saussarian role as vehicles in the communication of the NACADA message. The motivations that lead characters to either peddle, sell, supply and or consume drugs were found to be key in revealing the redemptive roles. The use of youthful characters played a key emulative role to the students in the audience who saw their own struggle to overcome drug and substance abuse. Most main characters are youth and hence themes are treated at the levels of their world views.

It was found out that portrayal of youth as being able to overcome their situations of need for drugs and substance was not exploited well in the three plays. Most of them relied on adults for help in overcoming the drug problem. Plays resolve by rehabilitating characters already hooked to the drug and substance abuse. Characters who supply drugs and substances are arrested and made to account for their deeds. Parental negligence is also a factor that leads to drug addiction, or supply in two of the plays i.e. *The Village Gauge and Friendly Fire*. Indictment of foreigners particularly at the coast of Kenya for messing the children through allures of money and material gains is seen in the play *The Docker*. Characters are offered a psychological and attitudinal rehabilitative dose that is encouraged in healing addicts in *Friendly Fire*.

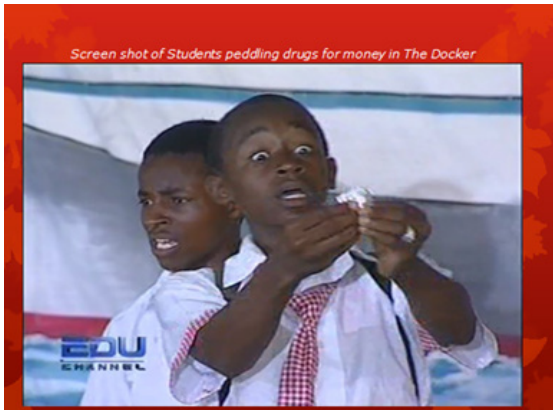

Image grab courtesy of KICD

Findings on Production Designs

In terms of the production design, the use of stage and hand props, costumes, set,

backdrops, as well as flaps, sound, lighting in regard to their semiotic symbolism as an antecedent to the theme of drug and substance abuse was investigated. It was established that the execution of production techniques enhanced the construction of the theme of the fight against drug and substance abuse in the selected plays. It is further argued that the use of sets, backdrops, props and sounds was purposeful in creating particular ambiances, traits of characters, settings both at temporal and spatial levels, moods, tones and styles that were necessary for the advancement of the plots and for the construction of the key meaning in the plays i.e. the fight against drug and substance abuse. Creatively, the production designs paint drug abuse as a menace both in school and at home. In the play *Friendly Fire*, the abstraction of the paintings and drawings of flaps and use of props simultaneously hides and reveals this destructive nature of drugs which as the plays suggests, can be found in normal day to day household consumables at home or in school. In all the plays, purposeful use of sets, backdrops, props and sounds to create particular ambiances, traits of characters, settings both at temporal and spatial levels, moods, tones and styles that were necessary for the advancement of the plots and for the construction of the key meaning in the plays i.e. the fight against drug and substance abuse.

Challenges of Using Theatre for Advocacy

Several challenges of using theatre as a tool of advocacy in the fight against drug and substance abuse were established. They are financial, technical and institutional constraints.

Financial: Schools do not have funds to mount serious productions of theatre for advocacy on health. Presently, a serious advocacy production may cost in the excess of Ksh. 500,000 which schools may not be able to invest in. More so, the theatre productions for advocacy is not a mainstream objective of education institutions hence the will to invest such amount of money may not be there.

Technical: Techniques of theatre for advocacy on health like use of participatory modes and facilitative theatre are not considered in the productions since, as stated earlier, the main objective of educational institutions is not to produce theatre pieces on advocacy.

Time and institutional constraints: Time at school is heavily regimented to the extent that a full program of theatre for advocacy on health, demand reduction and supply suppression of drugs is almost impossible to achieve.

A production technique in which drugs are represented as simultaneously bad but still alluring
Image courtesy of KICD

Recommendations

Multi Agentic Funding: Ministry of Education, Science and Technology should consider funding of the plays as theatre pieces that advocate for demand reduction and supply suppression. This is because the students in school are largely under the charge of Ministry of Education. In cases where school going youth are affected, it becomes not just the mandate of NACADA but also of

Ministry of Education to ensure their well-being.

There is need for training on the construction of advocacy themes especially in educational institutions. This capacity building will empower scriptwriters, directors and other theatre workers to create theatre pieces with specific and clear messages of the fight against drug and substance abuse.

There ought to be advance preparation through collaborations between NACADA and MoEST. This can include mainstreaming messages of drug demand reduction and supply suppression in lower levels of the Festival. Secondly, the National Agency for the Campaign Against Drug Abuse (NACADA) can make it a policy to send representatives well versed in both anti-drug abuse campaigns and theatre as a tool of advocacy to the lower levels of the festival to strengthen performances that don't make it to the national level so that they can be used as campaign platforms that go beyond the idea of giving awards. Such items can be used in various fora where youth are gathered like the world anti-drug day or sponsor some activities that reinvigorate their message. NACADA can also record the productions and archive them for later retrieval and screenings when the need arises.

Conclusion

In the fight against drug and substance abuse by youths, NACADA has engaged different sectors to reach the youth. One of the sectors is the education sector through the use of the creative arts particularly the schools and colleges' drama festival. NACADA has sponsored the 2013, 2014 and 2015 editions of the Kenyan Schools and colleges drama festival. This chapter has appraised these plays and their potency to communicate meaning of advocacy against drug and substance abuse. It has broken the play productions into three areas i.e. the structure, characterization and design. The study acknowledges that indeed theatre has potency to act as an agent for advocacy against drug and substance abuse. It concludes that the plays used characterization to communicate messages of drug and substance abuse. However, they could have bestowed the agency of rejection of drugs in the youth rather than in adult characters. In terms of structure, the plays meet the threshold by half as they tended to be preachy in the dénouement. The designs were purposeful to create ambiances and mind images of the fight against drug and substance abuse. The article further concludes that the greatest challenge to the use of theatre as a medium of advocacy among the youth in educational institutions is funding and capacity building. This can be overcomed through funding of target specific capacity building workshops on how to use theatre for advocacy against drug and substance abuse. Secondly MoEST could consider annual budgeting of funds for this capacity building workshops.

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