Policy Brief

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Youth at Risk: Alcohol and Drug Abuse (ADA) in Kenya

According to World Health Organization (WHO), drug and substance abuse is defined as the chronic or habitual use of any chemical substance to alter states of body or mind for other than medically warranted purposes[1].

Alcohol and Drug Abuse (ADA) among young people in Kenya is becoming a major social and public health problem due to its far-reaching impacts on the individuals, families and communities. ADA destroys the lives of young people, Kenya's most valuable asset and undermines socio-economic development and the efforts of harnessing a demographic dividend. The young people are exposed to drugs and alcohol at a very early age because of ease of accessibility, availability and affordability. Half of the drug abusers in Kenya are aged between 10-19 years with over 60 percent residing in urban areas and 21 percent in rural areas[2]. Taking drugs at an early age of 14 or younger, greatly increases the risks of drug problems in the future. ADA is associated with acute health consequences such as mental disorders and loss of eyesight—in some cases, even death[3].

Commonly abused drugs in Kenya are alcohol, tobacco, *bhang* (marijuana), glue, *miraa* (khat) and psychotropic drugs[4]. A study by the National Campaign Against Drug Abuse Authority (NACADA) in 2007, revealed that nationally, 8 percent of 10 to 14 year-olds have used alcohol—an increase from 2.4 percent in 2004, while about 40 percent of people aged 15 to 65 years have used one type of an alcoholic drink in the past[5]. According to WHO, alcohol causes 1.8 million (3.2% of total) deaths, one third (600,000) of which result from unintentional injuries. Alcohol also causes a loss of 58.3 million (4% of total) of Disability-Adjusted Life Years (DALY) of which 40 percent are due to neuro-psychiatric conditions[6].

This policy brief focuses on the extent of the ADA problem, effects on young persons, the precipitating factors, and possible interventions to the problem. The brief underscores the urgent need to address the problem in order to salvage the lives of young people and minimize incidences of alcohol and drug abuse.

ADA is a major risk factor for mortality and burden of disease. Alcohol kills more people than AIDS, TB or violence. Tobacco causes four million deaths annually. This figure is projected to rise to 1.6 million by the year 2025. If nothing is done urgently, achieving Kenya's Vision 2030 and harnessing the demographic dividend will remain a mirage as the productive young workforce is affected by ADA.

Status of ADA

A number of research studies that have been conducted locally and internationally have shown that alcohol and drug abuse is caused by a combination of many factors; individual, environmental, biological and psychological factors[7].

The main causes of ADA among young people include; poverty, peer pressure, easy access to drugs and alcohol and breakdown of traditional values—leading to dysfunctional families and high unemployment levels.

Other underlying factors include inadequate funding, which leads to weak programmes. The implementation of effective awareness programmes is often affected by limited facilities and personnel skills. Since these programmes are accorded low priority, they are often underfunded.

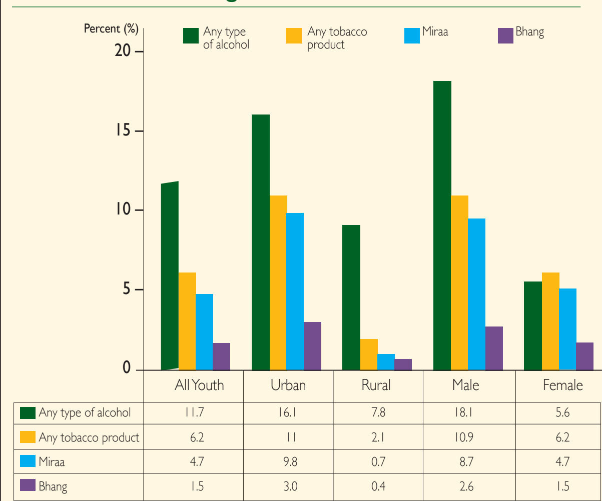
ADA often constitutes a crime in Kenyan law. Poor enforcement of the law, weak policies and corruption also directly contribute to the high prevalence of drug and substance abuse[8].

The effects of ADA include; increase in violence and crime, destruction of property, risky sexual behaviours—leading to increased exposure to HIV/AIDS, poor academic performance, school dropouts and low productivity. The youth are at the greatest danger as they are deliberately or unknowingly recruited into the drug culture. It was noted that learning institutions had become a hub for drug sale and consumption, with both licit and illicit substance dealers targeting students for recruitment into the business. The substances are sneaked into schools without detection by authorities since they are mixed with juice, sweets, cakes or chocolates[9]. Absenteeism from school and work are commonly associated with drug use, rendering the affected populations less economically productive.

Key Findings

A recent survey by NACADA[10] indicated that youths aged 15-24 years had abused alcohol, drugs and other substances (see figure 1). Findings show the tendency to abuse drugs and substances is higher in males than in females. Commonly abused drugs and substances by Kenyan youth include

Figure 1: Percentage of youth aged 15-24 years by current use and background characteristics



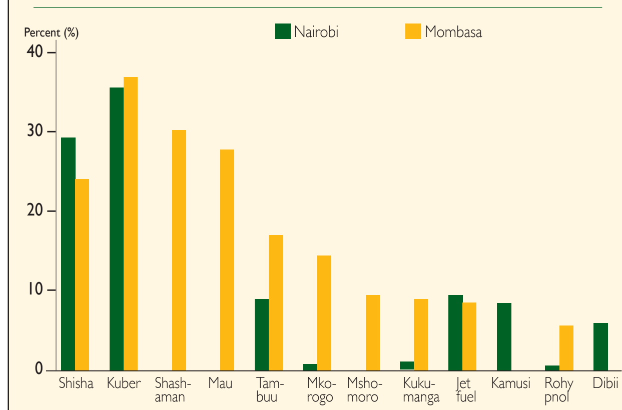
	All Youth	Urban	Rural	Male	Female
Any type of alcohol	11.7	16.1	7.8	18.1	5.6
Any tobacco product	6.2	11	2.1	10.9	6.2
Miraa	4.7	9.8	0.7	8.7	4.7
Bhang	1.5	3.0	0.4	2.6	1.5

Source: NACADA 2012

alcohol, followed by tobacco, *miraa* (khat) and bhang. The reason these drugs are commonly used is because they are easy to access and almost all are locally produced. The main sources of these drugs are usually the low income areas such as slums.

Figure 2 shows that the use of new and emerging drugs generally referred to as 'the legal-high' is becoming a major social problem among adolescents and young adults in Kenya11. There is continued increase in the use of new drugs getting their way into the country from neighboring countries like Ethiopia and Uganda whose chemical content is not known. The emerging drugs are a combination of the usual drugs and other chemicals or drugs which the youth are now giving new names. Most of the highly abused new and emerging drugs common in both Nairobi and Mombasa County were found to be; *kuber, shisha, shashaman, mau, tambuu, jet fuel, kukumanga,*

Figure 2: New and Emerging commonly abused drugs in Nairobi and Mombasa Counties



Source: NACADA 2013

mkorogo, mshomoro and *kamusi*. It was observed that the emerging drugs were mostly taken in combination with the usual drugs causing adverse health consequences.

Studies done in secondary schools by the Ministry of Education indicate that life skills were not taught in most schools since it is not examinable[12]. Most schools focus on guidance and counselling[13]. The content on ADA in the life skills syllabus is not adequate and does not equip learners with sufficient skills and knowledge that could help them resist the allure of drugs and substances. Most teachers and school counsellors also feel ill-equipped and inadequate addressing drug and substance abuse in schools.

The ADA problem cuts across the social and class divide and affects the individual, family, community and society as a whole.

Interventions to Reduce ADA

The Government of Kenya recognizes the threat posed by alcohol and drug abuse and enacted a legal and institutional framework within which the problem of alcohol dependency and drug abuse can be addressed. In 2007, the National Campaign Against Drug Abuse Authority (NACADA) was formed to coordinate a multi-sectoral campaign against drug abuse in Kenya[14]. Whereas NACADA has achieved several milestones in its efforts to conduct quality research on alcohol and drug abuse in Kenya which is aimed at guiding the country's drug abuse policies and programmes, there is continued increase in ADA cases, particularly the emerging drugs of abuse. These drugs are eating into the very core of our society, that is the youth—who prefer them to the mainstream illicit drugs.

To take action to reduce ADA in Kenya, the government has come up with the following policies and laws aimed at the regulation of production, sale and consumption of alcohol and drugs:

- The Dangerous Drugs Act Cap 245
- Laws against production, distribution and consumption of illegal brews
- Kenya National Drug Policy (MOH, 1994)
- The Tobacco Control Act of 2007
- Alcoholic Drinks Control Act 2010 (Mututho Laws)
- Restrictions on advertisements promoting ADA
- Establishment of The National Campaign Against Drug Abuse (NACADA) Authority in July 2007
- National Strategy on Prevention, Control and Mitigation of ADA in Kenya 2007-2017
- The Ministry of Education established ADA departments in every district
- Infused ADA in the school curriculum
- Trained and posted Guidance and Counselling teachers to schools.

Policy and Programme Implications

1. The issue of ADA among the youth should remain on the agendas of policy makers in the country, especially elected leaders, so as to maintain long-term commitment at solving the problem. In this regard, a uniform policy by the Ministry of Education for all schools is not only necessary but also urgent to guard against disparities in addressing ADA in schools. This policy would be an important component of a comprehensive ADA preventive strategy for youth in schools.
2. Implementation and enforcement of Alcoholic Drinks Control Act, 2010 should be supported by the County Governments to ensure that it is effective and responsive to the needs of various stakeholders. This includes the need for continuous monitoring and evaluation of the Act to ensure that its concerns and objectives are fully met.
3. A call for stricter enforcement of existing laws and policies on alcohol and drugs. While there is not an evidently significant use of the other emerging illicit drugs, laws should be put in place to reduce their influx.
4. Develop and operationalize a national Information, Education and Communication strategy for drugs and substance abuse.

NCPD is a semi-autonomous government agency that formulates and promotes population policy and coordinates related activities for sustainable development in Kenya.

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Recommendations

There is urgent need for:

1. **Continuous monitoring** by NACADA to identify emerging drugs and investigate their chemical constituents. This would provide evidence based approaches towards their regulation and control.
2. **Ministry of Education to increase intensive training** for all school counsellors and teachers to give them relevant skills to address ADA.
3. **Establishment and strengthening of** promotive, preventive, treatment and rehabilitation services by NACADA and Implementing partners for drug and substance abuse.
4. **Prevention efforts** by Ministry of Education in collaboration with NACADA to be geared towards the youth at a very young age, sensitizing them and their parents to the dangers of alcohol and drug abuse.
5. **Kenya Institute of Education (KIE) to reorganize the secondary school curriculum**, in the on going curricula reforms to provide additional time in the syllabus, teach ADA related issues. Head teachers should ensure all students participate in co-curricular activities to keep them occupied and reduce stress associated with academic demands.
6. **Effectiveness of guidance and counselling** as a method of addressing ADA in schools to be investigated by NACADA and Ministry of Education, given that it is emphasized.

Conclusion

This policy brief identifies the nature and extent of drug and substance abuse among young people in Kenya and the contributing factors and effects of ADA. It interrogates the interventions put in place to address ADA and the challenges facing the fight against drug abuse. The policy brief provides recommendations on how to curb and reduce drug abuse. The issues raised in this policy brief need urgent attention for reduction of ADA among the different segments of the population, including scaling up of prevention activities, development of behaviour change communication strategy and review of drug and substance abuse laws and policies. It further calls for better use of research findings through targeted dissemination to policy makers and development agencies for evidence based programming.

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