

UNIVERSITY OF NAIROBI

DEPARTMENT OF SOCIOLOGY AND SOCIAL WORK

**AN INVESTIGATION ON ALCOHOL AND DRUG ABUSE AMONG
VULNERABLE GROUPS IN KENYA: THE CASE OF FAMILIES IN MUKURU
KWA NJENGA SLUMS IN NAIROBI**

BY

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REG: C50/61532/2010

**A RESEARCH PROJECT SUBMITTED IN PARTIAL FULFILMENT OF THE
REQUIREMENTS FOR THE AWARD OF MASTER DEGREE OF ARTS IN
SOCIOLOGY (COUNSELING) AT THE UNIVERSITY OF NAIROBI.**

DECEMBER, 2017

DECLARATION

Declaration by the Student

This project is my original work and has not been presented for a degree or any other award in any other university.

Signed

.....

Caroline Wacuka

Date:

Declaration by the Supervisor

This project has been submitted for examination with my approval as the university supervisor.

Signed

.....

Dr. G. G. Wairire

Date:

DEDICATION

This research project is dedicated to everyone struggling with alcohol and drug abuse as well everyone who is committed to fight alcohol and drug abuse both locally and internationally.

ACKNOWLEDGEMENTS

I take this opportunity to thank the almighty God who has enabled me to successfully complete this work.

Thanks my dear husband Sammy for your support, encouragement and guidance all which was accorded with lots of love. Also special thanks goes to our son Chris and daughter Elsie for being very patient with mummy while she had to do this work.

My sincere gratitude goes to my mum for her financial support and encouragement towards this project. Thanks my bro Martin also for your relentless support.

I also highly appreciate my supervisor Dr. G. Wairire for his guidance and timely feedback throughout my research project.

To all my friends and all those who made this project become a reality; thank you very much. May the almighty God bless you abundantly.

ABSTRACT

Alcohol and drug abuse is a global problem which needs intervention at all levels. It cannot be ignored as its effects are not only felt by the abuser but also the society at large, either in their health, socially, emotionally or economically. ADA affects people in all walks of life; the rich, the middle class as well as the poor living in slums like Mukuru Kwa Njenga. This reality prompted the researcher to carry out a study on ADA Abuse Among Vulnerable Groups in Kenya: The Case Of Families In Mukuru Kwa Njenga Slums In Nairobi. The study was guided by the following objectives : To identify the specific alcoholic and other substances commonly abused by families living in Mukuru Kwa Njenga Slums in Nairobi, To establish the factors that contribute to alcohol and drug abuse by families living in Mukuru Kwa Njenga Slums in Nairobi, To establish the effects of consumption of alcohol and drugs on families living in Mukuru Kwa Njenga Slums in Nairobi and To suggest strategies for alcohol and drug demand reduction among families living in Mukuru Kwa Njenga Slums in Nairobi. The study used descriptive survey research design, a questionnaire and interview guides were used to collect primary data. Questionnaires were administered to a sample of 120 respondents who are adults and live in Mukuru kwa Njenga. Interviews were done to three key informants; the area chief, headteacher Kwa Njenga Primary and the priest in charge St. Bhakita Catholic Church. The following were the findings of the study: (i). Specifically, the respondents indicated that they were aware of marijuana, alcohol, cigarettes, bhang, cocaine, changaa, khat, sheesha, “kumikumi”, busaa, spirits and glue. (ii). the main factor contributing to consumption of alcohol and/or other drugs in Mukuru Kwa Njenga Slums is stress, followed by peer pressure, mass media, family breakups, pressure to do well in school and parental influence. (iii). Consumption of alcohol and other drugs, led to: wastage of money, aggressiveness, addiction, family break ups, increase in crime, depression, school drop outs, family disharmony and death. (iv). the findings indicated that the following measures were being employed to curb alcohol and drug abuse in the area: guidance and counseling, rehabilitation centers, awareness campaigns, peer education. In conclusion, the study recommends enforcement of laws on: distribution and sale of alcohol and other legal drugs, dealers of substances of abuse. Creation of employment opportunities, suggest ways of enhancing living standards in slums to reduce stress and set up more rehabilitation centers to help the addicted.

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ABBREVIATIONS AND ACRONYMS

ADA	Alcohol and Drug Abuse
NACADA	National Campaign Against Drug Abuse
WHO	World Health Organization
CBS	Central Bureau of Statistics
MOH	Ministry of Health
AADs	Alcohol Attributable Deaths
NIDA	National Institute on Drug Abuse
NACOSTI	National Commission for Science Technology and Innovation

CHAPTER ONE

INTRODUCTION

1.1 Background to the Study

Drug abuse is a global problem, which poses a great danger to the health of an individual, the society and even in some cases to the political stability and security in many countries (UN, 1988). More than 200 million people abuse drugs worldwide. These people are in all segments of society, they may include: the urban professionals snorting cocaine in a downtown nightclub, the glue sniffing street children in the slums of the developing world, the farmer addicted to the opium poppy he grows and the teenage ecstasy user in a comfortable home (UN, 2001).

Drug abuse among adolescents continues to be a major problem worldwide, and in particular, at an early age (De Miranda, 1987; Jaffe, 1998). The most widely abused substances are alcohol, tobacco and cannabis because they are readily available. According to the United Nations, (2009), substance abuse is worsened by complex socio-economic changes such as unemployment, poverty and crime in general. These challenges are prevalent in slums where the populations are high yet competing for few resources. These social ills devastate many families and communities. In addition, drug pushers force young people into taking drugs and related substances so that once they are hooked; they can manipulate their friends into taking them. (United Nations, 2009). Drugs are quite expensive; therefore, once these youths are hooked up and can no longer afford them, they are forced to become traffickers so they can get some in return. Others get involved in other criminal activities as a way of sustaining this habit. Too many youths seem to think of experimentation with substances as an acceptable part of transition into adulthood. Few take seriously the negative consequences of dependence on substances (Madu & Matla, 2003).

Many people, old and young abuse both legal and illegal substances. Legal substances are the counter and prescription medicines, such as pain relievers, tranquillizers including benzodiazepines, cough mixtures containing codeine and slimming tablets (Craig & Baucum, 2001). In addition, there are other agents such as solvents in glue, alcoholic

beverages, nicotine and inhalants, nail polish and petrol. Illegal substances are prohibited and the use, possession or trading of these substances constitute a criminal offence (De Miranda, 1987). These substances include cocaine powder, crack cocaine, heroin, ketamine, cannabis, ecstasy, fentanyl, morphine, methaqualone (Mandrax), opium, flunitrazipam (Rohypnol), methamphetamine and Wellconal (Craig & Baucum, 2001).

In traditional African communities, the use of some drugs such as alcohol and tobacco was allowed during specific occasions. The traditional rules and values prescribed who in the community was allowed to take such drugs. However, the erosion of customs and traditions has greatly diminished the traditional control on how the drugs are obtained and used (Mwenesi, 1995). Similarly, rapid urbanization and emergence of a money economy have aggravated the situation (KIE, 2002).

According to Mashele in Geyer et Al (2015), “[t]he drugs problem has become a serious developmental challenge and continues to undermine collective and individual efforts of African government.” Drug abuse, combined with high levels of poverty, increases the vulnerability of the African continent to social problems such as crime and HIV and Aids.

Africa is vulnerable transit continent for both cocaine and heroin; while west and central Africa have already witnessed increased cocaine trafficking during the past few years, East Africa is fast emerging as a transit route for Afghan opiates destined for the European market. West Africa is also emerging as a hub for methamphetamine production. The spillover effect of the increased trafficking of drugs through Africa on drug use in African countries is a matter of concern (UN, 2013).

Kenya is not exceptional. Due to its location, it has become a transit route for trafficking of drugs disposing the people to drugs of abuse acquired from other countries besides those acquired locally. This factor cannot be ignored as it was recently exposed by the Nation Television on their documentary “a story too familiar in Mombasa, heroin is tearing families to pieces- Lives in ruin” by Rosie Wangui on 23 august 2015, exposition on how people of Mombasa have suffered addiction, women have lost their husbands, sons and daughters to drugs, some have died. The port of Mombasa makes it an entry

point with immediate effect being suffered by the locals. From time immemorial, Kenyan people have been consuming and using intoxicants and drugs. Alcohol was the most popular form of intoxicant. However, control was tightened by prescribing the circumstances under which drugs especially alcohol could be consumed. Thus while the potential of these drugs being abused existed, the actual existence of drug abuse as a social problem was non-existent because of strong cohesion which acted as a mitigating mechanism (Mwenesi, 1995). The situation is different now as drug abuse is a serious menace.

Substance abuse, defined as the problematic use of alcohol, tobacco, or illicit drugs, has been called the nation's number one health problem. The costs to society are enormous; the National Institute on Alcohol Abuse and Alcoholism estimates that alcohol and drug abuse are associated with 100,000 deaths per year and cost society \$100 billion per year (Horgan, 2001).

Alcohol use has led to so many deaths in Kenya that it cannot be ignored. According to Nacada 2013, on 17th August 2012, 14 people died in Mbeere South District as a result of consuming adulterated alcohol. In September 2011, 32 people died while others went blind; 11 were in Nyahururu, 7 in Ol Kalau, 7 in Ruiru and 7 in Muchatha Kiambu Again, between May and August 2010, 45 people died while others went blind after consuming adulterated alcohol; these were 12 in Shauri Moyo, 5 in Thindigua Kiambu, 23 in Kibera and 5 in Laikipia. Other most conspicuous cases include the use of kumi kimi in November 2000 which resulted in 140 deaths and loss of sight among some users in poor Nairobi neighborhoods (Mukuru kwa Njenga and Mukuru Kaiyaba) (Mureithi, 2002; WHO, 2004). Similar incidents have also been in Muranga (Muthithi and Kabati areas), Naivasha and Machakos. This shows an urgent need to prevent and control alcohol abuse in Kenya, which however, would only be possible if such efforts were backed by scientific evidence. (Nacada, 2010). Other investigations indicated that 96 people lost their lives in the following counties; Embu, Kiambu, Makueni, Kitui, Nakuru, Murang'a, Nyeri, Nyandarua, Kirinyaga, Machakos, Trans Nzoia, Uasin Gishu, and Kajiado by 10th May 2014, additional 98 people were hospitalized over consumption of the illicit brews. (Nacada, 2014)

Today in Kenya, alcohol and drug abuse (ADA) is such a huge problem and a big threat to the economy that the president declared war against second generation alcohol and other substances of abuse after holding a crisis meeting with leaders from central Kenya on 1st July 2015. He ordered the county governments to wipe it out ruthlessly. This came at a time when reports were all over media of youths, men and women dying every day as a result of consuming intoxicated brews and other substances of abuse. The county governments embarked on impounding on sellers of the illicit alcohol and destroying it (Daily nation, 2nd July 2015).

In Kenya, there are a number of slums which include: Kibera, Mukuru Kwa Njenga, Korogocho, Kangemi, Kawangware among others. The upcoming and expansion of many slums in Nairobi is as a result of rural-urban migration among other factors. Being a big market, Nairobi has attracted a large population of rural-urban migrants who aspire to take advantage of the opportunities in the market. Since they are unemployed, the majority of the migrants end up in the slums where cheap housing is available. The fact that Nairobi slums host approximately three million people on 1/8 of the city's land space implies that these neighborhoods by far overstretch their carrying capacity. Kibera's population of 1 million people, for instance, is equal to the population of the rest of Nairobi residents who live in middle class or up-market neighborhoods, which account for 7/8 of the city's land space. Over-congestion in the slums – itself a consequence of the increase in rural-urban migration - has created immense pressure on housing, space for business, and other public utilities. Due to the high population in slums and few resources; Social problems such as trade in hard drugs, drug abuse, and child prostitution, robbery with violence, burglary, and murder are on the rise (Olang Sana and Okoth Okombo, 2012).

1.2 Problem Statement

Globally, the high prevalence of ADA is wanting. Studies on the use of substances have been conducted throughout the world such as Geyer et Al (2015), Nacada (2004) and Richard (2004). An estimated 13 million youths' worldwide aged 12 to 17 become involved with alcohol, tobacco and other substances annually (Lennox & Cecchini,

2008). In general, tobacco and alcohol are the most frequently used substances by young people, with cannabis use accounting for 90% or more of illicit substance use in North America, Australia, and Europe (Alexander, 2001). Furthermore, the Canadian Centre on Substance Abuse (2002) has conducted a survey which indicated that the average age for first users of substances was 12 years. About 64.7% of the youth in grades 7 to 12 reported the lifetime use of alcohol, 29% cannabis, 43% cocaine powder and less than 4% other substances including heroin, ketamine and crystal methamphetamine (Canadian Centre for Substance Abuse, 2002).

Abuse of alcohol and drugs among people in slum areas in developing countries is associated with a broad range of high-risk behavior. This type of behavior can have profound health, economic and social consequences, for example, some youth participate in deviant peer groups, unprotected sexual intercourse, interpersonal violence, destruction of property and perform poorly in their studies (De Miranda, 1987; Jaffe, 1998). At the same time, substance abuse among slum dwellers in most developing countries, Kenya included, costs a country a lot of money every year. This is evident in large sums of money that are used in prevention and treatment centers throughout South Africa (United Nations Office on Drugs and Crime, 2008). In fact, the issue of alcohol and drug abuse has remained a concern to the current Jubilee Government in Kenya since it took office in March 2012, other non-government organizations, and County governments. An effort to curb and contain the situation especially within the cities, city slums, has remained the most expensive task. The Kenya government recognized the seriousness of the drug problem and initiated the National Campaign against Drug Abuse (NACADA) in early 2001. This organization is charged with the responsibility of coordinating activities of individuals and organizations in the campaign against drug abuse. Its mandate is to initiate public education campaign and develop an action plan aimed at curbing drug abuse. Eventually this affects the whole country because these funds could be used in other avenues such as poverty alleviation programmes, since poverty is one of the reasons that lead to substance abuse.

Alcoholism is widespread in Kenya, a survey of alcohol related deaths by nacada found that lifetime use of alcohol was estimated at 37.9 percent for the whole country where

59.3% of males and 21% of females reported they had used an alcoholic drink at least once in the past. With respect to current use, which is defined as consumption of alcoholic drink in the last 30 days, the study found that 15 percent of Kenyans aged 15-64 are “current users” of alcohol. However, alcohol use levels as well as the type of alcoholic drink commonly used vary widely by gender, religion, region of residence, and education level. For instance, 29 percent of males use alcohol compared with only 4 percent of females (Nacada, 2013).

Abuse of alcohol in a family does not give a conducive environment to the bringing up of children, most fathers and mothers with chronic alcoholism have poor parenting skills including abuse and neglect of their children, harsh punishment and inconsistent practices which persist into adulthood (Shantz et al 1995). Alcoholism leads to aggressive behavior among the parents and this affects the children. Children whose parents often engage in angry fight are more non-compliant, which makes them prone to conflict and aggression both at home and in school, than children whose parents are more peaceful.

Various studies such as Nacada (2004) and Richard (2004) have been conducted in Kenya on the impact of drugs and alcoholic consumption in the Kenyan society. The results revealed that the most common substances used by young people were alcohol, tobacco, marijuana (bhang/cannabis sativa) miraa (khat, a plant used as a narcotic) and inhalants such as glue. These studies however, did not have any specific focus on slum situation in Kenya although there has been deaths in the slums like Mukuru Kwa Njenga resulting from consumption of illicit substances. This study therefore sought to investigate the extent to which consumption of alcohol and drug abuse has affected families living in Mukuru Kwa Njenga Slums in Nairobi.

1.3 Research Questions

- (i). What specific substances are commonly consumed by people living in Mukuru Kwa Njenga Slums in Nairobi?
- (ii). What contributes to alcohol and drug abuse by families living in Mukuru Kwa Njenga Slums in Nairobi?

(iii). What effects does consumption of alcohol and drugs have on families living in Mukuru Kwa Njenga Slums in Nairobi?

(iv). What strategies can help reduce abuse of alcohol and drugs among families living in Mukuru Kwa Njenga Slums in Nairobi?

1.4 Purpose of the study

The purpose of the study was to investigate the extent to which consumption of alcohol and drug abuse has affected families living in Mukuru Kwa Njenga Slums in Nairobi.

1.5 Objectives of the study

The study was guided by the following research objectives:

(i). To identify the specific alcoholic and other substances commonly abused by families living in Mukuru Kwa Njenga Slums in Nairobi.

(ii). To establish the factors that contribute to alcohol and drug abuse by families living in Mukuru Kwa Njenga Slums in Nairobi.

(iii). To establish the effects of consumption of alcohol and drugs on families living in Mukuru Kwa Njenga Slums in Nairobi.

(iv). To assess the strategies for alcohol and substance demand reduction among families living in Mukuru Kwa Njenga Slums in Nairobi.

1.6 Justification of the Study

Many studies on ADA have concentrated a lot on youths and especially those in secondary schools; forgetting that families living in slums are also quite vulnerable to ADA. This prompted the need to study abuse of alcohol and drugs among families living in Mukuru Kwa Njenga Slums in Nairobi and highlight what has really made them to indulge in ADA and the effects of this over indulgence.

This study is significant in that, it would bring into light and alert on the rising ADA in the slum areas. This would help the authorities concerned to decide on the right measures to be employed to curb the situation.

The findings of this study would be used to educate the youth and their parents in Mukuru Kwa Njenga slums on the health, social and economic consequences of substance (alcohol and drug) abuse. As a result, these families would be able to make informed decisions regarding ADA. The study would also help the policy makers set strategies for prevention of ADA amongst those who have not experimented with ADA, come up with measures to reduce consumption and also set up rehabilitation centers to rehabilitate the addicts. In addition, the research findings would not only be useful in Kenya but also other slums in Africa.

Family income is threatened as some men who are breadwinners have resorted into drinking in the community. This has forced many children to be out of school. It has also led to increased cases of domestic violence and family disintegration hence many single parents. Some families have resulted to brewing of illicit brews like “chang’aa” that has ready market as it is affordable, in order to cater for the families thereby increasing the problem.

Furthermore, the findings of this study would help educators, health care professionals, policy makers like the ministry of health and non-governmental organizations and other professionals involved with the management of alcohol and drug abuse to understand the prevalence of use and abuse, associated morbidities and most importantly, to develop effective evidence-based strategies and policies that could be used to control the substance abuse problem.

Other researchers and academicians carrying out studies on ADA can use the same knowledge from this study findings as a basis of their future studies for the results would help them form a good foundation of the discussion on alcohol and drug abuse. For instance, in future it would be important to assess the effectiveness of the policies put in place to curb ADA menace.

Alcohol intoxication has been identified a risk factor for rapid HIV transmission since it affects judgment hence influencing risky decision-making and reducing inhibitions. The Kenya Demographic and Health Survey of 2003 shows that HIV prevalence among women who had ever consumed alcohol was 19%, compared to 9% among their never-

drinking counterparts (CBS 2004). The study would be therefore very significant in fighting HIV and AIDs in the slums and other regions.

1.7 Scope and Limitations of the study

The focus of this study was on the factors that contribute to ADA among the families living in Mukuru Kwa Njenga slums, effects of ADA to the families living in Mukuru Kwa Njenga slums and also the strategies being employed to curb the menace of ADA. In addition, to evaluate the effectiveness of the strategies that have been put in place to curb ADA as well as explore other strategies that can be developed to reduce ADA among the families living in Mukuru Kwa Njenga slums. The study is only limited to people living in Mukuru kwa Njenga who are aged eighteen years and above.

1.8 Definition of key terms

Drug- refers to any chemical substance which when taken into the body can affect one or more of the body functions.

Drug abuse- refers to the sporadic or persistent excessive use of mind altering chemicals for any reason other than its acceptable medical purpose.

Substance abuse- refers to the abuse of either drugs and or alcohol.

Dependence/ addiction- refers to the condition whereby one becomes dependent on a drug such that he/she cannot do without it.

Alcoholic- according to WHO, alcoholics are those excessive drinkers whose dependence upon alcohol has attained such a degree that it shows a noticeable mental disturbance or an interference with their bodily and mental health, their interpersonal relations and their smooth social and economic functioning.

Alcoholism- it is a chronic disability which interferes with the social life of a people. It also applies to alcohol abuse or addiction.

Illicit brew- this is alcohol made at home without any professional background, it is illegal for example “changaa”

Adult- This is an individual aged eighteen years and above.

Vulnerable- means being at risk or being exposed to a particular danger. In this study, people in Mukuru kwa Njenga are viewed to be at a high risk of alcohol consumption and other substances of abuse due to the challenges they are facing like the high levels of poverty.

CHAPTER TWO

LITERATURE REVIEW

2.1 Introduction

This section presents the literature on alcohol and drug abuse. Information gathered from previous studies was used to provide an understanding of the factors that would contribute to substance abuse. The literature review focused on the following aspects; commonly abused substances, social-cultural factors that lead to prevalence of substance use and abuse, effects of alcohol and substance abuse and strategies of eradicating ADA.

2.2 Types of alcohol and drug Substances abused

According to Parry (2006) people abuse both legal and illegal substances. Legal substances are socially acceptable psychoactive substances and include over the counter and prescription medicines, such as pain relievers, tranquilisers including benzodiazepines, cough mixtures containing codeine and slimming tablets (Craig & Baucum, 2001). In addition, there are other agents such as solvents in glue, alcoholic beverages, nicotine and inhalants, nail polish and petrol. Illegal substances are prohibited and the use, possession or trading of these substances constitute a criminal offence. These substances include cocaine powder, crack cocaine, heroin, ketamine, cannabis, ecstasy, fentanyl, morphine, methaqualone (Mandrax), opium, flunitrazipam (Rohypnol), methamphetamine and Wellconal (Craig & Baucum, 2001).

In Kenya, the commonly abused drugs include: alcohol, tobacco, marijuana (bhang), inhalants and solvents, heroin, cocaine, prescription drugs-including sex enhancement drugs, anabolic steroids, contraceptives (Nacada, 2004). However, alcohol and tobacco are the mostly abused substances since they are readily available. Alcoholic beverages may be categorized as follows: first generation alcoholic beverages (which include legal beer and spirits. These are conventional and often are high priced with a low alcohol content, such as Amarula, Viceroy, Sminorff, Richot, Tusker, Pilsner and Guinness); second generation alcoholic beverages (which are brands that have been introduced lately into the market. These are low priced and often have a high alcohol content such as Senator Keg, Kenya Cane, Iceberg, Konyagi and Marry Cane); traditional liquor such as Busaa and Muratina; and illicit brews such as Chang'aa. Due to the high level of poverty

in the slums most people cannot afford the legally accepted alcohol instead they go for the illicit brews which are locally prepared like chang'aa and other forms of second generation alcohol like kumikumi. This has posed a big threat to the families living in the slums like Mukuru kwa Njenga and in Kenya as whole, in several occasions, it has led to the death of so many people and loss of eye sight among other problems. Bhang is also commonly abused despite being an illegal substance; this is because it's cheap as compared to others like cocaine and heroin and is also locally available.

2.3 Factors that contribute to alcohol and drug abuse

The causes of substance use are complicated and differ among individuals. Depression and life frustrations seem to be one of the reasons for substance abuse among adolescents. Life frustrations are sometimes driven by social settings of the families in the slum areas living in extreme poverty. Donald et al. (2007) revealed that many people who abuse drug and alcohol are overwhelmed by the challenges in their own lives, their families, and the society in which they live. The high level of poverty in some families makes it difficult for the parents to provide for the needs of their children. Adolescents from such families become stressed if their needs are not met. This then leads them to abuse substances in order to forget their problems. They then resort to substance abuse as a way of coping with their problems, not realizing that their use of substances will not solve their problems. Instead, the use of substances aggravates their problems. Parents who are unable to provide for their children may result in ADA as way of escaping from their frustrations.

In the slum areas, the family structures vary from single parent, nuclear, step parent, extended, up to child-headed families. A study by Success (2005) showed that some participants indicated that their fathers were not taking care of them while others did not have father figures at home. As a result, these male adolescents looked up to the behavior modeled by other male figures who could be substance abusers, in their environment and media. Participants from nuclear family also used substances even though they had a father figure in their family. This may imply that their fathers did not guide them or even advise them not to use substances.

Child-headed families also proved to be 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 developing adolescents are vulnerable; they need the care of parents, other family members, as well as other elders in the community. It is not easy to raise a child alone, hence the African proverb that “It takes the whole community to raise a child.” That means that children thrive when parents, educators, caregivers, doctors, nurses, psychologists, police officers, business people, volunteers, community members and community leaders care enough to provide for their needs. Together, these stakeholders can ensure that children are provided with opportunities, skills and support required to enable them deal effectively with their substance abuse problem and to help them succeed in life (Success, 2005).

The study by Success (2005) revealed that peer group pressure is one of the major factors for the use of substances. Adolescents rely on their peers for care and support; as such they have no option but to succumb to everything that their peers offer them. Children from slum areas are influenced by their friends to use substances. They also provide them with substances if they do not have them. This is simply because their peers are the only people who are available when they need help, they are able to talk to them and they spend most of the time with them.

Parenting style also contributes to substance abuse. Parents who allow their children to go to bars without reprimanding that type of behavior encourage their children to abuse substances. Children born from such families are free to use substances because no one corrects such behavior or even guides them. This confirms findings of previous studies that permissive parenting styles contribute to substance abuse (Oketch 2008). In addition to this, authoritative parents who do not allow their children time to relax may frustrate them. Such children may end up abusing substances. Parent-child conflicts were also noted as a cause of substance abuse. These conflicts often lead to poor communication and strained relations between parents and their children. Children who are in conflict 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 the love and support that they lack at home (National Institute on Drug Abuse, 2003). Their peers become the only people with whom they are able to communicate. Furthermore, these adolescents may end up not being able to relate well with others and grow up as parents who will not be able to relate well with their own children. This strained parent-child relation frustrates these adolescents and they end up being depressed.

Availability of substances is another cause of ADA in the slum areas. The findings in a study conducted by Kawaguchi (2004) revealed that despite the high rate of poverty, the male adolescents in the study could afford to buy substances which seem readily available in their communities. This was also reported in previous study by Liddle & Rowe (2006). Therefore, one may assume that there are too many outlets that sell alcoholic beverages and other substances and that people in slum areas have the means to buy these substances. Furthermore, it implies that laws prohibiting the sale of substances to minors are not implemented and adhered to. This then contradicts government strategy of providing services to previously disadvantaged areas and ensuring that all policies and laws protecting the rights of children and minors are adhered to at all time (Liddle & Rowe, 2006).

Substance abuse in slum areas can also be 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). However, other adolescents' parents do not abuse substances. Thus, children in such families learn to use substances from their peers and other adult figures in the community. This contradicts other findings that adolescents who abuse substances have parents who abuse substances. (Sue et al., 1994).

Mukuru kwa Njenga is one of the very densely populated slums in Nairobi with a population of almost 10000000 on an area of 0.9975 km². Therefore, there is a lot of competition for the scarce resources available such as housing, water among others.

Many people are jobless or engaged in economic activities that can hardly feed them or meet their daily needs, this therefore leads to lots of frustrations and despair, and this could push the people to indulge in ADA as a way of coping with the high level of poverty.

2.4 Effects of alcohol and drug abuse

The negative consequences of substance abuse affect not only individuals who abuse substances but also their families and friends, various businesses and government resources. The exact effect of a substance will depend on the substance used, how much is taken, in what way, and on each individual's reaction. Substances can be extremely harmful and it is relatively easy to become dependent on them. Substance abuse has profound health, economic and social consequences.

2.4.1 Health effects of substances

Alcohol

Ethyl alcohol, or ethanol, is an intoxicating ingredient found in beer, wine, and liquor. Alcohol is produced by the fermentation of yeast, sugars, and starches. It is a central nervous system depressant that is rapidly absorbed from the stomach and small intestine into the bloodstream. A standard drink equals 0.6 ounces of pure ethanol, or 12 ounces of beer; 8 ounces of malt liquor; 5 ounces of wine; or 1.5 ounces (a "shot") of 80-proof distilled spirits or liquor (e.g., gin, rum, vodka, or whiskey).

Effects of alcohol.

The immediate effects of alcohol abuse include impaired judgment, being sluggish and also delayed physical coordination. Alcohol abuse also causes diseases such as liver disease, heart disease, pancreatitis and diabetes. Alcohol misuse is also an important factor in a number of cancers, including liver cancer and mouth cancer, both of which are on the increase. Alcohol is second only to smoking as a risk factor for oral and digestive tract cancers. Evidence suggests that this is because alcohol breaks down into a substance called acetaldehyde, which can bind to proteins in the mouth. This can trigger an

inflammatory response from the body – in the most severe cases, cancerous cells can develop.

Alcohol also alters the brain's chemistry and increases the risk of depression. It is often associated with a range of mental health problems; a recent British survey found that people suffering from anxiety or depression were twice as likely to be heavy or problem drinkers.

Extreme levels of drinking (defined as more than 30 units per day for several weeks) can occasionally cause 'psychosis', a severe mental illness where hallucinations and delusions of persecution develop. Psychotic symptoms can also occur when very heavy drinkers suddenly stop drinking and develop a condition known as 'delirium tremens'.

Heavy drinking often leads to work and family problems, which in turn can lead to isolation and depression. For heavy drinkers who drink daily and become dependent on alcohol, there can be withdrawal symptoms (nervousness, tremors, palpitations) which resemble severe anxiety, and may even cause phobias, such as a fear of going out. Drinking large quantities of alcohol on a regular basis can also lead to addiction. This can have serious effects on the families, friends and partners, as well as the mental health of such individuals. Alcohol can also lead to death. (Nacada, 2004).

Tobacco

Tobacco causes many adverse effects to the user as well as other people surrounding the user and the society at large. According to Nacada (2004) these effects may include the following:

- Respiratory problems such as increased coughing, phlegm, wheezing, chest colds and shortness of breath.
- Serious ailments such as bronchitis, pneumonia, emphysema, strokes, heart attacks, ulcers, ear infections, osteoporosis and impotence.
- Asthma attacks or increased asthma symptoms.
- Dental problems such as yellow teeth, gum disease, tooth decay and tooth loss.
- Dulled sense of smell and taste.

- Cold fingers and toes.
- Zits –It takes longer for a smoker’s acne to heal.
- Hair loss –even for some teens.
- Low sperm count: Even teenage smokers have fewer than half as many sperm per ejaculate as non-smokers.
- Premature wrinkling and related signs of premature aging.
- Infertility, sudden infant death syndrome and low birth-weight babies.

Marijuana/bhang

Effects of bhang include the following:-

- Bhang affects the perception of time, distance, and speed. It upsets coordination, causing unsteady hands, a change in gait, uncontrolled laughter, and a lag between thought and facial expressions. Sexual functions are disturbed.
- One may suffer illusions and hallucinations, difficulty in recalling events in the immediate past, slowed thinking and narrowed attention span, depersonalization, euphoria, depression, drowsiness, lack of sleep, difficulty in making accurate self-evaluation, a lowering of inhibition, loss of judgment, mental and physical lethargy.
- Heavy use over a long period of time cause permanent changes in the brain. It has been found, for instance, that the brains of young heavy users of cannabis reduce in size. The loss in brain substance is comparable to that normally found in people seventy to ninety years old. Progressive brain damage may explain the psychic changes that occur after heavy long-term use.
- Individuals who smoke Bhang/hashish for long periods show a tendency toward bronchitis. The lungs of bhang users are more blackened than those of tobacco smokers because, to get an effect, cannabis smoke must be inhaled deeper and held longer in the lungs.

Studies have shown that testosterone, the most potent of the male sex hormones, is depressed in the blood of Bhang users, and reproductive function is inhibited. (Nacada, 2004)

Inhalants and Solvents

Short-term effects

Within seconds of inhalation, the user experiences intoxication along with other effects similar to those produced by alcohol. Alcohol-like effects may include slurred speech, an inability to coordinate movements, dizziness, confusion and delirium. Nausea and vomiting are other common side effects. In addition, users may experience light-headedness, hallucinations, and delusions.

Long-term effects

Compulsive use and a mild withdrawal syndrome can occur with long-term inhalant abuse. Additional symptoms exhibited by long-term inhalant abusers include weight loss, muscle weakness, disorientation, in-attentiveness, lack of coordination, irritability, and depression. After heavy use of inhalants, abusers may feel drowsy for several hours and experience a lingering headache. Because intoxication lasts only a few minutes, abusers frequently seek to prolong their high by continuing to inhale repeatedly over the course of several hours. By doing this, abusers can suffer loss of consciousness and even death. (Nacada, 2004)

Prescription Drugs

Prescription drug abuse is when someone takes a medication that was prescribed for someone else or takes their own prescription in a manner or dosage other than what was prescribed. Abuse can include taking a friend's or relative's prescription to get high, to treat pain, or because you think it will help with studying.

The Most Commonly Abused Prescription and Over-the-Counter Drugs.

Opioids (such as the pain relievers OxyContin and Vicodin), central nervous system depressants (e.g., Xanax, Valium), and stimulants (e.g., Concerta, Adderall) are the most commonly abused prescription drugs. Drugs available without a prescription—also known as over-the-counter drugs—can also be abused. DXM (dextromethorphan), the active cough suppressant found in many over-the-counter cough and cold medications, is

one example. It is sometimes abused to get high, which requires large doses (more than what is on the package instructions) that can be dangerous.

Effects of Prescription Drugs

Virtually every medication presents some risk of undesirable side effects, sometimes even serious ones. Doctors consider the potential benefits and risks to each patient before prescribing medications. They understand that drugs affect the body in many ways and take into account things like the drug's form and dose, its possible side effects, and the potential for addiction or withdrawal. For example, doctors know how to change the dose of a painkiller to prevent withdrawal symptoms. People who abuse drugs might not understand how these factors may affect them or that prescription drugs do more than cause a high, help them stay awake, help them relax, or relieve pain. Therefore, prescription drugs may cause: withdrawal, dizziness among other effects and in some cases death.

Cocaine

Cocaine is a powerfully addictive stimulant drug made from the leaves of the coca plant native to South America. It produces short-term euphoria, energy, and talkativeness in addition to potentially dangerous physical effects like raising heart rate and blood pressure. Cocaine is a strong central nervous system stimulant that increases levels of dopamine, a brain chemical (or neurotransmitter) associated with pleasure and movement, in the brain's reward circuit. Certain brain cells, or neurons, use dopamine to communicate. NIDA (National institute of alcohol and drug abuse, 2013)

Effects of cocaine:

Abusing cocaine has a variety of adverse effects on the body. For example, cocaine constricts blood vessels, dilates pupils, and increases body temperature, heart rate, and blood pressure. It can also cause headaches and gastrointestinal complications such as abdominal pain and nausea. Because cocaine tends to decrease appetite, chronic users can become malnourished as well.

Different methods of taking cocaine can produce different adverse effects. Regular intranasal use (snorting) of cocaine, for example, can lead to loss of the sense of smell; nosebleeds; problems with swallowing; hoarseness; and a chronically runny nose. Ingesting cocaine can cause severe bowel gangrene as a result of reduced blood flow. Injecting cocaine can bring about severe allergic reactions and increased risk for contracting HIV and other blood-borne diseases. Binge-patterned cocaine use may lead to irritability, restlessness, and anxiety. Cocaine abusers can also experience severe paranoia—a temporary state of full-blown paranoid psychosis—in which they lose touch with reality and experience auditory hallucinations.

Regardless of the route or frequency of use, cocaine abusers can experience acute cardiovascular or cerebrovascular emergencies, such as a heart attack or stroke, which may cause sudden death. Cocaine-related deaths are often a result of cardiac arrest or seizure followed by respiratory arrest.

Added Danger: Cocaethylene - when cocaine and alcohol are consumed together, the body forms a unique cocaine metabolite named cocaethylene. It is unique because it is formed only during the combined ingestion of cocaine and alcohol. (The name “cocaethylene” is derived from the words “cocaine” and “ethyl alcohol.”) It is unique also because it is the first known example of the body forming a third drug following ingestion of two other drugs. It is not a natural alkaloid of the coca leaf, and is not found in street cocaine.

Polydrug use—use of more than one drug—is common among substance abusers. When people consume two or more psychoactive drugs together, such as cocaine and alcohol, they compound the danger each drug poses and unknowingly perform a complex chemical experiment within their bodies. Researchers have found that the human liver combines cocaine and alcohol to produce a third substance, cocaethylene that intensifies cocaine’s euphoric effects. Coca ethylene is associated with a greater risk of sudden death than cocaine alone. (NIDA, 2013)

Heroin

Heroin is a powder obtained from the dried milk of the opium poppy plant. Pure heroin is white, but with impurities, it is brown powder commonly known as brown sugar. Other names by which heroin is known are Kichuri, Kiketi, Skag, junk, unga, pony, mzingo, stuff, boy, maponaji, prama, daba daba, kete, joy powder, hard stuff, white stuff, horse, mwimbwi among others.

Effects of Heroin

As with other opioids, heroin is used as both a pain-killer and a recreational drug and has high potential for abuse. Frequent and regular administration is associated with tolerance, moderate physical dependence, and severe psychological dependence which often develops into addiction. Despite this, heroin has been proven to act as an extraordinary fever reducer.

One of the most common methods of illicit heroin use is via intravenous injection (colloquially termed “shooting up”). Heroin base (commonly found in the UK and Europe), when prepared for injection will only dissolve in water when mixed with an acid (most commonly citric acid powder or lemon juice) and heated. Heroin in the US is most commonly in its hydrochloride salt, requiring just water to dissolve. Users tend to initially inject in the easily accessible veins in the arm, but as these veins collapse over time through damage caused by the acid, the user will often resort to injecting in other veins. (Nacada, 2004)

2.4.2 Social effects of substances

Dependence on any substance is damaging to the individual as well to society (Oketch 2004). Substance abuse does not only affect the individual, it also affects the family, friends, teachers at school and other members of the community. People from slum areas abusing substances may become withdrawn, moody, irritable or aggressive. That often leads to deterioration in family, peer group, and school relationships. For the case of school children, academic performance drops and truancy often increases (Burger, 2007; Donald et al.) and they end up being expelled from school due to their behavior (Donald et al., 2007). Furthermore, school children who use substances often suffer from

impairment of short-term memory and other intellectual faculties, impaired tracking ability in sensory and perceptual functions, preoccupation with acquiring substances, adverse emotional and social development and thus generally impaired classroom performance. Reduced cognitive efficiency leads to poor academic performance, resulting in a decrease in self-esteem and the adolescent may eventually drop out altogether. This contributes to instability in an individual's sense of identity which, in turn, is likely to contribute to further substance consumption, thus creating a vicious circle (Lakhanpal & Agnihotri, 2007).

The more a student uses tobacco, alcohol, cannabis, cocaine, and other substances, the more likely he or she will perform poorly in school, drop out, or not continue on to higher education (Davison et al., 2004). Furthermore, adolescents who abuse substances may neglect their schoolwork and even be absent from school. They are less likely to value academic achievements; they expect less academic success and do, in fact, obtain lower grades. In addition to that, they also become aggressive towards teachers and other learners. Some substances are expensive, thus a need to sustain the dependence may lead to theft, involvement in violence and eventually even to organized drug-related crime (Donald et al., 2007). Some adolescents drop out of school and turn to other crimes such as robbery and gang-related activities to support their habit.

Previous studies confirm that there is a link between substance abuse and criminal activities (Karen Lesly, 2008; United Nations Office on Drugs and Crime, 2009). Young people often steal money to buy substances. The substance, and obtaining it, becomes the Centre of the abuser's existence, governing all activities and social relationships. The effect of these substances in general is inhibition of impulses, social judgment is often distorted. Involvement in other social problems such as impulsive violence, casual or exploitative sex, racial and other forms of intolerance or abuse may result. It is believed that over half of all murders are committed under the influence of substances; as are rape, assault and family violence (Davison et al., 2004). This adds to the danger to the adolescents and to others (Donald et al., 2007). Drugs can trigger violent reactions and users can harm themselves or others. Furthermore, substance abuse issues are encountered at every level of the criminal justice system, from the international trade in

substances and the use of the proceeds of that trade for corrupt ends to driving under the influence of alcohol or other substances (United Nations Office on Drugs and Crime, 2008). The high cost of substances means that dependents must either have great wealth or acquire money through illegal activities, such as theft, prostitution or the selling of substances (Davison et al, 2004).

The correlation between opiate dependence and criminal activities is thus rather high, undoubtedly contributing to the popular notion that substance dependence per se causes crime (Davison et al., 2004). Substance use impacts on the criminal justice system, with evidence of links between drinking at risky levels, committing crime, or being a victim of crime (Karen Lesly, 2008; United Nations office on Drugs and Crime, 2008). Most substance-related crimes, however, are the culmination of a variety of factors. That is, personal, situational, cultural, and economic. In Kenya, there has been an outcry that many road accidents are as a result of driving under the influence of alcohol and other substances.

When teenagers depend on alcohol and other substances to deal with daily stresses, they fail to learn responsible decision-making skills and alternative coping mechanisms. These young people show serious adjustment problems, including chronic anxiety, depression and antisocial behavior, which are both the cause and consequences of taking drugs (Oketch, 2004). They often enter into marriage, childbearing and the work world prematurely and fail at them. These are painful outcomes that encourage further addictive behavior. Thus substance use does not only have an effect on the users only but also has an effect on the lives of other people.

Consumption of drugs and other substances of abuse lead to many other adverse effects. First, people are known to have sold their property and wasted their livelihood and inheritance in order to maintain their addiction. These people have been rendered homeless and hopelessness has crept in. They have no sense of belonging in the community. Secondly, families have broken up as wives leave their alcoholic and irresponsible husbands. This has led to the emergence of women headed families, as men are no longer able to be heads. The men can no longer make sound judgments and

decisions. Third, within communities where there is addiction, there is an increasing trend of theft within the community as addicts steal to feed their addiction, resulting in conflict within the community. There are other effects such as (i) spread of HIV/AIDS due to promiscuity; (ii) low levels of education as children drop out of school because their parents are unable to educate them further due to poverty, stemming from the addiction habits; (iii) increase in many single people as men and women are “unable and incapable of starting families”; (iv) lack of proper guidance to children leading to child delinquency in communities and children loitering in the streets for lack of proper parenting; and (v) increased prostitution and promiscuity. (Nacada, 2012)

2.4.3 Economic effects of substance abuse

Substance abuse has a negative impact on the economy of the country. This includes a range of problems such as inefficiency, impaired work performance, accidents and absenteeism at a considerable cost to both industry and society (Oketch; 2008). ADA also leads to a deteriorated economy because the youth become largely unproductive. The other economic related effects include: (i) low levels of investments because the available cash is used on alcohol and not in developmental activities; (ii) lack of employment due to a low number of qualified people; and (iii) increased theft and conflict in the areas where alcohol and drug abuse is high.

The net effect of all these is that the economy of the area becomes poor. Work productivity declines. For example, 2.5 million workdays are lost due to absenteeism arising from substance-related illnesses (Department of Social Development, 2006). Furthermore, the use of substances has a negative impact on the health care system including the depletion of scarce resources available to improve the health of people (Department of Health, 2007). Medical resources are wasted and lives are lost in substance-related accidents. High amounts of money are spent in hospitals, on prevention campaigns and in treatment centers for substance dependents (Plüddermann et al., 2007; United Nations Office on Drugs and Crime, 2008). Although most people from slum areas who abuse substances do not seek professional help, people who abuse alcohol constitute a large proportion of new admissions to mental hospitals and general hospitals (Davison et al., 2004; Department of Social Development, 2006). Other costs

include repairs to property damaged by addicts, food and accommodation in prisons, transportation of addicts to courts in terms of those still awaiting trial (United Nations Office on Drugs and Crime, 2008).

Treatment for addiction to substances is quite expensive; it calls for rehabilitation of the abuser for a period of not less than three months. The use of alcohol and other substances presents law-enforcement problems as well. Thus, substance dependence is a financial burden for the country. The adolescent not only suffers progressive physical and psychological deterioration but also loses the ability psychologically, socially and often economically to break out of the cycle of substance abuse (Donald et al., 2007). The health and socioeconomic consequences of substance use and abuse undermine democracy, good governance and has a negative impact on the country. As with alcohol, the socio-economic cost of smoking is staggering. Each year smokers compile over 80 million lost days and 145 million days of disability, considerably more than do nonsmoking peers (Davison et al., 2004).

2. 5 Strategies for Alcohol and drug demand reduction

The government has made a concerted effort in the recent past to ensure a coordinated response to alcohol and drug abuse. Prior to 2007, this effort was applied, in a piecemeal approach, using isolated legislations such as “The Dangerous Drugs Act Cap. 245”. The predecessor of NACADA, the Narcotics Bureau, under the direction of the Ministry of Health, coordinated activities relating to trafficking of drugs in the country. As well, there were laws against the production, distribution and consumption of local brews including busaa and chang’aa. In 1994, the government of Kenya developed “The Kenya National Drug Policy” (MOH, 1994) which, among other things, proposed the amendment of “The Dangerous Drugs Act Cap. 245” in order to create two Acts. One was to be for the medicinal use of dangerous drugs and other for the illicit trafficking of dangerous drugs. In order to ensure wide distribution of information on drugs, it was proposed in the policy that information be disseminated to the public in a language ‘understandable by all’. This was to be done using District Development Committees, among other bodies and by targeting all groups, particularly the youth and students. The policy also identified the need to use different modes of communication to disseminate information, including the

use of print and electronic media, traditional media such as songs, dances, poems and drama. For many years, though, the government seems to have been using a two pronged approach in the control of alcohol and other substances of abuse. Those substances for which the law allows their selling in the country, the unwritten approach seemed to focus on making access to these substances – alcohol and cigarettes – more expensive, through imposition of higher taxes and changes such as new packaging requirements. All of them were aimed at making the substances more expensive and passing messages on health related consequences of their use or misuse. These are however, products which are allowed by the country's legal regime. For those products which are not legally allowed, such as bhang, cocaine and heroin, the focus has been on legal mechanisms such as stiffer penalties for those found in possession of these banned substances. However, the policy and legal environment in the country has changed drastically over the past couple of years since the first National Survey on Alcohol and Drug Abuse was conducted in 2007. Specifically, these changes have focused on tobacco control through the “The Tobacco Control Act of 2007” and “The Alcoholic Drinks Control Act of 2010”. Both of these new legislations have had a direct impact on the use of alcohol and substances of abuse in the country.

The Tobacco Control Act, 2007

The Tobacco Control Act 2007 came into force on 8th July, 2008 to control the production, manufacture, sale, labelling, advertising, promotion and sponsorship of tobacco products. Specifically, the Act seeks to protect individuals from disease and death caused by tobacco; protect consumers of tobacco products from misleading inducements to use tobacco; protect children by restricting their access to tobacco products; educate the public on the dangers of tobacco use; protect non-smokers from second hand smoke; protect tobacco growers, workers and sellers by providing alternative economic activities; protect the Government by dealing with illicit trade; protect smokers by providing for cessation and promote research and dissemination of information. The Act therefore prohibits sale to persons under the age of 18 years, requires health warnings on cigarette packages, bans promotions through media, bans

smoking in public places but provides for designated smoking areas and bans sponsorship of educational, cultural, entertainment or trade fairs. (Republic of Kenya, 2010).

The Alcoholic Drinks Control Act, 2010

The Alcoholic Drinks Control Act, 2010, was assented to, on 13th August, 2010. The Act controls and regulates the production, manufacture, sale, labelling, promotion, sponsorship and consumption of alcoholic drinks. The Act seeks to protect the health of individuals; protect the consumers of alcoholic drinks from misleading and deceptive inducements; protect the health of persons under the age of 18 years; inform and educate the public on the health effects of alcohol abuse; adopt and implement measures to eliminate illicit trade in alcohol, like smuggling; promote and provide for treatment and rehabilitation programmes; and promote research and dissemination of relevant information. Therefore, the legislation seeks, among other things, to mitigate the negative health, social and economic impact, resulting from the excessive consumption and adulteration of alcoholic drinks. The Act also seeks to legalize the production and consumption of chang'aa by repealing the Chang'aa Prohibition Act. It provides for the legalizing of chang'aa and its manufacture to conform to prescribed standards as a way of protecting consumers. Some of the key provisions include prohibition of the sale of alcoholic drinks to persons under the age of 18 years; prohibition of sale of alcoholic drinks in sachets or in a container less than 250 ml; and provision of mandatory warning labels on information and potential health hazard as well as a statement as to the constituents of the alcoholic drink. Such health warnings and messages include: excessive alcohol consumption is harmful to your health, excessive alcohol consumption can cause liver cirrhosis (liver disease) and not for sale to persons under the age of 18 years. (Republic of Kenya, 2010).

In addition, there is new law which restricts sale of alcohol, bar opening and closing times, prescribes penalties on offering brewers, sellers, patrons etc. However, it is temporarily on hold after an association of bar owners from Muranga in Central Kenya filed a court case to delay its implementation.

A study by Nacada 2013, revealed that the two acts popularly known as “Mututho law” is moderately well known, that is, (55.4%) of Kenyans know it. The same study found that Lifetime use of alcohol was estimated at 37.9 percent for the whole country with 59.3% of males and 21% of females reported they had used an alcoholic drink at least once in the past. With respect to current use, which is defined as consumption of alcoholic drink in the last 30 days, the study found that 15 percent of Kenyans aged 15-64 are “current users” of alcohol.

Analysis of Alcohol-Attributable Deaths (AADs) for 2010, 2011 and 2012 found that alcohol accounted for an average of 4.5 percent of all the deaths that occurred in the country during that period. Specifically, such deaths accounted for 4.9 percent, 3.9 percent and 4.9 percent in 2010, 2011, and 2012 respectively. Nairobi and Central regions have the highest proportion of alcohol-attributable deaths (5.4 percent of total deaths) while North Eastern region has the least proportion at slightly over two percent (Nacada 2013). Therefore, this clearly shows that despite having the two acts, ADA is still rampant in Kenya and the effects have devastated the country. This implies that a lot needs to be done to control the menace, may be strengthen the two acts or and come up with more policies to curb ADA.

2. 6 Theoretical Framework

Sociological theories explain various issues in the society, one of them being ADA. However, understanding ADA can be complex and confusing. Addicted individuals compulsively consume alcohol and other drugs despite the negative consequences. They seem helpless or unable to do without them. Youths experiment with drugs out of curiosity, peer pressure while others use them for leisure. A variety of theoretical models have arisen to try to explain the complexity of substance abuse. This study was guided by social learning theory and symbolic interaction theory in investigating the factors that contribute to ADA and the effects of ADA on families living in Mukuru kwa Njenga slums.

2.6.1 Social learning theory

Social learning theory attempts to explain socialization and its effect of the development of the self. Social learning theory, like others, looks at the individual learning process, the formation of self, and the influence of society in socializing individuals (Bandura, 1977).

Social learning theory considers the formation of one's identity to be a learned response to social stimuli. It emphasizes the societal context of socialization rather than the individual mind. This belief of psychoanalytic theorists), but instead is the result of modeling oneself in response to the expectations of others. Behaviors and attitudes develop in response to reinforcement and encouragement from the people around us. While social learning theorists acknowledge that childhood experience is important, they also believe that the identity people acquire is formed more by the behaviors and attitudes of others. Social learning theory has its roots in psychology and was shaped greatly by psychologist Albert_Bandura. Sociologists most often use social learning theory to understand crime and deviance. According to social learning theory, people engage in crime because of their association with others who engage in crime. Their criminal behavior is reinforced and they learn beliefs that are favorable to crime. Similarly, most individuals learn about ADA from their peers, relatives, celebrities and other members of the society. Then they model them. (Burger, et Al. 2007).

2.6.2 Symbolic interaction theory

The symbolic interaction perspective, also called symbolic interactionism, is a major framework of sociological theory. This perspective relies on the symbolic meaning that people develop and rely upon in the process of social interaction. Although symbolic interactionism traces its origins to Max Weber's assertion that individuals act according to their interpretation of the meaning of their world, the American philosopher George Herbert Mead introduced this perspective to American sociology in the 1920s.

Symbolic interaction theory analyzes society by addressing the subjective meanings that people impose on objects, events, and behaviors. Subjective meanings are given primacy because it is believed that people behave based on what they believe and not just on what is objectively true. Thus, society is thought to be socially constructed through human

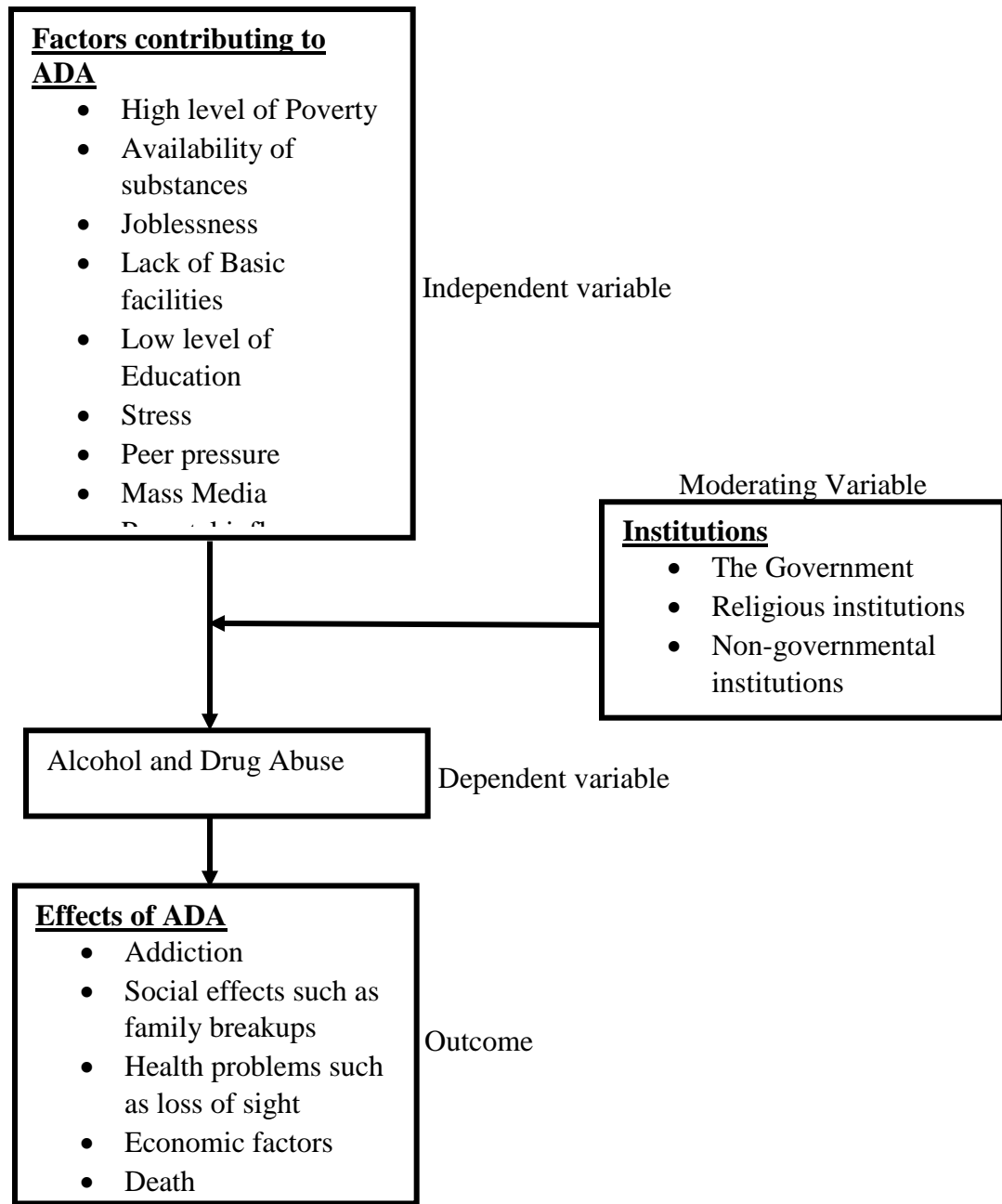
interpretation. People interpret one another's behavior and it is these interpretations that form the social bond. These interpretations are called the "definition of the situation." For example, why would young people smoke cigarettes even when all objective medical evidence points to the dangers of doing so?

The answer is in the definition of the situation that people create. Although teenagers are well informed about the risks of tobacco, they think that smoking is cool, that they themselves will be safe from harm, and that smoking projects a positive image to their peers. So, the symbolic meaning of smoking overrides those actual facts regarding smoking and risk. (Anderson and Taylor 2009).

2.7 Conceptual Framework

The conceptual framework below presents the variables in the study which include the factors that contribute to ADA and its effects. Factors contributing to ADA constitutes the independent variable. Availability of substances, high level of poverty, peer pressure, low level of education, joblessness, mass media and parenting styles are some of the factors that predispose individuals to use of substances.

Figure 2. 1 Conceptual Framework showing factors contributing to ADA and its effects



ADA has negative effects on one’s health, social and economic aspects. These effects are also felt by the community at large. These effects constitutes the outcome while ADA is the dependent variable. The government, religious institutions and the non-governmental institutions have a major role in preventing and curbing ADA. The government has set up

laws governing advertisement, sale and consumption of alcohol and other substances of abuse. However according to a study by NACADA, the law is well known but lifetime use of alcohol is estimated at 59.3% male and 21% female (NACADA 2013). The religious institutions are charged with the responsibility of guiding its members, giving hope and providing solutions to challenges facing their members. Non-governmental institutions also help to address social problems. However, ADA is a challenge in the slums despite the interventions of these institutions. The institutions are the moderating variable.

CHAPTER THREE

RESEARCH METHODOLOGY

3.1 Introduction

This chapter gives a description of the research methodology that was used in the study. The chapter presents the research design, target population, sample size and the sampling procedures. The validity and reliability of the research instruments, data collection procedures and data analysis techniques are also presented.

3.2 Research Design

The study used descriptive survey research design. Descriptive survey design allows the researcher to gather information, summarize, present and interpret it for the purpose of clarification (Orodho, 2002; Kothari, 2003). According to Shields & Nandhini (2013) descriptive research is used to describe characteristics of a population or phenomenon being studied. This design was ideal for this study as the researcher sought to investigate ADA among families living in the slums. The design involved asking a large group of respondents' questions about a particular issue (Mugenda and Mugenda, 1999).

3.3 Research Site

The study was carried out in Mukuru Kwa Njenga slum, located in East of Nairobi (the capital city of Kenya). The slum is in Embakasi Constituency. The slum has an area of 0.9975 km² which is equal to 246.47 acres of land and carries a population of up to 750,000 residents. It comprises of 7 villages that have informal structures namely; Moto Moto, Wape Wape, Riara, Vietnam, Sisal and Milimani. The population is so high in consideration with the size of the area as a result there is a lot of pressure on the available resources. As a result, so many temporary structures have been put up to serve as houses, other basic facilities such as latrines and water are also limited, drainage is very poor among other challenges. The poverty level is very high, resulting in stress and frustration.

3.4 Target Population, Sample Size and Sampling procedures

Target population is the entire set of units for which the data is to be used to make inferences. Mugenda & Mugenda (1999) defines target population as that population to which a researcher wants to generalize the results of a study. The target population of this study was about 750,000 residents of Mukuru kwa Njenga. The target population comprised of men and women, aged eighteen years and above. The choice of this category was based on the fact that they are perceived to be adults and therefore, they understand well the extent of effects of drug and alcohol abuse amongst them. Besides, the researcher interviewed key informants who included: the area chief, a priest and a Head teacher.

Sampling is concerned with the selection of a subset of individuals from within a statistical population. According to Orodho & Kombo (2002), sampling is the process of selecting a number of individuals or objects from a population such that the selected group contains elements representative of the characteristics found in the entire population. Sampling is the process of obtaining information about the entire population by examining only part of it (Kothari, 1985). Purposive sampling was used to select three groups living in Mukuru kwa Njenga slums whose members are charged with the responsibility of garbage collection, security and road maintenance. These groups were purposely selected because they freely interact with families living in Mukuru kwa Njenga and therefore are aware of their problems which include ADA. They are also organized and available. Simple random sampling method was used to select forty members from each group; the researcher met the chairperson and secretary of each group and explained the aim of the study, hence requested for a list of the members and from the list picked the first forty members as the groups have over one hundred members. Forty members from three groups made a sample of One hundred and twenty people from the total target population. In addition to the sample selected through random sampling, purposive sampling was used to select the chief in charge of the location, one religious leaders (priest from St Bhakita Catholic Church) and Head teacher from Kwa Njenga Primary School. The three key informants were selected since they were

perceived to have the required information with respect to the research objectives; they were interviewed separately.

3.5 Methods of Data collection and Research Instruments

The data was obtained through primary and secondary sources.

3.5.1 Secondary sources

Secondary data was collected through library research. A number of literature was reviewed which include journals, books, newspapers, government publications, and research reports and records. Secondary data is important because it shows the nature and the extent of the Problem. It also complements the primary data.

3.5.2 Primary sources

Primary data was collected in the field from individuals living in Mukuru kwa Njenga slums aged 18 years and above, these individuals were targeted because they were assumed to be adults and therefore aware of ADA in the area. The following tools were used to obtain the data.

Survey

The survey employed use of questionnaires which contained closed ended questions and a few open ended questions which therefore means that the data gathered was be both quantitative and qualitative. The open-ended questions served to get in-depth information from the respondents. One hundred and twenty questionnaires with adequate instructions were drafted in a clear language and were hand delivered to the respondents who are adults aged eighteen years and above charged with the responsibility of garbage collection, security and road maintenance by the researcher and /or assistants. The researcher made observations across the constituency while traversing the study site. This enriched the study and helped to fill some information gaps.

The items on the questionnaire were designed to measure the respondent's knowledge on the types of drugs abused, reasons for abusing the drugs as well as the effects these drugs

have on them. They also gathered information on the various measures put in place to control the habit of drug taking. They also sought to understand how the locals thought the issue should be addressed.

Key Informant Interview Guide

Interviews were particularly organized for key informants who included; the area chief, the priest in charge, St Bhakita Catholic Church and the Head teacher, Kwa Njenga Primary School. These are particularly selected since they know the issues affecting the people on the ground, including alcohol and drug abuse. They interact with many individuals living in Mukuru Kwa Njenga. They are also involved in handling cases related to substance and drug abuse such domestic violence, rape cases, theft, truancy, dropping out of school among others.

3.6 Validity and Reliability of Instruments

Mugenda and Mugenda (1999) define validity as the accuracy and meaningfulness of inferences, which are based on the research results. In other words, validity is the degree to which results obtained from the analysis of the data actually represents the phenomena under study. Validity according to Borg and Gall (1989) is the degree to which a test measures what it purports to measure. There are various types of validity. Construct validity occurs when the theoretical constructs of cause and effect accurately represent the real-world situations they are intended to model. This is related to how well the experiment is operationalized, Convergent validity occurs where measures of constructs that are expected to correlate do so. This is similar to concurrent validity (which looks for correlation with other tests), Discriminant validity occurs where constructs that are expected not to relate do not, such that it is possible to discriminate between these constructs, while Content validity occurs when the experiment provides adequate coverage of the subject being studied (Mugenda and Mugenda, 1999). This includes measuring the right things as well as having an adequate sample. Samples should be both large enough and be taken for appropriate target groups. The perfect question gives a complete measure of all aspects of what is being investigated. However, in practice this is

seldom likely, for example a simple addition does not test the whole of mathematical ability.

The study used content validity in its efforts towards achieving the objectives of the study. To ensure validity of the instruments, the researcher worked with the supervisors who are specialists in the area of study while framing the questionnaires and interview schedules. The supervisors or lecturers in the departments were considered to be experts in research and therefore reliably guided the researcher to develop valid instruments.

3.7 Data Collection Procedures

After approval of the proposal from the University, the researcher obtained a research permit from the National Commission for Science and Technology Innovation (NACOSTI). After this, the researcher visited the site to administer the questionnaires. The respondents were assured of utmost confidentiality and all effort was made to make them comfortable during the process. The researcher made clarification on all the areas after which the respondents filled them. The researcher then booked appointments with the chief, the priest and the Head teacher for the interviews.

3.8 Data Analysis

This involved the analysis of data once it had been collected to summarize the essential features and relationships of data so as to determine patterns of behaviour and particular outcomes. The data was assessed and comparison was made so as to select the most accurate and quality information from the feedback given by various respondents. This involved assessing and evaluating the questionnaires. Descriptive statistics analysis was used whereby the Statistical Package for Social Sciences (SPSS) was used in aid. The quantitative data was then coded to enable the responses to be grouped into various categories. Data was grouped into frequency distribution to indicate variable values and number of occurrences in terms of frequency. Frequency distribution tables are informative in summarizing the data from respondents. Tables and other graphical presentations as appropriate were also used to present the data collected for ease of understanding and analysis.

3.9 Ethical Considerations for the study

The researcher used introduction letter to notify the respondents on the purpose of the study and assure them of confidentiality. In this case respondents were advised that the participation was voluntary and that they were not required to reveal their names for anonymity reasons.

CHAPTER FOUR

DATA ANALYSIS AND INTERPRETATION

4.1 Introduction

This chapter focuses on data analysis, results presentation and discussion of the findings. The general objective of this study was to investigate the extent to which consumption of alcohol and drug abuse has affected families living in Mukuru Kwa Njenga Slums in Nairobi. The study also sought to identify the specific alcoholic and other substances commonly abused by families living in Mukuru Kwa Njenga Slums in Nairobi; to establish the factors that contribute to alcohol and drug abuse by families living in Mukuru Kwa Njenga Slums in Nairobi; to establish the effects of consumption of alcohol and drugs on families living in Mukuru Kwa Njenga Slums in Nairobi; and to suggest strategies for alcohol and drug demand reduction among families living in Mukuru Kwa Njenga Slums in Nairobi. The research findings were presented in form of tables, graphs and charts.

The sample size of this study was 120 men and women aged 18 years and above, out of which 108 responses were obtained. This gives a response rate of 90%. A 100% response rate was not obtained because some questionnaires were halfway filled and others had inconsistent information. According to Babbie (2002) any response of 50% and above is adequate for analysis thus 90% is even better. In addition, interviews were conducted with the priest in charge, the area chief and the head teachers.

4.2 General Information

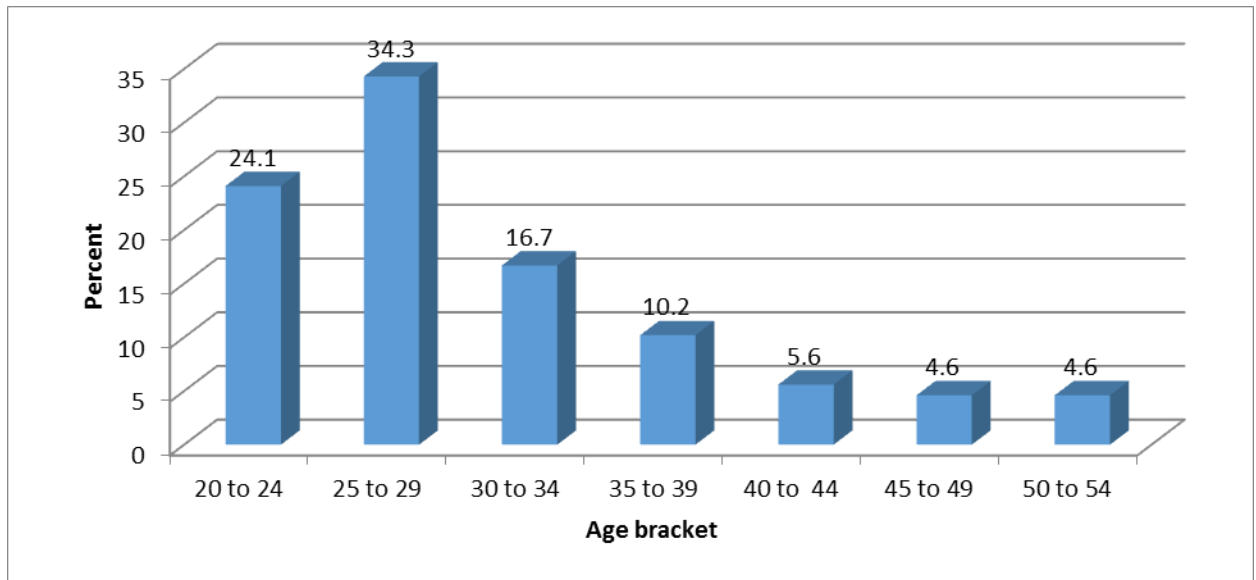
As part of the general information, the respondents were asked to indicate their age, sex, level of education and employment status.

4.2.1 Age composition of the Respondents

The respondents were requested to indicate their age. From the findings, 34.3% of the respondents indicated that they were aged between 25 and 29 years, 24.1% indicated between 20 and 24 years, 16.7% indicated between 30 and 34 years, 10.2% indicated between 35 and 39 years, 5.6% indicated between 40 and 44 years, 4.6% indicated

between 45 and 49 years and the same percent indicated between 50 and 54 years. This implies that most of the respondents in this study were aged between 25 and 29 years.

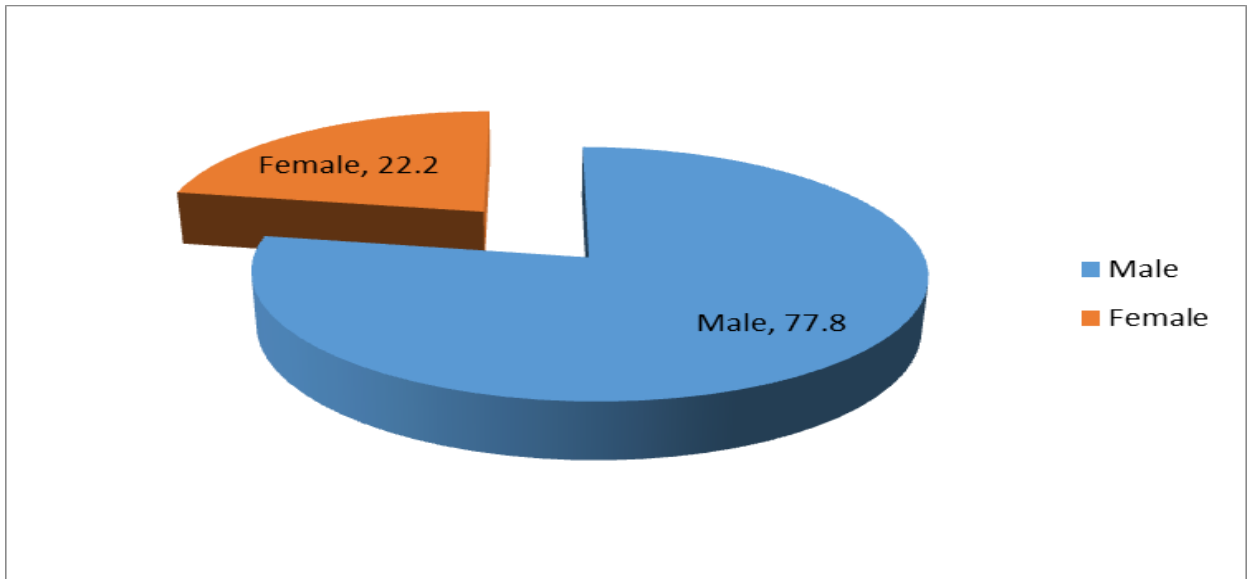
Figure 4. 1 Percentage Age Bracket of the Respondents



4.2.2 Respondents' Sex

The respondents were asked to indicate their sex. According to the findings, 77.8% of the respondents indicated that they were male while 22.2% indicated that they were female. This shows that most of the respondents were men. From the information gathered from the key informants it was clear that most of the individuals who engage in ADA in Mukuru kwa Njenga are youths and majority are male. This implied that valuable data was collected as majority of the respondents being men meant they understood the issue of ADA too well.

Figure 4. 2 Percentage of Respondents' by Sex



4.2.3 Respondents Level of Education

From the findings, 42.6% of the respondents indicated that they had primary education, 30.6% had secondary education, 7.4% had bachelor's degrees, 9.3% had diplomas, 5.6% had CPAs and 4.6% had done driving courses. This shows that most of the respondents had primary education and secondary education. The key informants indicated that indulging in drugs at early level of education leads to dropping out, not being able to pursue high levels, which contributes to drugs and substances abuse and that majority of those affected are illiterate and they believe that joblessness and hopelessness in life have led them to that menace. However, they also argued that anyone at whichever level of education can fall prey but an educated youth is aware of the outcome of the substance abuse but uneducated youth is not aware of the side effects of drug and substance abuse.

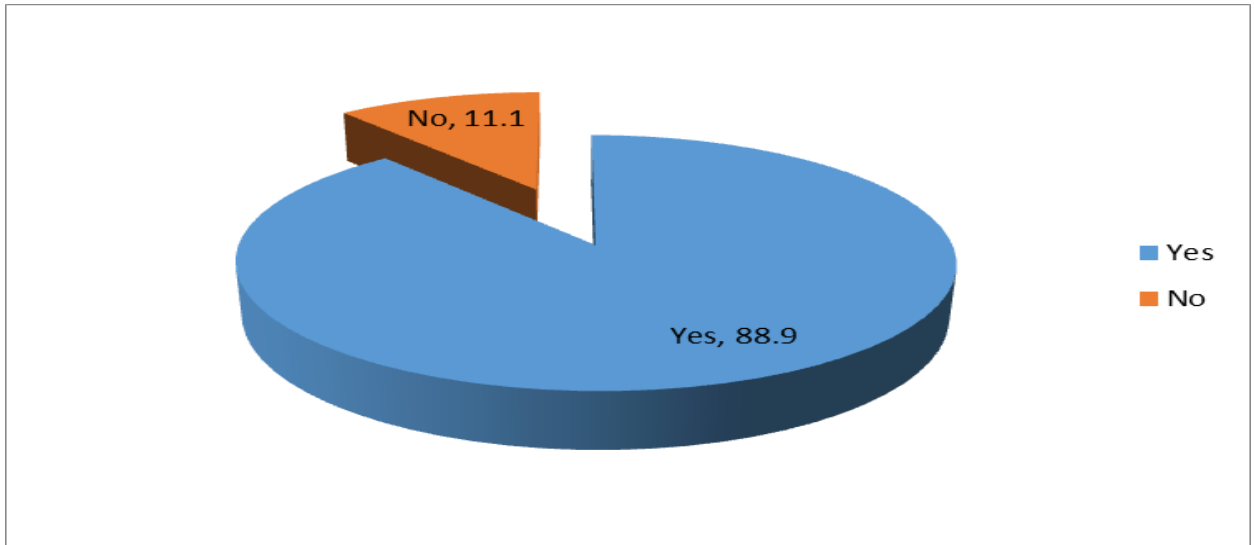
Table 4. 1 Percentage Distribution of Respondents by their Level of Education

	Frequency	Percent
Bachelor's degree	8	7.4
Diploma	10	9.3
CPA	6	5.6
Driving	5	4.6
Secondary education	33	30.6
Primary education	46	42.6
Total	108	100.0

4.2.4 Respondents' Employment Status

According to the findings, 88.9% of the respondents indicated that they were employed while 11.1% indicated that they were not employed. This shows that most of the respondents were employed. The respondents specified that they were employed as casual laborers, cleaners, self-employed, drivers, mechanics, secretaries, machine operators and receptionist. The respondents also indicated that they were employed in companies such as bags and balers manufacturing company, Portland cement, EPZ, Darling and Hand limited. Due to the slums proximity to industrial area, East Africa Portland Cement Company and EPZ, most of the community members were able to get casual jobs. This implies that majority of the respondents are able get some income.

Figure 4. 3 Employment Status of the Respondents



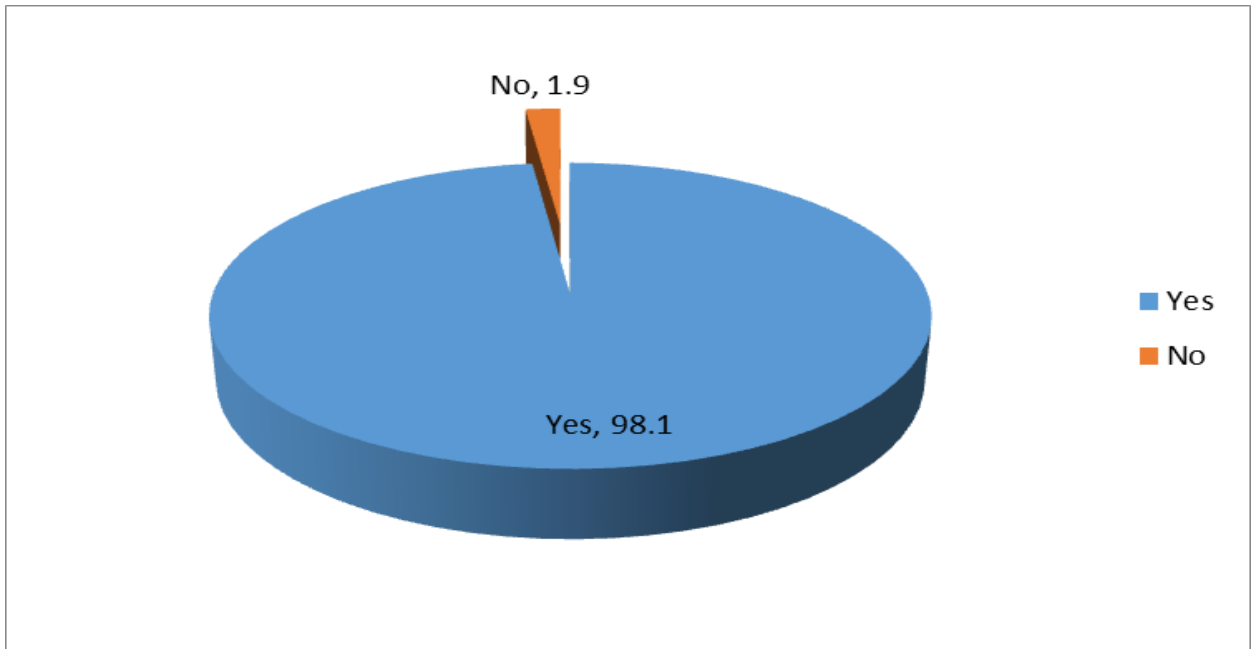
4.3 Alcoholic and Other Substances Commonly Abused

The first objective of this study was to identify the specific alcoholic and other substances commonly abused by families living in Mukuru Kwa Njenga Slums in Nairobi County.

4.3.1 Awareness of Any Drugs and Substances of Abuse

The respondents were asked to indicate whether they were aware of any alcoholic beverages and other drugs of abuse. From the findings, 98.1% indicated that they were aware of some alcoholic beverages and drugs of abuse while 1.9% indicated that they were not aware. This shows that most of the respondents were aware of some alcoholic beverages and drugs of abuse in the slums. Specifically, the respondents indicated that they were aware of marijuana, alcohol, cigarettes, bhang, cocaine, changaa, miraa, sheesha, kumikumi, busaa, spirits and glue.

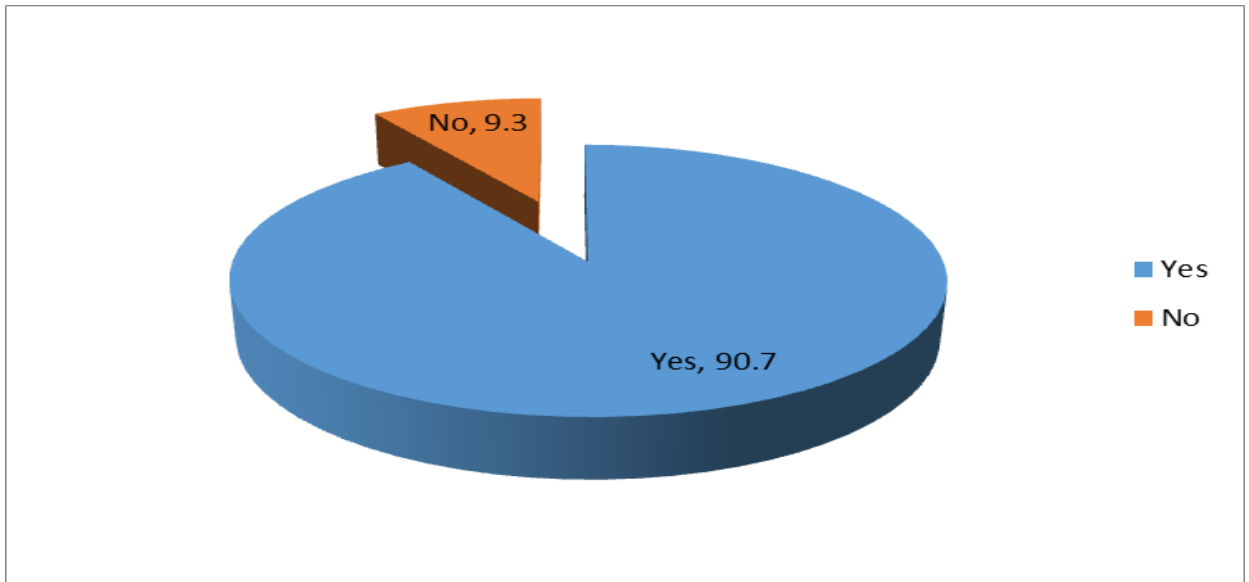
Figure 4. 4 Respondents knowledge of Any Drugs and Substances of Abuse



4.3.2 Use of Alcohol and Drugs

The respondents were asked to indicate whether they had ever used alcohol or any other drugs/ substances. According to the findings, 90.7% of the respondents indicated that had ever used alcohol or any other drugs/ substances while 9.3% indicated that they had never used alcohol or any other drugs/ substances. This implies that most of the community members in Mukuru Kwa Njenga Slums had used alcohol or any other drugs/ substances. The respondents specified that they had used alcohol, cigarettes, busaa, white spirit, beer, wine, spirits, sheesha, kumikumi, changaa, miraa as well as bhang.

Figure 4. 5 Use of Alcohol and Drugs



4.3.3 Age of First Use Alcohol and/or Other Drugs and Substances

The respondents who indicated that they had used alcohol or any other drugs/ substances, were also asked to indicate age at which they first used alcohol and/or other drugs and substances. From the findings, 10.9% of the respondents indicated that they first used alcohol and/or other drugs and substances between the age of 10-15 years, 84.3% indicated that they first used alcohol and/or other drugs and substances between the age of 16 and 20 years while 5.9% indicated that they had first used alcohol and other substances at over 20 years of age. This shows that most of the respondents first used alcohol and/or other drugs and substances at the age of 18 years. These findings agree with Liddle and Rowe (2006) findings that laws prohibiting the sale of substances to minors are not implemented and adhered to in the slums. This then contradicts government strategy of providing services to previously disadvantaged areas and ensuring that all policies and laws protecting the rights of children and minors are adhered to at all time.

Table 4. 2 Age of First Use Alcohol and/or Other Drugs and Substances

Age bracket	Frequency	Percent
10 - 15	10	9.8
16 - 20	86	84.3
Above 20	6	5.9
Total	102	100.00

4.3.4 Where the Respondents Get the Alcohol or Substances

The respondents were asked to indicate where they got the alcohol or substances that they used. According to the findings, they indicated that they were getting alcohol and other substances from bars, pubs, clubs, village kiosks, local joints, from friends, from shamba, drug peddlers, vendors, and local dens. This indicates, alcohol and other substances of abuse are readily available and accessible in Mukuru kwa Njenga. These findings agree with Liddle and Rowe (2006), argument that there are too many outlets that sell alcoholic beverages and other substances and that people in slum areas have the means to buy these substances.

4.3.5 Types of Drugs and Substances Abused

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%), chang'aa (47.2%), bhang (44.4%), kumikumi (38.0%), glue (19.4%), cocaine (4.6%), cuber (2.8%) and heroine (1.9%). This implies that cigarettes, miraa, beer, busaa, spirits, chang'aa, bhang and kumikumi were commonly used in Mukuru kwa Njenga slums. However, cocaine, cuber, and heroine were not very common. These findings agree with Nacada (2004) report that in Kenya, the commonly abused drugs include: alcohol, tobacco, marijuana (bhang), miraa, inhalants and solvents, heroin and cocaine. However, alcohol and tobacco are the mostly abused substances since they are readily available. Due to the high level of poverty in the slums most people cannot afford the legally accepted alcohol instead they go for the illicit

brews which are locally prepared like chang'aa and other forms of second generation alcohol like kumikumi.

Table 4. 3 Types of Drugs and Substances Abused

Types of substance of Abuse	Frequency			Percent		
	Yes	No	Total	Yes	No	Total
Cigarettes	102	6	108	94.4	5.6	100
Beer(Keg)	81	27	108	75.0	25.0	100
Spirits (industry produced)	71	37	108	65.7	34.3	100
Chang'aa (locally produced spirits)	51	57	108	47.2	52.8	100
Busaa	74	34	108	68.5	31.5	100
Kumikumi	41	67	108	38.0	62.0	100
Glue (industrial adhesives sniffed)	21	87	108	19.4	80.6	100
Bhang	48	60	108	44.4	55.6	100
Heroin	2	106	108	1.9	98.1	100
Cocaine	5	103	108	4.6	95.4	100
Cuber	3	105	108	2.8	97.2	100
Miraa (khat-stimulant)	86	22	108	79.6	20.4	100

4.4 Factors that contribute to alcohol and drug abuse

The second objective of this study was to establish the factors that contribute to alcohol and drug abuse by families living in Mukuru Kwa Njenga Slums in Nairobi.

4.4.1 Factors Contributing to Regular Consumption of Alcohol, Drugs and Substances

From the findings, 64.8% of the respondents indicated that stress contributed to regular consumption of alcohol and/or other drugs and substances. In addition, 61.1% indicated that peer pressure contributed to regular consumption of alcohol and/or other drugs and substances. Other factors that contribute to regular consumption of alcohol and/or other

drugs and substances include influence from mass media (36.1%), family break up/ disharmony (16.7%), improve academic performance (13.9%), pressure to do well in school (11.1%) and parental influence (6.5%). This shows that the main factor contributing to regular consumption of alcohol and/or other drugs and substances in Mukuru Kwa Njenga Slums is stress. This is followed by peer pressure, mass media, family breakups, pressure to do well in school and parental influence. Other reasons that lead to abuse of various types of drugs include for fun, they are cheap, unemployment/ idleness, influence from the mass media and lack of money. These findings concur with Donald et al. (2007) findings that depression, peer pressure, family breakups and life frustrations are some of the reasons for substance abuse among adolescents. The findings also agree with success (2005) findings that peer group pressure is one of the major factors for the use of substances. Adolescents rely on their peers for care and support; as such they have no option but to succumb to everything that their peers offer them. Children from slum areas are influenced by their friends to use substances. They also provide them with substances if they do not have them.

Table 4. 4 Factors Contributing to Consumption of Alcohol, Drugs and Substances

Factors contributing to ADA	Frequency			Percent		
	Yes	No	Total	Yes	No	Total
Peer pressure	66	42	108	61.1	38.9	100
Stress	70	38	108	64.8	35.2	100
Improve academic performance	15	93	108	13.9	86.1	100
Family break up/ disharmony	18	90	108	16.7	83.3	100
Pressure to do well in school	12	96	108	11.1	88.9	100
Influence from mass media	39	69	108	36.1	63.9	100
Parental influence	7	101	108	6.5	93.5	100

In the interview guide with the area chief, the priest and the head teacher were asked to indicate the key factors that contribute to alcohol and substance abuse in the area. From the findings, they indicated that idleness, unemployment, boredom, misuse by politicians, literacy and peer pressure of the youth are the key factors. They also cited that other factors that include dropping out of school, exposure of the drugs to the youth and public,

lack of employment that leave many depressed and confused as well as to forget their worries. Furthermore, lack of good role models at home and in the neighborhood, lack of proper parenting and low level of education were cited as key factors. These findings agree with Oketch (2008) findings that parenting style also contributes to substance abuse. Parents who allow their children to go to bars without reprimanding that type of behavior encourage their children to abuse substances. Children born from such families are free to use substances because no one corrects such behavior or even guides them.

The key informants also indicated that cultural factors were playing a role in alcohol and drugs abuse. They indicated that during ceremonies like burials, circumcision, wedding and others, drinking is part of culture and youths have to practice their cultures. They further reported that some people believe that if one is not among those who abuse drugs then they are losers. They also stated that funeral gatherings and cultural dances where there is use of traditional brews and tobacco sniffs influences drug and substance abuse. For instance, among the Kikuyus and Kambas during the customary weddings, youth should celebrate with liquor and in such activities they continue to use alcohol and later on they change to other brews.

Mass media was also playing a major role in drugs and substance abuse. The key informants cited the positive influences of the mass media that include creating awareness to understand the effect of drugs, exposing the experiences of others and how they work/ uses and lack of prescriptions, and it is a platform for giving detailed and more information relating to drug issue and publicly talking on drug effects. However, the key informants indicated that by advertising some of the brands at each commercial break make the youth develop the urge of wanting to find out maybe the taste and smell and strength over the other. In addition, youths who do not know how to inject or how to sniff learn from the media, and specifically movies involving drug activities influence youths into this menace very much. The key informants also stated that the media was advertising the drugs through television with colorful wallpapers even though they print the age limit using celebrities' actions and alcohol brands they use. The media affects drug and substance abuse through advertising, in styling and promotions whereby they use strong young men showing that drugs have no effect on people. They also cited that

mass media influences the youths in terms of accessibility to drugs and they get direct communication with the sellers.

Another factor influencing abuse of drugs and substance is cost and availability of drugs. The interviewees indicated that if the price is too low, the youth can afford to buy it especially substances like bhang, mogokaa (miraa), local brews which are sold at a cheaper price thus making them easily affordable. In addition, cheaper drugs are being abused most and that selling small units of drugs makes it affordable to the abusers. They also indicated that since many of the drug users are unemployed they tend to turn to theft and burglary to sustain their addiction to drugs and that change in cost influences addicts to criminal acts due to the high cost of drugs. These findings are in line with Kawaguchi (2004) findings that despite the high rate of poverty, the male adolescents in the study could afford to buy substances which seem readily available in their communities.

4.5 Effects of consumption of alcohol and drugs

The third objective of this study was to establish the effects of consumption of alcohol and drugs on families living in Mukuru Kwa Njenga Slums in Nairobi.

4.5.1 Effect of Consumption of Alcohol on the Respondents Life

From the findings, the respondents indicated that consumption of alcohol and other drugs; led to wastage of money (17.6%), aggressiveness (13.9%), addiction (13.0%), family break ups (15.7%), increase in crime (4.6%), depression (12.0), school drop outs (14.8%), family disharmony (8.3%) and death (6.5%). In addition, consumption of alcohol causes breathing problems, which lead to hospitalization. Also, consumption of alcohol led to poor decision making and laziness. Further, the respondents indicated that consumption of alcohol gave them confidence. However, this was as a result of addiction. These findings concur with Nacada (2004) report that the immediate effects of alcohol abuse include impaired judgment, being sluggish and also delayed physical coordination.

According to the key informants the effects of alcohol consumption include mood swings, impaired judgment, coordination issues, trouble concentrating, memory problems, slurred speech and uncontrolled eye movements, . In addition, alcoholism may

also lead to long term effects that include cirrhosis, alcoholic hepatitis, liver cancer, pancreatitis, cardiomyopathy (stretching and weakening of heart muscle), irregular heart rhythm, high blood pressure, stroke, mouth and throat cancer, breast cancer, weakened immune system, irritability and suicidal ideation. These findings agree with Nacada (2004) report that alcohol misuse is also an important factor in a number of cancers, including liver cancer and mouth cancer, both of which are on the increase. These findings also agree with NIDA (2013) findings that extreme levels of drinking can occasionally cause ‘psychosis’, a severe mental illness where hallucinations and delusions of persecution develop.

Table 4. 5 Effect of Consumption of Alcohol on the Respondents Life

Effects of Consumption of Alcohol	Frequency			Percent		
	Yes	No	Total	Yes	No	Total
Wastage of money	19	89	108	17.6	82.4	100.0
Aggressiveness	15	93	108	13.9	86.1	100.0
Addiction	14	94	108	13.0	87.0	100.0
Family break ups	17	91	108	15.7	84.3	100.0
Increase in crime	5	103	108	4.6	95.4	100.0
Depression	13	95	108	12.0	88.0	100.0
School drop outs	16	92	108	14.8	85.2	100.0
Family disharmony	9	99	108	8.3	91.7	100.0
Death.	7	101	108	6.5	93.5	100.0

4.5.2 Effects of drugs and substances of abuse have on the community

The respondents were asked to indicate the effects of drugs and substances of abuse on the community. According to the findings, the respondents indicated that drugs and substances of abuse lead to an increase in crime (25.5%), increases fighting among the community members (17.6%), leads to poverty (5.6%), causes family break ups (6.5%), leads to unemployment (7.4%), leads to an increase in case of rape and immorality (13.0%) and deaths (13.9%).

The key informants also indicated that the abuse of alcohol and other drugs by youth may result in family crises and jeopardize many aspects of family life, sometimes resulting in family dysfunction. Both siblings and parents are profoundly affected by alcohol- and drug-involved youth. Substance abuse can drain a family's financial and emotional resources. In addition, the key informants indicated that women who are not drug abusers may be affected by problems related to drug abusing men. The problems of male partners may affect women in the form of difficulties in interpersonal relationships, instability, violence, child abuse, economic insecurity, deprivation of schooling and risk of sexually transmitted disease, including HIV infection.

The key informants further indicated that drugs and substances of abuse lead to behavioral problems like aggressiveness, hallucinations, addiction, impaired judgment, loss of self-control and impulsiveness. They also indicated that people who live with substance dependence have a higher risk of all bad outcomes including unintentional injuries, accidents, risk of domestic violence, medical problems, and death. In addition, pregnant women who use illicit drugs may engage in other unhealthy behaviors that place their pregnancy at risk, such as having extremely poor nutrition or developing sexually transmitted infections.

Table 4. 6 Effects of drugs and substances of abuse have on the community

Effects of ADA on the community	Frequency			Percent		
	Yes	No	Total	Yes	No	Total
Increase in crime	27	81	108	25.0	75.0	100.0
Deaths	15	93	108	13.9	86.1	100.0
Increases fighting among the community members	19	89	108	17.6	82.4	100.0
Leads to poverty	6	102	108	5.6	94.4	100.0
Causes family break ups	7	101	108	6.5	93.5	100.0
Unemployment	8	100	108	7.4	92.6	100.0
Leads to an increase in case of rape and immorality	14	94	108	13.0	87.0	100.0

4.6 Strategies for alcohol and drug demand reduction

The fourth objective of this study was to assess the laid down strategies for alcohol and drug demand reduction among families living in Mukuru Kwa Njenga Slums in Nairobi.

4.6.1 Measures Undertaken to Curb Alcohol and Drug Abuse in the Area

The respondents were asked to indicate the measures that have been undertaken to curb alcohol and drug abuse in the area. From the findings, 74.1% of the respondents indicated that guidance and counseling was used to curb alcohol and drug abuse in the area. In addition, 50.0% indicated that rehabilitation centers were used to curb alcohol and drug abuse. Also, 33.3% indicated that drug awareness campaigns were used to curb alcohol and drug abuse in the area. Further, 19.4% reported that peer education on drugs and substance abuse was used to curb alcohol and drug abuse in the area. However, only 1.9% indicated that alerting relevant authority was used to curb alcohol and drug abuse in the area.

Table 4. 7 Measures Undertaken to Curb Alcohol and Drug Abuse in the Area

Measures of curbing ADA	Frequency			Percent		
	Yes	No	Total	Yes	No	Total
Drug awareness campaigns	36	72	108	33.3	66.7	100.0
Guidance and counseling	80	28	108	74.1	25.9	100.0
Peer education on drugs and substance abuse	21	87	108	19.4	80.6	100.0
Alerting relevant authority	2	106	108	1.9	98.1	100.0
Rehabilitation centers	54	54	108	50.0	50.0	100.0

4.6.2 Ways to Discourage Drugs and Substances

The respondents were asked to suggest ways in which drugs and substances can be discouraged in schools. From the findings, they indicated that these ways include avoiding opening bars near schools, punishing those who use drugs, educating students about drugs and holding sermons. In addition, the respondents indicated that counselling students by appointing counselling teachers and holding seminars by inviting guest speakers are key in discouraging drugs and substances abuse. Further, the respondents indicated that students using drugs should be enrolled in rehabilitation centers. Also, schools should have strict rules and regulations and should report the members using the drugs to the police. Other ways include introducing drug awareness classes, peer education and parents to monitor children.

The respondents were asked to suggest ways in which drugs and substances can be discouraged in homes. From the findings, they indicated that ways to discourage drugs and substance use in homes include: creating employment opportunities, limiting the time to access bars during day time, conducting drugs awareness campaigns, alerting the children on the effect of drugs and substances abuse, provision of good parenting as well as family meetings/ gatherings guidance campaigns. The respondents also indicated that parents should lead by example and should have interactions with children where they discuss about drugs. Also, the respondents indicated that community members should learn from those who have been using drugs. In addition, parents should involve children in work to eliminate boredom and idleness. Further, there should be guidance and counselling sessions in the community as well as awareness campaigns through seminars.

The respondents were asked to suggest ways in which drugs and substances can be discouraged in the community. According to the findings, the respondents indicated that drugs and substances abuse can be discouraged through campaigns on drugs awareness, carrying out awareness on drugs and substantive abuse, health centers, creating employment and campaigns, establishing counselling centers, community policing and through rehabilitation centers. The respondents also indicated that there should be community policies that direct people. In addition, the authority should stop encouraging drug business and conduct a crackdown on drug dealers and arrest the culprits. Further, should take up the responsibility of alerting the relevant authority.

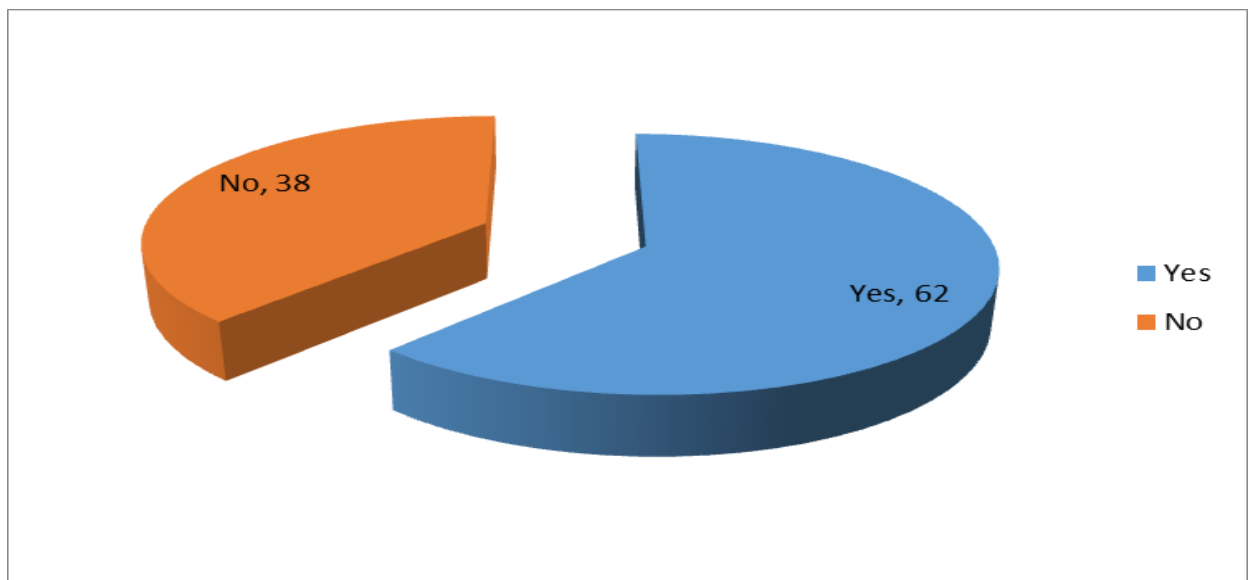
The key informants also added the youth who are addicted to alcohol and drugs should be sent to the rehab centers, should be given some employments to keep them busy, should be counseled, should be encouraged to form youth groups and help them to start small scale business. In addition they should be invited to talks concerning drugs and how to avoid them. Also, the key informants indicated that parents and family members should be responsible for the upbringing the youth, little children should not be exposed to alcohol and drugs in their homes. In addition, forums which should involve youths who indulge themselves in ADA should be organized where the youth who have succeeded in life (role models) talk to the affected youths. In addition, all the loopholes or routes which are used by drug dealers should be sealed; dealers should be traced and arrested,

the supply and demand channel should be cut and that a high penalty should be put for all drug dealers.

4.6.3 Knowledge of Places where People with drug or alcohol abuse problems can be helped

The respondents were asked to indicate whether they knew of places where people with drug or alcohol abuse problems can be helped. From the findings, 62% of the respondents indicated that they had knowledge where people with drug or alcohol abuse problems can be helped while 38% indicated that they did not know. In addition, the respondents indicated that people with drug or alcohol abuse problems can be helped in churches, schools, hospitals, counselling centers and rehabilitation centers like Uhai center in Kware. The key informants also confirmed that churches and schools are actively involved in campaigns against ADA as well as counseling those who are involved. However, they added that the government and non-governmental organizations need to set up more counseling centers and rehabilitation centers.

Figure 4. 2 Knowledge of Places where People with drug or alcohol abuse problems can be helped



CHAPTER FIVE

SUMMARY OF THE FINDINGS, CONCLUSIONS AND RECOMMENDATIONS

5.1 Introduction

This chapter presents a summary of the findings, conclusions, practical recommendations and areas for further research. The purpose of this study was to investigate the extent to which consumption of alcohol and drug abuse has affected families living in Mukuru Kwa Njenga Slums in Nairobi.

5.2 Summary of the findings

5.2.1 Alcoholic and Other Substances Commonly Abused

The study found that most of the individuals above 18 years in Mukuru Kwa Njenga Slums, had abused alcohol and/ substance at least once. In addition, they had abused alcohol and substances for the first time at the age of 18 years, which implies that laws prohibiting the sale of substances to minors are not, implemented and adhered to in the slums.

The study also found that cigarettes, miraa, beer, busaa, spirits, chang'aa, bhang and kumikumi are very common. Alcohol and tobacco are the mostly abused substances since they are readily available. Due to the high level of poverty in the slums most people cannot afford the legally accepted alcohol instead they go for the illicit brews which are locally prepared like chang'aa and other forms of second generation alcohol like kumikumi. In addition, drugs such as cocaine, cuber, and heroine were not commonly used because they are expensive compared to others. Also, drugs were obtained from places such as bars, pubs, clubs, village kiosks, local joints, from friends, from shambas, drug peddlers, vendors, and local dens.

5.2.2 Factors that contribute to alcohol and drug abuse

The study found that stress was the main factor contributing to regular consumption of alcohol and/or other drugs and substances in Mukuru Kwa Njenga Slums. This was followed by peer pressure, mass media, family breakups, pressure to do well in school and parental influence. Other reasons that lead to abuse of various types of drugs include fun, low cost of drugs, unemployment/ idleness, mass media and poverty. Other factors

cited include idleness, unemployment, misuse by politicians, illiteracy, dropping out of school, exposure of the drugs to the youth and public, access to electronic devices such as phones that expose children to drugs and how to use them and lack of employment that leave many depressed and confused to forget their worries. Further, lack of good role models in the family and neighborhood, lack of proper parenting and low level of education were cited as key factors.

In relation to cultural factors, the study found that during ceremonies like burials, circumcision, wedding and others, drinking is part of culture and youths have to practice their cultures. In addition, funeral gatherings and cultural dances where there is use of traditional brews and tobacco sniffs influences drug and substance abuse. Mass media was also playing a major role in drugs and substance abuse. By advertising some of the brands at each commercial break make the youth develop the urge of wanting to find out maybe the taste and smell and strength over the other. In addition, youths who do not know how to inject or how to sniff learn from the media, and specifically movies involving drug activities. The media advertises drugs through television with colorful wallpapers even though they print the age limit using celebrities' actions and alcohol brands they use. The media affects drug and substance abuse through advertising, in styling and promotions whereby they use strong young men showing that drugs have no effect on people.

Another factor influencing abuse of drugs and substance is cost and availability of drugs. The interviewees indicated that if the price is too low, the youth can afford to buy it especially substances like bhang, mogokaa (miraa), local brews which are sold at a cheaper price thus making them easily affordable. In addition, cheaper drugs are being abused most and that selling small units of drugs makes it affordable to the abusers.

5.2.3 Effects of consumption of alcohol and drugs

The study found that consumption of alcohol leads to wastage of money, addiction, death and family break ups, increase in crime, depression, school drop outs and family disharmony. In addition, consumption of alcohol causes loss of eye sight, breathing problems, which lead to hospitalization. Also, consumption of alcohol led to poor

decision making and laziness. Other effects of alcohol consumption include mood swings, impaired judgment, coordination issues, trouble concentrating, memory problems, slurred speech, uncontrolled eye movements and coma. In addition, alcoholism may also lead to long term effects that include cirrhosis, alcoholic hepatitis, liver cancer, pancreatitis, cardiomyopathy (stretching and weakening of heart muscle), irregular heart rhythm, high blood pressure, stroke, mouth and throat cancer, breast cancer, weakened immune system, irritability and suicidal ideation.

In the community, ADA among the community members, leads to poverty, deaths, family break ups, insecurity, unproductivity, unemployment, increase in cases of rape and immorality. In addition, abuse of alcohol and other drugs by youth may result in family crises and jeopardize many aspects of family life, sometimes resulting in family dysfunction. Further, both siblings and parents are profoundly affected by alcohol- and drug-involved youth. Substance abuse drains a family's financial and emotional resources. Also, the problems of male partners may affect women in the form of difficulties in interpersonal relationships, instability, violence, child abuse, economic insecurity, deprivation of schooling and risk of sexually transmitted disease, including HIV infection.

Behavioral effects of substance and drugs abuse include aggressiveness, hallucinations, addiction, impaired judgment, loss of self-control and impulsiveness. In addition, people who live with substance dependence have a higher risk of all bad outcomes including unintentional injuries, accidents, risk of domestic violence, medical problems, and death. In addition, pregnant women who use illicit drugs may engage in other unhealthy behaviors that place their pregnancy at risk, such as having extremely poor nutrition or developing sexually transmitted infections.

5.2.4 Strategies for alcohol and drug demand reduction

The study found that to discourage drugs and substances in schools can be done through avoiding opening bars near schools, counselling of learners, rehabilitating those who are addicted to alcohol and drugs, educating students about drugs and holding sermons. In addition, schools should have strict rules and regulations and should report the members

using the drugs to the police. Other ways include introducing drug awareness classes, peer education and parents to monitor children.

The study also found that to discourage drugs and substances in homes can be done through creating employment opportunities to avoid idleness and to reduce frustrations, limiting the time to access bars during day time, conducting drugs awareness campaigns, alerting the children on the effect of drugs and substances abuse, provision of good parenting as well as family meetings/ gatherings guidance campaigns. In addition, parents should lead by example and should have interactions with children where they discuss about drugs.

The study established that to discourage drugs and substances in the community can be done through campaigns on drugs awareness, carrying out awareness on drugs and substantive abuse, health centers, creating employment and campaigns, establishing counselling centers, community policing and through rehabilitation centers. In addition, the authority should stop encouraging drug business by taking bribes from dealers to cover them and instead, conduct a crackdown on drug dealers and arrest the culprits. Community members should take up the responsibility of alerting the relevant authority. Also, forums which should involve youth themselves should be organized where the youth who have succeeded in life (role models) talk to the affected youths. More counseling centres and rehabilitation centres should be set up to help address ADA menace as respondents only mentioned one counseling and rehabilitation centre (Uhai center in Kware.)

5.3 Conclusions

The study concludes that most of the individuals above 18 years in Mukuru Kwa Njenga Slums have used alcohol and or other substance for at least once. In addition, cigarettes, miraa, beer, busaa, spirits, chang'aa, bhang and kumikumi were commonly used in Mukuru kwa Njenga slums. However, cocaine, cuber, and heroine were not very common. Alcohol and tobacco were the most commonly abused substances since they are

readily available. Drugs were obtained from places such as bars, pubs, clubs, village kiosks, local joints, from friends, from shambas, drug peddlers, vendors, and local dens.

The study also concludes that the factors contributing to regular consumption of alcohol and/or other drugs and substances in Mukuru Kwa Njenga Slums include stress, peer pressure, mass media, family breakups, pressure to do well in school and parental influence. Other factors include fun (to be high), cost of drugs, availability, unemployment/ idleness, misuse by politicians, illiteracy, dropping out of school, exposure of the drugs to the youth and public, access to electronic devices such as phones that expose children to drugs and how to use them and lack of employment that leave many depressed and confused to forget their worries. The study also found that during ceremonies like burials, circumcision, wedding and others, drinking is part of culture and youths have to practice their cultures.

The study concludes that short term individual effects of alcohol consumption include mood swings, impaired judgment, coordination issues, trouble concentrating, memory problems, slurred speech, uncontrolled eye movements, and coma. In addition, alcoholism may also lead to long term effects that include: loss of eye sight, cirrhosis, alcoholic hepatitis, liver cancer, pancreatitis, cardiomyopathy (stretching and weakening of heart muscle), irregular heart rhythm, high blood pressure, stroke, mouth and throat cancer, breast cancer, weakened immune system, irritability and suicidal ideation. The social effects of alcohol consumption include: increase in crime, theft in the community, increase fighting among the community members, poverty, deaths, family break ups, insecurity, unemployment, low productivity, addiction and increase in cases of rape and immorality.

The study concludes that discouraging drugs and substances in schools can be done through avoiding opening bars near schools, counselling of students, rehabilitating those who are addicted to ADA, educating students about ADA and holding sermons. In addition, schools should have strict rules and regulations and should report the members using the drugs to the police. Discouraging drugs and substances in homes can be done through creating employment opportunities, limiting the time to access bars during day

time, conducting drugs awareness campaigns, alerting the children on the effect of drugs and substances abuse, provision of good parenting as well as family meetings/ gatherings guidance campaigns. Discourage drugs and substances in the community can be done through campaigns on drugs awareness, carrying out awareness on drugs and substance abuse, creating employment and campaigns, establishing counselling centers, community policing and through rehabilitation centers.

5.4 Recommendations

The study recommends that NACADA in conjunction with other government agencies like the police and the local administration should strictly enhance the ban on sale of drugs and alcohol to children.

The study established that low education is a risk factor to drug and substance abuse. Therefore, this study recommends that the government should not only encourage enrollment of all children but also follow up to ensure completion. Further, the government should come up with programs highlighting the adverse effects of drug use.

The study found that availability of alcohol and other substances of abuse in the community has greatly contributed to their abuse. This study recommends that local authorities should do everything in their means to wipe out all the sources especially the second generation alcohol that is sold in too many joints and in bottles of all sizes. This can be done through a major crackdown and thereafter conduct patrols to ensure that the problem does not recur. The dealers should also be guided on other kinds of business which are beneficial not only to them but also other members of the community. There should be campaigns to enlighten people in this area about the adverse effects of ADA.

The study also established that lack of employment and idleness has contributed to alcohol and substance abuse among the youth to a very great extent. The study therefore recommends that the employment opportunities to the so many unemployed individuals. This will help to dispel the wrong ideas people have of drug use.

The study established that cost of drugs influences ADA among families living in Mukuru kwa Njenga slums. Therefore, the study recommends that the prices of all legal substances including: alcohol, miraa and tobacco be put at increased to discourage

consumption of these drugs. The high cost on legal drugs will also earn the country more tax revenue which can be used to campaign against drug use.

5.5 Suggestions for Further Studies

This study sought to investigate the extent to which consumption of alcohol and drug abuse has affected families living in Mukuru Kwa Njenga Slums. Being a case study, the findings of this study cannot be generalized to other slums and counties in Kenya since various counties have different opportunities, challenges and level of economy and hence further studies should be conducted in other parts of the country, both in the urban and rural areas. The study also recommends further studies on the role of peer pressure in drug and substance abuse among the youth in Kenya. In addition, the study recommends assessment of the already laid strategies of ADA reduction to evaluate their effectiveness.

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APPENDICES

Appendix 1: University Authorization to Collect Data

Appendix 2: Questionnaire

**ALCOHOL AND DRUG ABUSE AMONG VULNERABLE GROUPS IN KENYA:
A CASE STUDY OF FAMILIES IN MUKURU KWA NJENGA.**

My name is Caroline Wacuka a postgraduate student at University of Nairobi pursuing a master’s degree in sociology-counselling cluster. As part of my research project your area has been selected to participate in the study that will help us understand more about alcohol and drug abuse among vulnerable groups in Kenya. In this regard, I kindly request you to respond to a few questions in the attached questionnaire. This information will be purely for academic purposes and will be treated with confidence. Your kind response is highly appreciated.

Instructions: Kindly respond to the following questions to the best of your knowledge.

1. What is your age?
2. Sex
Male () Female ()
3. Highest education qualification.....
4. Are you employed? Yes ()/ No ()
5. If yes, please specify.....
6. a). Are you aware of any drugs and Substances of abuse? Yes ()/ No ()
b). If yes, which ones are you aware of
.....
.....
7. have you ever used alcohol or any other drugs/ substances
Yes () or No ()
(ii) If yes, which ones
.....
.....
8. At what age did you first use alcohol and/or other drugs and substances.....
9. Which of the factors here below contributed to your regular consumption of alcohol and/or other drugs and substances.....
Peer pressure ()

- Stress ()
- Improve academic performance ()
- Family break up/ disharmony ()
- Pressure to do well in school ()
- Influence from mass media ()
- Parental influence ()
- Others (specify)

10. From where do you get the alcohol or substances that you use?.....

11. In what ways has the consumption of alcohol affected your life?

.....

.....

.....

12. Which drugs and substances of abuse do most people here take?

- Cigarettes ()
- Beer ()
- Spirits ()
- Chang'aa ()
- Busaa ()
- Kumikumi ()
- Glue ()
- Bhang ()
- Heroine ()
- Cocaine ()
- Cuber ()
- Miraa ()

Others (specify)

13. Why do people in these area abuse the above mentioned substances in your opinion

.....
.....
.....

14. Where do they obtain them from?

.....
.....
.....

15. What effects do these drugs and substances of abuse have on the community?

.....
.....
.....

16. Which of the following measures have been undertaken to curb Alcohol and Drug Abuse in this area?

- Drug awareness campaigns ()
- Guidance and counseling ()
- Peer education on drugs and substance abuse ()
- Alerting relevant authority ()
- Rehabilitation centers ()
- Any other specify)

.....
.....
.....

17. Suggest ways in which drugs and substances can be discouraged in the following places

Schools.....
.....
.....

Homes.....
.....
.....

Community.....
.....
.....

18. What do you know on the dangers of Alcohol and Drug Abuse?

.....
.....
.....

19. Do you know any place where a person with a drug or alcohol abuse problem can be helped? Yes () No ()

If yes, list them

.....
.....

Appendix 3: Interview guides

Interview guide for the priest in charge

ALCOHOL AND DRUG ABUSE AMONG VULNERABLE GROUPS IN KENYA: THE CASE OF FAMILIES IN MUKURU KWA NJENGA.

My name is Caroline Wacuka, a postgraduate student at the University of Nairobi pursuing a master's degree in sociology-counseling cluster. As part of my research project, your area has been selected to participate in the study that will help us understand more about alcohol and drug abuse among vulnerable groups in Kenya. In this regard, I kindly request you to respond to a few questions in the attached interview guide. This information will be purely for academic purposes and will be treated with confidence. Your kind response is highly appreciated.

Instructions: Kindly answer the following questions to the best of your knowledge.

1. As a religious leader in this region, do you think abuse of alcohol and drugs is a problem in Mukuru kwa Njenga?
2. If yes, who is mostly affected; the youth, men or women?
3. Do your Christians speak about it, or do they come to seek for a solution from your office?
4. Are you aware of the types of drugs commonly abused by the people living here in Mukuru kwa Njenga? Yes () or No ().
5. If yes, please name the types of drugs you know.
6. Why do you think people living here Mukuru kwa Njenga abuse alcohol and drugs?
7. Where do you think they obtain these drugs from?
8. How do you address this problem when these people come to you?
9. Has the church laid down policies and procedures in regard to addressing ADA menace in this region?
10. In your opinion, is the government addressing ADA menace in this area, if yes, how?
11. What else should be done to curb this problem of alcohol and drug abuse?

Interview guide for the area chief

ALCOHOL AND DRUG ABUSE AMONG VULNERABLE GROUPS IN KENYA: THE CASE OF FAMILIES IN MUKURU KWA NJENGA.

My name is Caroline Wacuka, a postgraduate student at the University of Nairobi pursuing a master's degree in sociology-counseling cluster. As part of my research project, your area has been selected to participate in the study that will help us understand more about alcohol and drug abuse among vulnerable groups in Kenya. In this regard, I kindly request you to respond to a few questions in the attached interview guide. This information will be purely for academic purposes and will be treated with confidence. Your kind response is highly appreciated.

Instructions: Kindly respond to the following questions to the best of your knowledge.

1. As the chief of this location, is alcohol abuse a problem in the community? Give some indicators.
2. Which sex is mostly affected? Is it women or men?
3. Are you aware of the types of alcohol and drugs commonly abused by the people living here in Mukuru kwa Njenga?
4. In your opinion, what do you think are some of the reasons that make people in your location abuse drugs?
5. What age group is mostly affected?
6. What could be the possible reasons for consuming the said substances?
7. How many cases do you handle in regard to alcohol and drug abuse? Probe to establish whether it's on daily basis, monthly basis. Also to establish the nature of the cases.
8. State common problems that face the families as a result of alcohol and drug abuse.
9. In cases where there are marital conflicts, who is the aggressor and who is the victim?
10. How are the affected families coping?
11. In your view, what do you think should be done about this problem?
(Probe to establish whether there is need of rehabilitation services.)

Interview guide for the Head teacher

ALCOHOL AND DRUG ABUSE AMONG VULNERABLE GROUPS IN KENYA: THE CASE OF FAMILIES IN MUKURU KWA NJENGA.

My name is Caroline Wacuka, a postgraduate student at the University of Nairobi pursuing a master's degree in sociology-counseling cluster. As part of my research project, your area has been selected to participate in the study that will help us understand more about alcohol and drug abuse among vulnerable groups in Kenya. In this regard, I kindly request you to respond to a few questions in the attached interview guide. This information will be purely for academic purposes and will be treated with confidence. Your kind response is highly appreciated.

Instructions: Kindly respond to the following questions to the best of your knowledge.

1. As the Head teacher Mukuru kwa Njenga primary school, do you think abuse of alcohol and drugs is a problem in this area?
2. If yes, who is mostly affected; the youth, men or women?
3. Are parents of this school victims of alcohol and drug abuse, if yes, how are you able to recognize the victims?
4. Are teachers in this area affected by alcohol and drug abuse, if yes, how are they affected?
5. Are pupils of this school victims of alcohol and drug abuse, if yes, how are you able to recognize the victims?
6. Which substances are commonly abused by people living here in Mukuru kwa Njenga?
7. Does age matter when it comes to abuse of these substances?
8. What are the possible reasons for ADA by the following;
 - a) Parents
 - b) Teachers
 - c) Pupils
9. Where do you think they get the substances from?
10. What effects do these substances have on;
 - a) Parents

- b) Teachers
- c) Pupils

11. What is your office doing to assist the following when affected by ADA;
 - a) Parents
 - b) Teachers
 - c) pupils
12. Do you think the government is adequately addressing the ADA menace in Mukuru kwa Njenga?
13. In your opinion, what else should be done to curb this problem of alcohol and drug abuse?

Appendix 4: Map of Mukuru Kwa Njenga



