DRUG ABUSERS AND PARENTAL KNOWLEDGE ON FACTORS PREDISPOSING THE YOUTH TO DRUGS AND SUBSTANCE ABUSE IN NAIROBI PROVINCE, KENYA.

BY

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DECLARATION

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

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DEDICATION

This thesis is dedicated, firstly, to the Lord Jesus Christ for His grace and strength throughout my course. Secondly to my husband, Mr. Peter K. Okumu and my parents Mr. and Mrs. Johnson Gikonyo whose support and encouragement have seen me through my study.
ACKNOWLEDGEMENT

I am grateful to God who has given me grace and strength to carry out this study. I am indebted to my supervisors; Prof. Romanus O. Okelo and Dr Ephantus W. Kabinu who have been very pleasant and have diligently supported me with fatherly care. Dr. Tabitha Ndungu of USIU and Rev Wilfred Kogo have been of immense support and inspiration on aspects of drug abuse. My family members especially my parents, Mr and Mrs Johnson Gikonyo have given me their utmost support throughout this work. Special thanks to Pastor Victor Ongeto, Miss Mercy Nyawira, and Miss Grace Migwi for their great assistance in preparation, typing and printing of this work. I appreciate the support of the staff at the study sites during data collection. I am grateful to Apostle and Mama Das, Pastor Isaac Muita, Pastor David Githinji, and Prof. Richard Mibe for their prayers and encouragement.

Finally it is not possible to enumerate the dedicated conscientious, tireless effort, patience and prayer of my dear husband Peter Okumu without whom this work could not be successful.
<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Description</th>
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<tr>
<td>CEWG</td>
<td>Community Epidemiology Work Group</td>
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<tr>
<td>COMESA</td>
<td>Common Market for East and South Africa</td>
</tr>
<tr>
<td>D.A.R.T</td>
<td>Drug and Alcohol Treatment and Rehabilitation Centre</td>
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<tr>
<td>ECOWAS</td>
<td>Economic Community of West Africa States</td>
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<td>ICN</td>
<td>International Council of Nurses</td>
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<td>IDP</td>
<td>International Drug Prevention</td>
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<td>IEWG</td>
<td>International Epidemiology Work Group on Drug Abuse</td>
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<td>ILO</td>
<td>International Labour Organization</td>
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<td>INCB</td>
<td>International Narcotics Control Board</td>
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<td>NACADA</td>
<td>National Agency for Campaign Against Substance Abuse</td>
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<td>NGO</td>
<td>Non Governmental Organization</td>
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<td>NIDA</td>
<td>National Institute of Drug Abuse</td>
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<tr>
<td>OAU</td>
<td>Organization of African Unity</td>
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<td>ROK</td>
<td>Republic of Kenya</td>
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<td>SADC</td>
<td>South African Development Community</td>
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<tr>
<td>UN</td>
<td>United Nations</td>
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<td>UNDCP</td>
<td>United Nations Drug Campaign Programme</td>
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<td>UNAIDS</td>
<td>United Nations Programme on HIV/AIDS</td>
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<td>UNESCO</td>
<td>United Nations Scientific and Cultural Organization</td>
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<td>WHO</td>
<td>World Health Organization</td>
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ABSTRACT

Adolescence and young adulthood are periods most associated with the onset of drug abuse worldwide. The fact that the Kenyan youth is at peril is indisputable. The youth being the future generation for any community clearly indicate that there is a need for initiatives to be targeted towards young people for the prevention of substance use and abuse. Any effective control or prevention will have to focus on demand and control structures as well as the empowerment of custodians of the children. Parents are expected to be the first custodians of their children. The objective of this study was to assess the parental awareness about drug abuse by the youth in Nairobi Province, Kenya. It also sought to find out relational problems between parents and their offspring that could precipitate this problem and how this could be modified. This was a descriptive cross-sectional study, which was carried out in drug abuse treatment and rehabilitation centers. Interviews were used to find in-depth information on parents' knowledge on drug abuse. From this study, it was found that most of the parents had fair knowledge on drug abuse (63%) although their knowledge was poor at the point when the children begun to take drugs. They had poor knowledge on existence of help services for drug abuse as all the parents studied had to be introduced by another party to the rehabilitation centers and they took more than 6 months to seek help (94.7%). A sizeable number of the parents (74.4%) were not aware of the age when their children started abusing drugs. More than half (62.2%) of the parents had never expected that their children would be involved in drug abuse, 32.6% associated and expected drug abuse to be found among street children, 41.3% from well to do homes and 26.1% from poor homes ($\chi^2=8.31, df=3, p<0.05$). A significantly higher number of parents with formal education had children abusing drugs ($\chi^2=17.4$, $df=5$, $p<0.01$). Although there was no significant association between the occupation of a parent and their expectation that their child could abuse drugs ($\chi^2=4.88$, $df=2, p>0.05$), there were more cases of drug abuse among children of parents in formal and informal employment than there were for the unemployed. Most of the drug abusers had good knowledge about drugs but most of them had not known their health effects when they begun (90.2%). Majority (56.1%) had drug-abusing parents. There was a strong association between reasons leading a child into taking drugs and one's position in the family ($\chi^2=11.17$, $df=4$, $p<0.002$). The results of this study will be useful in designing strategies for parents as guidelines for developing and implementing personal programmes of primary prevention as a way of influencing their children against drug abuse as a lifestyle.
CHAPTER 1: INTRODUCTION

1.1 BACKGROUND INFORMATION

It is becoming increasingly important to study health risk behaviour because statistics shows that the leading causes of death are attributed to behaviour patterns that are modifiable. Substance abuse, especially smoking, is risk behaviour and is one of the main preventable causes of death in the world (Astrom, et al., 2003). The world drug problem is seen primarily as a social problem. This is understandable from the insidious long-term effects of chronic drug abuse and its impact on the drug abuser, the family, the community and the society (INCB, 2002).

Substance abuse can be described as the repeated non-medical use of potentially addictive chemical and organic substances. It includes the use of chemicals in excess of normally prescribed treatment dosage and frequency, and routes that intensify or speed up drug reaction (WHO, 2000). The principal characteristic of abused drugs is their potential for altering mood and behaviour and for creating dependence. Although many of them have considerable therapeutic value, they are widely misused, thereby creating a series of adverse consequences to society (UNCDP, 1998). No nation is immune to the devastating problems caused by substance abuse, which has become a human tragedy. It is more than just a "street problem". It has invaded homes and individuals of all ages and classes. Beyond human destruction, substance abuse also damages traditional values, lifestyles and national economies (INCB, 2003). It also breeds threats to the security and integrity of nations and regions. Social and public costs, health-care, crime control, and disability associated with substance abuse are enormous if not immeasurable. Moreover, deaths associated with substance abuse are the result of a complex
interaction between the drug, the individuals and the setting in which it is taken (Miller, 1984).

Substance abuse has permeated all strata of society with the youth being the most affected. Most users fall between 16-30 years of age with experimentation beginning much earlier even at 4 years (Gacicio, 2001). These are critical years in human development; be it at physical, psychological or intellectual levels. When the young people indulge in drug abuse at this early stage, their future is bleak and so is the country’s (Kaguthi, 2001).

Initiation of substance abuse can be by; (1) gateway drugs (beer, tobacco and miraa), which are legally marketed, relatively inexpensive and widely acceptable, (2) transition drug (marijuana), which is less expensive than hard drugs and is viewed as less dangerous and hard drugs (cocaine, heroin, tranquilizers and sedatives among others) (NACADA, 2000). Reasons given for drug abuse include: (1) gain of acceptance by peers, (2) experience pleasure as presented by advertisements, (3) feeling of courage and independence, (4) need to reject convention institutions of society, (5) feeling of transition to adulthood, (6) tackling boredom/idleness and stress (occupational, financial, social migration and urbanization), lack of social supervision and festivities among others (Ndetei, 2001). Bad parentage, easy access, peer influence, deep seated lack of identity and self esteem have also been cited as reasons for drug abuse in the youths. (Kuria, 1996).
1.2 STATEMENT OF THE PROBLEM

Drug abuse is presently recognized as a major problem among the youth. About 92% of Kenyan adolescents and young adults aged between 16-26 years (6,021,380 out of 6,544,978 persons) have experimented with drugs in the process of growing up; 89% of which have been involved with beer and spirits, cigarettes/tobacco, local brews, local spirits in the order of preference (NACADA, 2000). One of the major factors contributing to this phenomenon is the easy availability of alcohol and drugs in the community. This is compounded by the fact that in Kenya, although there are laws that restrict access of the legal drugs by age, many commercial outlets do not observe them, hence these drugs are abundantly available. For the illicit drugs, the traffickers know how to get their consumers and vise versa. In addition, advertisement of alcohol and tobacco is not restricted in the print or electronic media and this may play a major role in encouraging their use. Advertisement may greatly influence the perceptions of youth, who imitate with images of being more successful, sporty or trendy (Asma et al., 2003).

Despite the efforts made by the Republic of Kenya through the Ministry of Health, Ministry of Education Science and Technology and other law enforcement agencies such as the police, provincial administration and the NACADA group, the aspect of drug abuse is an escalating problem in the Kenyan society especially among the youth. Identification of strategies to combat the problem of drug abuse is therefore a priority.

While people of all ages are at risk, the age bracket between 16-26 years face a greater risk of getting into the tangle of drug abuse due to growth and development changes especially during the transition period from childhood to adulthood (Paxman
and Zuckerman, 1987). This social problem can be solved gradually by addressing both its symptoms and causes through social solidarity education and strengthening of cultural and family values (Rogers and McCarthy, 1999).

Though the risk of the problem may take long to reach unmanageable proportions, the overall picture shows a steady upward trend, which raises questions regarding the effectiveness of the Kenyan government strategies and other agencies in dealing with the problem. While most studies done have focused on the youth, parents can have a preventive aspect when intervention begins early. No study in Kenya had so far has looked into this aspect. Parents possess the greatest potential for generating behaviour change because they have the greatest control over the significant aspects of their children's environment (Goldenberg, 1996). Successful intervention to this problem may have to involve empowering the parents with necessary information so as to detect the problem early enough. Based on the above factors, this study proposed to investigate factors leading to substance abuse and the parental awareness about them with an aim of trying to institute effective interventions on drug abuse among the youth.
1.3. JUSTIFICATION OF THE STUDY

Drug abuse has harmful and debilitating effects on the individual user, the family and the society. Kenya, like many other nations, has only limited resources to cater for the basic needs of its people. Abuse of drugs drains the economy because of control of supply and demand reduction, which is an expensive undertaking. It also has a setback to the country, as youth become less productive. Efforts made to stem the tide of drug-related behaviour among the adolescents and youth seems to have been unsuccessful. The overall picture of the problem shows an upward trend as indicated by seizure statistics, the media reports about drug abusers, traffickers and highlights of seizures.

Perhaps parents in Kenya today, if empowered with knowledge about drug abuse, can be instrumental in the development of health-promoting lifestyles during childhood. However, no study had looked into this aspect in Kenya. As watchdogs, they can be a reliable source of influence in directing young people away from drug use. This can help prevent the more difficult task of changing stabilized and resistant damaging behaviour in adults. In this study, information on factors leading to drug abuse by the youth and the parents' knowledge of these factors were sought. This information will be useful in designing proper intervention strategies to curb substance abuse.
1.4: RESEARCH QUESTIONS
The study sought to answer the following questions:

1) What are the factors that predispose the youth to substance abuse?
2) What is the level of parents’ and abusers knowledge about factors that predispose the youths to drug abuse?

1.5. NULL HYPOTHESES
1) There is no significant relationship between parents’ knowledge on substance abuse and drug abuse by their children.
2) There is no significant relationship between drug abusers' knowledge and their abuse of drugs.
3) There is no significant relationship between parents educational and occupational status and drug abuse by their children.

1.6 OBJECTIVES OF THE STUDY
1.6.1 General objective
The main objective of this study was to determine drug abusers and parental knowledge on factors predisposing the youth to substance abuse.

1.6.2 Specific objectives
1) To determine the parents educational and occupational status.
2) To determine parents and youths prior knowledge on drug abuse and awareness on availability of help services.
3) To determine the parents expectation on their children's abuse of drugs.
4) To investigate youths knowledge and practice on drugs.
CHAPTER 2: LITERATURE REVIEW

2.1 CATEGORIES OF ABUSED SUBSTANCES

Drug types are described in various ways, depending on their origin and effect. They can either be naturally occurring, semi-synthetic (chemical manipulations of substances extracted from natural materials) or synthetic (created entirely by laboratory manipulations).

2.1.1 Opiate or Opioids

Opiates is the generic name given to a group of substances which includes naturally occurring drugs derived from the opium poppy (*Papaver somniferum*) such as opium, morphine and codeine, heroine, (which is semi synthetic) and opioids which are wholly synthetic products such as methadone, pethidine and fentanyl (UNCDP,1998). Medically, morphine is the standard by which other pain relievers are measured (Cohen and, Kay 1998). These drugs originate mainly from the Golden Triangle [Myanmar (formerly Burma), Laos and Thailand], Golden Crescent (Afghanistan, India and Pakistan), and from Iran and Mexico. Around eight million people abuse opiates, mostly in South East and South West Asia (World Drug Report, 2000). Opiates depress the central nervous system and are used therapeutically as analgesics (pain relievers). Users report that heroin produces a “rush “or a “high“ immediately after it is taken. It also produces a state of profound indifference and may increase energy. Opiates produce different effects under different circumstances. Their effects are influenced by the drug takers’ past experience and expectations as well as the method of administering the drug (which can be by injection, ingestion, or inhalation), (UNDCP, 1996). Their effects include euphoria, reduced appetite resulting to malnutrition, chronic bronchitis due to suppressed cough reflex, and reduced oxygen to the brain due to suppressed
respiration, which can lead to coma or death. High doses of opiates lead to a reduction in sexual drive and fertility, resulting in impotence in men and severe irregularities in the female menstrual cycle, as well as mood instability, lethargy and anorexia (UNCDP, 1998).

Some of the most severe effects of heroin abuse stem less from the drug itself but from unhygienic injecting practices, which may cause hepatitis, HIV/AIDS and skin infections due to sharing of needles and syringes (CEWG, 2000). Children born of mothers abusing opiates have low birth weight. They undergo withdrawal symptoms immediately after birth, which includes kicking movements in the legs, anxiety, insomnia, nausea, sweating, cramps, vomiting, diarrhoea and fever (Breitbart et al., 1998).

2.1.2 Depressants

This group of substances includes alcohol, barbiturates, synthetic sedatives and sleeping tablets (hypnotics). They have a common ability to cause a degree of drowsiness or sedation or a pleasant relaxation but may also produce "disinhibition" and loss of learned behavioural control as a result of their depressant effect on the higher centers of the brain. Except alcohol the other depressants have been used since the early 1900s to relieve anxiety and induce sleep (IEWG, 1999). Barbiturates are powerful central nervous system depressants. They can cause excessive drowsiness and thereby put the user at risk if driving or operating machinery. Abuse may lead to respiratory problems such as bronchitis and emphysema and at high doses can cause unconsciousness or death through respiratory failure. Sudden withdrawal can also cause death. Alcohol is a major cause of disease burden, particularly for adult men. Excessive use of alcohol is the leading cause of disability for men in the developed regions and fourth leading cause
of disability in the developing regions (WHO, 2000). Its consumption is decreasing in
developed regions, while it is increasing in the developing nations (World Drug
Report, 2000).

Depressants can have adverse consequences for the cognitive function such as
memory and concentration. Withdrawal symptoms include shaking, insomnia,
anxiety and restlessness. Sedatives, which include minor tranquilizers that are
distributed under such names as Valium® and Librium®, are medically used for the
treatment of anxiety, insomnia and epilepsy. They are safer than the older drugs but
their addiction has become a problem (WHO, 2000).

2.1.3 Stimulants

Commonly abused stimulant drugs are cocaine ("crack") and the amphetamines
("Ecstasy", "E", or "speed"). Cocaine is a white crystalline powder with a bitter taste,
is extracted from the leaves of the South American coca bush. About 13 million
people (0.23 percent annual prevalence) are estimated to abuse cocaine worldwide.
The highest prevalence is reported in the United States and in Latin American
countries (CEWG, 2000). It is used medically to produce anesthesia for surgery of
the nose and throat and to constrict blood vessels and reduce bleeding during
surgery. However, abuse can lead to severe psychological and physiological
problems (WHO, 2000).

Sources of these drugs include South American countries (Peru, Bolivia, Columbia,
Chile and Brazil), West Indies, Java, India and Australia (UNCDP, 2002). Worldwide,
30 million people are estimated to use stimulants with an annual prevalence of 0.52
percent. High prevalence rates are shown in Western Europe, Australia, and some
Latin American countries (World Drug Report, 2000). Amphetamines, introduced in
the 1930s for the treatment of colds and hay fever, and were later found to affect the
nervous system (WHO, 2000). For a while, people trying to lose weight used them. Today their use is restricted primarily to the treatment of narcolepsy (some sleep disorders). Both amphetamines and cocaine can produce psychosis similar to that of schizophrenia and suppress the appetite if abused. They are smoked or injected intravenously (WHO, 1993). From this group, the society accepts nicotine from tobacco, khat and tea which are locally produced in Kenya. Tobacco is either smoked as cigarette, snorted or chewed. Tea and coffee are used as beverages, while khat is chewed and its juice swallowed (UNDCP1999). However, their mechanism of action is different from that of cocaine and amphetamines. Coffee and tea contain caffeine that alleviates mild degrees of fatigue. They produce very low levels of dependence and withdrawal symptoms if any. Khat contains cathine and cathinone, which have actions similar to those of amphetamines (WHO, 1990). Among its adverse effects are sleeplessness, constipation, gastritis hypothermia, reduced appetite, depressed sexual potency and clinical spermatorrhoea which are occasionally accompanied by testicular pain (Hakim, 2002).

2.1.4 Hallucinogens

These substances include naturally occurring substances such as psilocybin (in magic mushrooms) and mescaline (in peyote), and semi synthetics such as lysergic acid diethylamide (LSD) and phencyclidine PCD (“angel dust” or “rocket fuel”) (UNDCP, 1997). They are not used medically in most countries except occasionally in the treatment of people with mental illness, drug abusers and alcoholics (WHO, 1990). Phencyclidine (PCD) has no current use among human beings but is used by veterinary surgeons for animals. They are used illicitly for their mind-altering effect. Lysergic acid diethylamide (LSD) causes perceptual distortion of time and place, visual hallucinations and synaesthesia (crossing of senses such that colours are
heard", and sounds are "seen") (WHO, 1993). PCD, by contrast, produces euphoria, a sense of detachment and a reduction in sensitivity to pain; it may also result in either triggering or producing symptoms like those of acute schizophrenia that even professionals confuse the two states (INCB, 2002). It also produces feelings of unreality and distortions of time and space. The combination of this effect and indifference to pain has sometimes resulted in bizarre thinking, occasionally marked by destructive behaviour. Hallucinogens are taken orally (WHO, 1998).

2.1.5 Cannabis

It is also called "weed", "grass" or "bhang". Its derivatives, hashish and hashish oil is from the concentrated plant resin while marijuana is the crushed plant and flowers. It is the most widely abused drug in all parts of the world. An estimated 141 million people use cannabis (WHO, 2000). Its abuse is particularly high in Western Africa, Oceania, Central America, North America and in a number of European countries (IEWG, 1999). It grows wildly in Africa, China, Asia, North and South America and Middle East. Though prohibited, it is commercially planted in Mexico, U.S.A., Jamaica, Columbia, Brazil, Paraguay, Ghana, Nigeria, Kenya and Uganda (UNCDP, 1997). Hashish and hashish oil are produced in Morocco, Syria, Afghanistan, India, Pakistan and Lebanon (UNCDP, 1997).

The drugs are usually smoked, often mixed with tobacco in a cigarette or 'joint', but they can also be ingested orally. Their effects are similar: a state of relaxation, accelerated heart rate, perceived slowing of time and a sense of heightened hearing, taste, touch and smell, shortening of concentration span and impairment of coordination. In low doses it has a relaxing and mood enhancing effect but in higher doses and/or in certain individuals it can cause anxiety, panic or paranoia (IDP,
2000). Smoking the drug carries a similar and possibly aggravated series of risks to those associated with cigarette smoking and respiratory cancers, bronchial and cardiovascular problems and the likelihood of foetal and neonatal complications (Breitbart et al., 1998). These effects can be quite different, however, and depend on the amount of drug consumed and the circumstances under which it is taken. Marijuana and hashish are not thought to produce psychological dependence except when taken in large daily doses (CEWG, 2000). The drugs can be dangerous, however, especially when smoked before driving. Cannabis has been used as a folk remedy for centuries, but it has no well-established medical use today (INCB, 2001).

2.1.6 Inhalants

This group includes volatiles or solvents in glue, toluene, petroleum-CPDs and aerosols. These are mainly for industrial use. They are volatile in nature and are therefore inhaled. Most users are the street dwellers. These substances are not usually considered drugs but as substances that are abused such as glue, paint thinners and petrol. Most such substances are sniffed for their psychological effect, and action to depress the central nervous system. Low doses can produce slight stimulation, but in higher amounts they cause loss of control or lapse into unconsciousness (UNDCP, 1997). The effects, which are immediate, can last for as long as 45 minutes. Headache, nausea and drowsiness may follow. Sniffing inhalants can impair vision, judgment, muscle reflex control and can damage the circulatory system (ICN and WHO, 2000).
2.2 THE GLOBAL PICTURE OF SUBSTANCE ABUSE.

It is difficult, if not impossible to precisely estimate the actual extent of abuse of illicit drugs at the global level. This is primarily because there are significant gaps in data and also because the data provided by some countries are of unknown quality (WHO, 1998). Nevertheless, the fact is that every country in the world developed or developing incurs substantial costs as a result of damages caused by substance abuse. Current evidence reveals a continuing upward trend in substance abuse worldwide (World Drug Report, 2000).

Evidence exists to indicate that human beings have used tobacco since pre-historic times and that the habit originated in the Americas (World Bank, 1999). Currently the World Health Organization (WHO) estimates that 1.1 thousand million people, representing a third of the world population above the age of 15 years, use tobacco principally in the form of the manufactured cigarette. Out of these smokers, 800 million live in developing countries, of which 700 million are males (WHO, 2000). While smoking rates have been declining in the developed world, these rates have increased by as much as 50% in developing countries, especially those of Asia and the Pacific region, over the last decade. Smoking is therefore a major habituation in developing countries. Tobacco causes 4 million deaths annually besides prenatal morbidity and mortality (WHO, 2000). This figure is projected to rise to 1.6 billion by the year 2025, 70% of which will occur in the developing world if the current trends continue (INCB, 2002). Developing countries are burdened by economic, political, and social problems. Civil strife and war, poverty, HIV/AIDS, crime and corruption in some countries are closely related to the drug problem (INCB, 2003). Despite eradication efforts in some countries in Africa the region remains a major supplier of cannabis, which is one of the most widely abused drugs. The abuse of psychotropic
substances is widespread because of inadequate systems of licensing and inspecting trades in such substances. There is a high incidence of drug abuse among young people and children (IDP, 2001).

The relationship between drugs and HIV/AIDS cannot be overlooked as was highlighted in an international conference on AIDS held in Durban South Africa in July 2000 (INCB, 2002). This was further confirmed by the UNCDP in a study done among the Kenyan youths in 1999 (UNDCP, 1999).

More than 100,000 injection drug users in New York have been infected with HIV, and more than 50,000 cases of AIDS are reported among injection drug users, their sexual partners and their children in the New York City (Jarlais and Marmor, 2000). These cases account for 1/10 of the total number of AIDS cases in the United States and are more than the total number that has occurred in any single European country (UNAIDS, 2000). International organizations such as WHO, ILO, UNCDP, UNICEF, UNESCO as well as the World Bank have been involved in the fight against drug abuse. Regional and sub-regional organizations that have addressed the issues on drug control in Africa include OAU, COMESA, SADC and ECOWAS (World Bank, 1999). UNCDP estimates that 100 million people may be habitual users of illicit drugs, 18 million people are Latin Americans (UNCDP, 1997). In 1998, UNCDP reported 23.1 million drug related deaths among men and 5 million deaths in females from Australia, Italy, Sweden, United Kingdom, and USA (UNCDP, 1998).
2.3. HISTORICAL AND CULTURAL BACKGROUND OF DRUG ABUSE

The use and abuse of drugs from natural origins has been known since antiquity. For centuries, man has tried to escape from the unpleasant features of life, whether real or imaginary by using fermented liquors or plant products such as opium, coca leaves, cannabis and khat (miraa) (Hassan, 1995).

In the pre-colonial days, drugs were used and consumed as part of the traditions of the community. The traditional rules, values and taboos were in place to dissuade the misuse of these powerful substances (Mbiti, 1993). Cultures strictly prescribed the circumstances under which drugs and intoxicants were obtained, used and consumed (Amayo, 1998). Secondly, there was a cultural stigma towards drunkenness, while the consumption of alcohol was liberally acceptable during specific occasions such as weddings, harvest festivals, funeral ceremonies, and other social events (Kaguthi, 2001).

In general, drinking of alcohol was allowed to elders only, especially male elders and so was the use of tobacco, while restrictions were placed on the use of these substances by youth (Odhiambo, et al., 2001). Alcohol was the most popular form of intoxicant. It was made from various ingredients such as sugarcane, honey, banana, and cashew fruits. Alcohol was consumed in its natural form, or was distilled into a spirit and then consumed (Mbiti, 1993). Herbs, roots, bark, leaves, and plants were the sources of drugs. The common ones included tobacco leaves, khat leaves and the outer skin from twigs, and bhang (marijuana) leaves. They formed the basis of indigenous pharmacology (Njagi, 2001). Drug abuse as a social problem did not exist. With industrialization and urbanization, lifestyles of most Africans have changed. Individualism rather than close family ties is emphasized (Yambo, 1993).
The social control by the family on its members has been eroded and being an institution designed as the primary source of socialization, it has been marginalized in its primary role of protecting its offspring (Larry and Merril, 1986). As a result, several parents have lost control over their children and freed from parental control, and some children have succumbed to substance abuse (NACADA, 2004).

In Africa, the history of drug use is relatively short (Mwenesi, 1995). Despite this, it is nevertheless escalating rapidly from cannabis abuse to the more dangerous drugs such as cocaine, heroine, opium and from limited group of drug users to a wider range of drug users. The situation in Africa and the lifestyle of Africans have drastically changed over the past years due to the influence of industrial and urban development (Nordberg, 1998).

2.4 THE PUBLIC HEALTH AND SOCIAL IMPLICATIONS OF DRUG ABUSE

2.4.1 Social Problems

The social problems include behaviour problems arising due to the user being unable to function as expected. There could be economic losses that have an impact on the users' immediate social circle (the family) that may be depended on him or her (WHO, 1986). The family relations also deteriorate and problems in peer relationships occur (Werner, 1995). The association of social problems and chronic drug use among certain groups is very evident. This correlation has been found to exist even among casual users of illicit drugs. Adolescents are continually expected to develop new skills and acquire knowledge, both in school and in their social environment outside school (UNDCP, 1996). According to WHO 1981, laboratory experiments with animals have demonstrated that a variety of psychoactive drugs impair the learning process and similar results have been found in human studies.
(UNAIDS, 2000). The effect of acute administration of cannabis upon memory have been extensively investigated and have been found uniformly to result in impairment of memory (WHO, 1998). Similar effects have been reported for diazepam. Since memory and other cognitive functioning are so essential to learning, it seems clear that frequent ingestion of drugs causes behavioural changes that may lead to poor academic performance, school absenteeism, and school drop-outs (WHO, 1990).

2.4.2 Criminal Behaviour

Criminal behaviour has been reported among drug users in various forms. Beyond the illicit possession of drugs for their own consumption, they may be involved in crimes committed in order to ensure their own supplies, in addition to crimes of violence committed under the influence of drugs (WHO, 1995). The most misused and the most dangerous substance involved in road traffic accidents is alcohol (WHO, 1986). Due to the impaired performance of the driver, he is more likely to cause accidents (WHO, 1986). Drug use is capable of producing psychotic reactions, which may lead to violence or suicidal tendencies (Flisher and Chalton, 2001).

2.4.3 Social Economic Effects

Drug use leads to demands on social services and medical resources, the cost of which is borne not only by the individual user but also by the public (WHO, 1995). The effects include the societal responses such as prevention in form of rehabilitation and control programmes (Burge, 1995). The loss of resources already committed to education in the school dropouts and intangible costs that are too difficult to assign monetary value. For example, broken-up families, poor child development, and deterioration of schools as learning institutions (Ongango, 2001). Drug users are potential agents in the spread of drug abuse in both their immediate social environment, and in national and international settings (NACADA, 2004).
2.4.4 Health Problems
Drug abuses can lead to hepatitis B, HIV/AIDS infection, and septicemia from the use of non-sterile injection methods in the administration of drugs (UNAIDS, 2000). The acquiring of HIV/AIDS among drug users in Africa may not be so much because of injection but due to lack of proper mind judgment under the influence of drugs leading to unprotected sex (Levy, 1995).

Physical disabilities may result from road traffic accidents and other accidents occurring under the influence of drugs ingested. Deaths may occur due to over dose or mixing of psychotropic drugs with other substances (UNDCP, 2002). Alcoholism is known to cause damage to tissue or organs e.g. liver cirrhosis while smoking causes lung and cardiovascular diseases (WHO, 1986). Non-specific health disorders may also result from neglect of personal hygiene and inadequate nutrition. Mental disorders such as cannabis psychosis have been reported to contribute 12-40% of all psychosis in Africa (UNDCP, 2002).

2.5. PRESENT SITUATION OF DRUG ABUSE IN KENYA.
In Kenya drug trafficking and abuse is considered a criminal offence under the Narcotic Drugs and Psychotropic Substances Control Act of 1994. The Kenya police through its anti- narcotic unit has its officers strategically deployed at entry and exit points. The police force is supposed to make sure that the laws regarding this issue are enforced.

In Kenya, exact information does not exist on the number of addicts or people hooked on substances of abuse. Although official statistics are part of this answer, they only refer to those who come to official attention and no one knows what proportion of this is of the total (Chakaya, 2001). It is evident that the use of hard
drugs is not yet widespread among the general Kenyan population. The use of the licit (legal) substances, alcohol and tobacco is quite high in the general population probably due to their social acceptability, easy availability and the result of sales promotions through uncontrolled advertisements (UNCDP, 1999). A survey carried out by Pride International in 1998 indicated that one in every 15 learners in Kenya took illicit drugs especially bhang. The report further showed that 80% of these learners in schools were aware of illicit drugs but only 6% of them knew the harmful effect of drugs (Gacicio, 2001).

Majority of the users start with gateway drugs (alcohol and tobacco) and then get into bhang, which is a transition drug. In the urban areas, hard drugs such as cocaine, heroine, and opium are on the increase (Amayo, 1998). The students have now graduated from the traditional/social drugs (alcohol and tobacco) that they refer to as mild to more sophisticated ones (Ogunde, 1999).

It is postulated that social cultural factors can keep substance abuse in check. For example, in most traditional Kenyan communities, women who smoke or drink in public are shunned (Amukoye et al., 2003). Similar social cultural factors could keep the youths from the use of drugs especially through the primary unit, the family (Stephen and Addei, 1991). Dysfunctional family life, rather than poverty, seems to be one of the most significant factors in predisposing an individual to take drugs (Crany, 1986). Conversely, the existence of a stable, supportive family life is frequently, though by no means always, thought to be a vital protective factor (UNCDP, 1998).
CHAPTER 3: MATERIALS AND METHODS

3.1.1 The Study Area

The study was carried out in Nairobi, which is a province in the central part of Kenya (App.1). Nairobi is geographically situated at latitude1°15’S and longitude 36°48’E. The reason for the choice of the study area was drug availability as demonstrated by seizures made by the Kenya Police Anti narcotic Unit. For example, at the international airport, from vehicles destined to Nairobi and the arrests of culprits all indicated that Nairobi was a transit point for illicit drugs. Nairobi is going through the phase of rapid urbanization and development. Accompanying this is social instability in many forms: principally unemployment, overcrowding, family break-ups loneliness, lack of parental guidance and crime. This type of environment could be conducive for drug use by many especially the youth.

The study was carried out in drug abuse treatment and rehabilitation centers that gave consent to the study. These centers were Bright side D.A.R.T. center situated in Kitisuru, Nairobi, Mathare Mental Hospital, and Oasis Drug Abuse Rehabilitation Center and private treatment specialists in the city center who reach a wider clientele. Other centers that were earlier considered either did not consent to the study or did not have the clients of interest by the researcher.

3.1.2 Study Population

The study population comprised parents whose youth were undergoing treatment and rehabilitation for drug abuse, the youths who turned up for treatment and the treatment specialists in the rehabilitation centers.
3.1.3 Ethical Considerations
Permission to carry out the research was sought and granted by the relevant authorities including Kenyatta University, Ministry of Health, Ministry of Education, Science and Technology and the respective treatment centers. Participation was voluntary and willing participants were required to give informed consent. The researcher kept all information obtained in strict confidence.

3.2. Sampling Procedure
The study was carried out in substance abuse treatment and counseling centers and convenience sampling was used. In this case the parents/guardians, who turned up and met the conditions of the inclusion criteria and the drug abusers in the treatment centers, were recruited in the study. Only 97 respondents were willing to participate in the study. Of these 46 were parents, 41 were drug abusers, and 10 were treatment specialists/counselors.

3.2.1. Sample Size Calculation
Sample size was arrived at by calculation using the formula as used by Fisher et al. (1998) as shown here below:-

\[ n = \frac{Z^2pqD}{d^2} \]

Where n= Sample size
\( Z \) = Standard normal deviate (1.96) which corresponds to 95% confidence interval
\( P \) = proportion of the target population estimated to have particular characteristics
\( q = 1-p. \)
\( d = \) Degree of accuracy = 0.05
\( D = \) design effect = 1
Thus, \( N = 1.96^2 \times 0.5 \times 0.5 \times 0.05^2 = 384 \)

However 400 were considered.

Since the total population was less than 10,000, further calculation was done.

Estimated number of people undergoing treatment and rehabilitation was 500 (N).

\[
N_f = \frac{n}{1 + (n/N)}
\]

\( n = 400 \)

\[
= \frac{400}{1 + 400/500} = 222.2.
\]

However, only 97 respondents were willing to participate in this study.

### 3.3. LIMITATIONS OF THE STUDY

1) Some of the administrators of the selected centers for study refused to allow the study to be carried out in their centers. Some could strictly not allow any access to their clients or information with a claim that they were maintaining absolute confidentiality. However, this might have been coupled with suspicion that one was assessing or evaluating their performance.

2) The study subjects of the drug abusers found during the study were predominantly males. This could have been due to the expectation in many societies that boys and young men are more daring, risk-taking and rule breaking than girls and young women.

3) The study took much longer that it was planned. This was because time had to be taken to create rapport before the clients could open up. In other cases, the
drug abusers brought to the centers had to take time to attain a stable mental condition so as to be interviewed.

3.4. DATA COLLECTION
Data was collected from November 2002 to September 2003. The respondents were issued with questionnaires written in English. The investigator used either English or Kiswahili. The respondents were interviewed and the researcher took down the answers. This was done after proper rapport was created between the researcher and the respondents. The researcher had to be close to them so that they could answer questions. Most of the interaction was during group therapy and break times. To minimize biases and errors, a standard questionnaire was used on all clients. The questionnaire was pre-tested first before being used in the field.

3.5. DATA MANAGEMENT AND ANALYSIS
The data processing was done using SPSS statistical package. Data analysis was done using chi-square to determine whether associations between the dependent variable of substance abuse and that of independent variables of parents' knowledge, preparedness in handling drug abuse were significant.
CHAPTER 4: RESULTS

4.1. DEMOGRAPHIC CHARACTERISTICS

A total of 97 respondents participated in the study. Of these, 41 were drug abusers, 46 were parents whose children were abusing drugs and 10 were treatment specialists and counselors.

4.1.1 Age

The abusers age ranged from 16-30 years with a mean age of 26.6. The majority of the abusers were 21 years old. The oldest abuser interviewed was 30 years old while the youngest was 16 years old. The parents/guardians age ranged between 27-72 years.

4.1.2 Sex

There were more male abusers (73.2%) than female abusers (26.8%). In contrast there were more female parents (60.9%) than the male parents (39.1%) in the study.

4.2. INFORMATION ON PARENTS

4.2.1 Level of Education of Parents

Most parents had acquired some formal education especially up to primary level. Majority had at least completed secondary school (58.8%) while 21.7% had completed primary. Only 13 % (6) did not have any formal education. When data in table 1 were subjected to chi-square for goodness-of-fit, it was shown that there was a significant difference between the observed and expected ($\chi^2 = 17.4$, df=5, p<0.01).
Table 1: Level of Education of Parents

<table>
<thead>
<tr>
<th>Education level</th>
<th>Freq</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>No formal education</td>
<td>6</td>
<td>13</td>
</tr>
<tr>
<td>completed primary</td>
<td>10</td>
<td>21.7</td>
</tr>
<tr>
<td>Not Completed primary</td>
<td>3</td>
<td>6.5</td>
</tr>
<tr>
<td>completed secondary</td>
<td>18</td>
<td>39.2</td>
</tr>
<tr>
<td>Not Completed secondary</td>
<td>5</td>
<td>10.9</td>
</tr>
<tr>
<td>Post secondary</td>
<td>4</td>
<td>8.7</td>
</tr>
<tr>
<td>Totals</td>
<td>46</td>
<td>100</td>
</tr>
</tbody>
</table>

4.2.2 Parents Occupation

Majority of the parents were salaried 45% (21) followed by those in business 37% (17) as shown in table 2. Only 17.3% (8) of the parents’ sample had no form of employment. However this difference was not statistically significant ($\chi^2=4.876$, df=2, p>0.05).

Table 2: Parents Occupation

<table>
<thead>
<tr>
<th>Occupation</th>
<th>Frequency</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Formal employment</td>
<td>21</td>
<td>45.7</td>
</tr>
<tr>
<td>Informal employment</td>
<td>17</td>
<td>37</td>
</tr>
<tr>
<td>Not Employed</td>
<td>8</td>
<td>17.3</td>
</tr>
<tr>
<td>Totals</td>
<td>46</td>
<td>100</td>
</tr>
</tbody>
</table>
4.2.3. Parents' Prior Knowledge on Drug Abuse and Awareness of Help Services

4.2.3.1 Knowledge About Drug Abuse Before Their Children Were Involved in It.
Over a half of the parents studied (63%) already knew about drug abuse even before they saw it in their children. However, 37% of the parents had not known this. This difference was however shown to be non-significant ($\chi^2=2.44$, df=1, p>0.05). When the parents were asked for the sources of information about drugs some said they got the information from religious gatherings (50%), seminars (10.9%) radios (17%) and 4.3% heard through a combination of the three. Only 17.8% had not heard about drug abuse before.

**Figure 1: Parents' Awareness of Their Children Age of Initiation into Drug Abuse**

A significant majority ($\chi^2=22.43$, df=2, p<0.001) of the parents said they did not know the age when their children got into drugs as shown in figure 1.
4.2.3.2 Parents’ Expectation

The fact that drug abuse was never expected by most parents (62.2%) caused it to happen without their awareness. Some associated it with well to do homes (41.3%), street children (32.6%) or poor homes (26.1%). These differences were significant ($\chi^2=8.31$, $df=3$, $p<0.05$). Of the 46 studied, 37 (80.4%) were informed of the vice in their children by other people such as siblings (45.7%), police cases (8.6%), relatives or teachers (30.5%), and 15.2% observed it by themselves as in table 3.

Table 3: Parents’ Source of Information on Drug Abuse in Their Children

<table>
<thead>
<tr>
<th>Persons informing</th>
<th>Freq.</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Siblings</td>
<td>21</td>
<td>45.7</td>
</tr>
<tr>
<td>Teacher/ relatives</td>
<td>14</td>
<td>30.5</td>
</tr>
<tr>
<td>Police cases</td>
<td>4</td>
<td>8.6</td>
</tr>
<tr>
<td>Self observation</td>
<td>7</td>
<td>15.2</td>
</tr>
<tr>
<td><strong>Totals</strong></td>
<td><strong>46</strong></td>
<td><strong>100</strong></td>
</tr>
</tbody>
</table>
There was a notable delay by the parents in seeking professional help for their drug-abusing children as shown in figure 2 (n=46; $\chi^2=28.17$, df=3, $p<0.01$). Parents were assisted or advised by friends (39.1%), health workers, church members (8.7%) or relatives (21.7%) to seek professional help.

Table 4: Relationship Between Parents' Gender and Expectation About Drug Abuse

<table>
<thead>
<tr>
<th>Gender</th>
<th>Male</th>
<th>Female</th>
</tr>
</thead>
<tbody>
<tr>
<td>Expect anything</td>
<td>5; 31.3%</td>
<td>11; 68.8%</td>
</tr>
<tr>
<td>Do not expect</td>
<td>8; 26.7%</td>
<td>22; 73.3%</td>
</tr>
</tbody>
</table>

Although the data in table 4 shows that a higher number of female parents (68.8%) expected their children to be involved in drug abuse there was no significant association between parents' gender and their expectation ($\chi^2=0.84$, df=1, $p>0.05$).
Table 5: Relationship Between Parents' Occupation and Expectation About Drug Abuse

<table>
<thead>
<tr>
<th>Employment</th>
<th>Formal Employment</th>
<th>Informal employment</th>
<th>Not employed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Expect</td>
<td>4; 36.4%</td>
<td>4; 36.4%</td>
<td>3; 27.2%</td>
</tr>
<tr>
<td>Do not expect</td>
<td>17; 48.6%</td>
<td>15; 42.9%</td>
<td>5; 8.5%</td>
</tr>
</tbody>
</table>

There was no statistical association between parents' occupation and their expectation of their children getting into drug abuse ($\chi^2=1.57$, df=2, $p>0.05$). However, except for the non-employed most of those in formal and non-formal employment indicated that they did not expect any of their children to be involved in the abuse of drugs as shown in table 5.

Table 6: Time Spent With Children

<table>
<thead>
<tr>
<th>Time spent with children</th>
<th>Freq</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>1-evenings</td>
<td>21</td>
<td>45.5</td>
</tr>
<tr>
<td>2-weekends</td>
<td>9</td>
<td>19.6</td>
</tr>
<tr>
<td>3-end months</td>
<td>7</td>
<td>15.1</td>
</tr>
<tr>
<td>4-holidays</td>
<td>8</td>
<td>17.4</td>
</tr>
<tr>
<td>5-when time allows</td>
<td>1</td>
<td>2.2</td>
</tr>
<tr>
<td>Totals</td>
<td>46</td>
<td>100</td>
</tr>
</tbody>
</table>

Table 6 shows that most parents (45.7%) spent at least evenings while others spent the weekends with their children (19.6%), holidays (17.4%), and month ends
(15.1%). Only one (2.2%) said he interacted with the children when he had time. These differences were significant ($\chi^2=31.81, df=2, p<0.001$).

**4.3.0 Duty to Control Drugs**

The most mentioned approach to control drug abuse was the government (43.5%). Others felt that a combination of government, school, church and family efforts would be the best approach to control drug abuse (34.8%). The duty of family and church in the control of drug abuse was mentioned by five parents in each case (10.9%). This is shown in table 10. However this difference was statistically insignificant.

**Figure 3: Duty to Control Drugs**

![Duty to Control Drugs Pie Chart]

- All, 34.8%
- Teachers/Church, 10.9%
- Government, 43.4%
- Family, 10.9%
4.4. INFORMATION ON DRUG ABUSERS

4.4.1 Drug Abusers Level of Education

Table 7 shows that the majority of the drug abuser had some formal education, at least they went beyond primary school level. Respondents with at least secondary school level and above constituted 48.8%; those with primary education level 12.2 %, 36.6 % did not complete secondary school while 2.4% had no formal education. Of those with secondary school level and above 12.2 %, had not completed college. These differences were significant ($\chi^2=24.93, df=4, p<0.001$)

<table>
<thead>
<tr>
<th>Level of Education</th>
<th>Freq</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Non formal</td>
<td>1</td>
<td>2.4</td>
</tr>
<tr>
<td>Complete primary</td>
<td>5</td>
<td>12.2</td>
</tr>
<tr>
<td>Incomplete secondary</td>
<td>15</td>
<td>36.6</td>
</tr>
<tr>
<td>Complete secondary</td>
<td>15</td>
<td>36.6</td>
</tr>
<tr>
<td>Incomplete college</td>
<td>5</td>
<td>12.2</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>41</strong></td>
<td><strong>100</strong></td>
</tr>
</tbody>
</table>
Table 8: Drug Abusers Occupation When They Got into Drugs Abuse.

<table>
<thead>
<tr>
<th>Occupation</th>
<th>Freq</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Formal employment</td>
<td>6</td>
<td>14.6</td>
</tr>
<tr>
<td>Non Formal employment</td>
<td>4</td>
<td>9.8</td>
</tr>
<tr>
<td>Not employed</td>
<td>4</td>
<td>7.3</td>
</tr>
<tr>
<td>Student</td>
<td>27</td>
<td>65.9</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>41</strong></td>
<td><strong>100</strong></td>
</tr>
</tbody>
</table>

Students constituted the highest number of respondents for the drug abusers (65.9%) when they got into drug abuse followed by employed (14.6%), then business and unemployed which had (9.8%) as indicated in table 8.

Table 9: Marital Status of the Drug Abusers

<table>
<thead>
<tr>
<th>Marital status</th>
<th>Freq</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Single</td>
<td>31</td>
<td>75.6</td>
</tr>
<tr>
<td>Married</td>
<td>8</td>
<td>19.5</td>
</tr>
<tr>
<td>Married but separated</td>
<td>2</td>
<td>4.9</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>41</strong></td>
<td><strong>100</strong></td>
</tr>
</tbody>
</table>

Those that were not married formed the highest number of the drug abusers (75.6%) followed by those who were single (19.5%) and then those who were separated (4.9%) (Table 9). These variations were significant ($\chi^2=31.81$, df=2, $p<0.001$).
4.4.2. Distribution of Number of Children in the Families

Majority of families had four children (29.3 %), followed by families that had three children (24.4 %), those with five and one child children had the same percentage (12.2%) while the maximum numbers of children were eight.

There was no association between the size of the family and reasons for taking drugs. However, both frustration and influence were given as reasons for taking drugs mainly in those families of three and four children.

Table 10: Position of the Drug Abuser In The Family

<table>
<thead>
<tr>
<th>Position</th>
<th>Frequency</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>First born</td>
<td>11</td>
<td>26.8</td>
</tr>
<tr>
<td>Second born</td>
<td>7</td>
<td>17.1</td>
</tr>
<tr>
<td>Third born</td>
<td>6</td>
<td>14.6</td>
</tr>
<tr>
<td>Fourth</td>
<td>2</td>
<td>4.9</td>
</tr>
<tr>
<td>Fifth</td>
<td>4</td>
<td>9.8</td>
</tr>
<tr>
<td>Last born</td>
<td>11</td>
<td>26.8</td>
</tr>
<tr>
<td>Total</td>
<td>41</td>
<td>100</td>
</tr>
</tbody>
</table>

Firstborns and lastborns had equal (26.8%) and comparatively higher numbers of drug abusers than other positions of birth. Theses were followed by second borns (17.1%), third borns (14.6%), fifth borns (7.3%) and fourth borns (4.9%) in that order ($\chi^2=9.70$, df =4, p<0.05) (table 10). These differences were significant.

There was an association between reasons for taking drugs and one's position in the family with the majority being first second and last borns citing influence as a reason
(χ²=12.7, df=4, p<0.02). Although most 3rd-borns indicated frustration as a reason for taking drugs, it features less in other positions of birth. Another thing as can be seen in this table 11 is that second borns also gave influence as a reason.

Table 11: Relationship Between Reasons For Drug Abuse And Ones Position In The Family

<table>
<thead>
<tr>
<th>Position</th>
<th>1st</th>
<th>2nd</th>
<th>3rd</th>
<th>4th</th>
<th>5th</th>
<th>Last</th>
</tr>
</thead>
<tbody>
<tr>
<td>Influence</td>
<td>9;33.3%</td>
<td>5;18.5%</td>
<td>1;3.7%</td>
<td>2;7.4%</td>
<td>3;11.1%</td>
<td>7;25.9%</td>
</tr>
<tr>
<td>Frustration</td>
<td>2;14.3%</td>
<td>2;14.3%</td>
<td>5;35.7%</td>
<td>0</td>
<td>1;7.1%</td>
<td>4;28.6%</td>
</tr>
</tbody>
</table>

4.5 Knowledge and Practice of Drug Abusers

Table 12: Age at Initiation into Drug Abuse

<table>
<thead>
<tr>
<th>Age at initiation</th>
<th>Freq</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Not Known</td>
<td>1</td>
<td>2.4</td>
</tr>
<tr>
<td>11 – 15</td>
<td>22</td>
<td>53.7</td>
</tr>
<tr>
<td>16 – 20</td>
<td>13</td>
<td>31.7</td>
</tr>
<tr>
<td>Above 20</td>
<td>5</td>
<td>12.2</td>
</tr>
<tr>
<td>Total</td>
<td>41</td>
<td>100</td>
</tr>
</tbody>
</table>

In this study, it was shown (table 11) that abuse of drugs started mostly at early teenage years (11-15) (43%) followed by ages 16-20 years (36%). A few started this
habit at the advanced age of 20 years. This difference was significant ($\chi^2=17.27$, df=3, p<0.001). Most of them (80.5%) were influenced into the vice by friends.

Table 13: Drug of Initiation to Drug Abuse

<table>
<thead>
<tr>
<th>Drug of initiation</th>
<th>Freq</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Social drugs</td>
<td>37</td>
<td>90.2</td>
</tr>
<tr>
<td>Bhang</td>
<td>3</td>
<td>43.9%</td>
</tr>
<tr>
<td>Glue</td>
<td>1</td>
<td>36.6%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>41</strong></td>
<td><strong>100</strong></td>
</tr>
</tbody>
</table>

Drug abuse started mostly with social drugs such as 'changaa' (local brews), beer (alcohol) tobacco, and 'miraa' (khat), (97.2%), 7.4% started with bhang while 2.4% used glue at the point of start. During this study, 46.3% were recovering alcoholics, 34.2% were receiving treatment from effects of cannabis and 19.5% had abused hard drug such as heroin and cocaine as shown in table 13.

Table 14: Relationship Between Reasons for Drug Abuse and Age of Initiation

<table>
<thead>
<tr>
<th>Reasons for drug abuse</th>
<th>Influence</th>
<th>Frustration</th>
</tr>
</thead>
<tbody>
<tr>
<td>Not known</td>
<td>1; 100%</td>
<td>0</td>
</tr>
<tr>
<td>11-15yrs</td>
<td>14; 63.6%</td>
<td>8; 36.4%</td>
</tr>
<tr>
<td>16-12yrs</td>
<td>9; 69.2%</td>
<td>4; 30.8%</td>
</tr>
<tr>
<td>Above 20yrs</td>
<td>3; 60%</td>
<td>2; 40%</td>
</tr>
</tbody>
</table>
As shown in table 14, influence and frustration as reasons for taking drugs had a non-significant association with age of the drug abusers, with few of those above 20 years among the interviewees being drug takers ($\chi^2=1.47, df=2, p>0.05$).

### Table 15: Awareness of Risks Involved in Drug Abuse

<table>
<thead>
<tr>
<th>Risks Awareness</th>
<th>Freq</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aware</td>
<td>2</td>
<td>5.4</td>
</tr>
<tr>
<td>Not aware</td>
<td>39</td>
<td>94.6</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>41</strong></td>
<td><strong>100</strong></td>
</tr>
</tbody>
</table>

As seen in table 15 only 5.4% were aware of risks of drug abuse before they started using them. The rest (94.6%) were not aware and this gave a high significant difference ($\chi^2=27.68, df=1, p<0.001$).

### Table 16. Duration Taken to Seek Professional Help

<table>
<thead>
<tr>
<th>Duration taken to seek help</th>
<th>Freq</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>3 months</td>
<td>1</td>
<td>2.4</td>
</tr>
<tr>
<td>6 months</td>
<td>5</td>
<td>12.2</td>
</tr>
<tr>
<td>More than 12 months</td>
<td>35</td>
<td>85.4</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>41</strong></td>
<td><strong>100</strong></td>
</tr>
</tbody>
</table>

Of the abusers studied, 26 (63.4%) took more than one year to seek help on how to deal with drug abuse. Five could not recall how long they took to seek help. These
findings show (table 16) that of the persons studied, a significant number took long to seek help ($\chi^2=46.56$, df=2, $p<0.001$).

A higher number of parents were significantly mentioned ($\chi^2=19.28$, df=3, $p<0.001$) (78%) as those who introduced the abusers to help centers as well as friends (17.2%) and health workers (4.9%).

Table 17. Drug Abusers' Awareness About Availability of Help Services Before Getting into Drugs.

<table>
<thead>
<tr>
<th>Awareness</th>
<th>Freq</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aware</td>
<td>4</td>
<td>9.8</td>
</tr>
<tr>
<td>Not Aware</td>
<td>37</td>
<td>90.2</td>
</tr>
<tr>
<td>Total</td>
<td>41</td>
<td>100</td>
</tr>
</tbody>
</table>

A significant majority ($\chi^2=21.2$, df=1, $p<0.001$) (90.2%) of the respondents were not aware of availability of any help centers before they started using drugs. Only 9.8% of those studied knew about these services as shown in table 17.

Table 18. Relationship Between Caretaker at Early Stages and Reasons for Drug Abuse

<table>
<thead>
<tr>
<th>Caretaker</th>
<th>Both parents</th>
<th>Father</th>
<th>Mother</th>
<th>Other</th>
</tr>
</thead>
<tbody>
<tr>
<td>Influence</td>
<td>18(66.7%)</td>
<td>1(3.7%)</td>
<td>7(25.9%)</td>
<td>1(3.7%)</td>
</tr>
<tr>
<td>Frustration</td>
<td>9(64.3%)</td>
<td>0</td>
<td>5(35.7%)</td>
<td>0</td>
</tr>
</tbody>
</table>
From table 18 it is shown that in most cases studied both parents influenced and frustrated their children, which may have led them into drug abuse. This was followed by those who lived with their mothers.

Table 19. Parents' Abuse of Drugs

<table>
<thead>
<tr>
<th>Parents' abuse of drugs</th>
<th>Freq</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Parents taking drugs</td>
<td>23</td>
<td>56.1</td>
</tr>
<tr>
<td>Parents not taking</td>
<td>18</td>
<td>43.9</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>41</strong></td>
<td><strong>100</strong></td>
</tr>
</tbody>
</table>

Although most drug abusers (table 19) had parents taking drugs (51.2%), this did not differ significantly with those whose parents were not taking drugs (41.5%) ($\chi^2=0.236$, df=1, $p>0.05$).

There was a non-significant association between reasons for taking drugs and whether or not parents take drugs ($\chi^2=0.005$, df=1, $p>0.05$)
CHAPTER 5: DISCUSSION

5.1 DEMOGRAPHIC CHARACTERISTICS

In this study parents with drug abusing children and drug abusing youth were considered. Parents exhibited good knowledge on drug abuse. They gave religious gatherings (50%), seminars (10.9%) radios (17%) as sources of information about drugs. Some 4.3% had heard through a combination of the three. The above could therefore be used to disseminate information about drug abuse to the general population. However this did not match with their knowledge in handling the problem in their children. Most of the abusers studied did not know of risks of taking drugs when they started the habit (85.4%).

Christians were the majority of the respondents (87.8%). This gives a similar picture of the religious distribution of the wider society of Kenya. Muslims and other religions formed 4.9% each. Only one client had no religious affiliations. These findings suggest that religious leaders may be used to disseminate information on abuse of drugs and their effect on health.

Males formed a higher percentage of the sample surveyed for the drug abusers (73.2%). The reason for this could be because of the expectation in many societies whereby boys and young men are expected to be more daring, risk taking and rule breaking than girls and young women. This may be concluded that masculinity and femininity could influence drug-taking behaviour. In contrast, female parents formed a higher percentage of the sample surveyed (60.9%). This could be because mothers spend more time with their children, and hence they are able to monitor them. In most cases the mothers brought the child to the drug treatment clinic. Usually the fathers may have had claims of being too busy or too angered by the
child for the behaviour. Similar to the findings of this study, another one done in Burma (Khant, 1985) revealed that the father merely forced the child to go to the clinic but the mother accompanied the child. The father rarely accompanied the child. He further stated that fathers often stopped talking to a child who is an abuser of drugs and threatened not to allow the child to remain at home (U Khant, 1985).

5.2. Parents Educational and Occupational Status

Parents in formal and informal employment as well as those with formal education had the highest number of drug abusing children. This may suggest that either the employed and business parents have no time to monitor their children or their children have access to money so that they can afford to buy drugs. There could be a relationship between parents' level of education and substance abuse by the children. This is because most parents with drug abusing children had acquired some formal education. NACADA findings of 2004 indicated that the lowest risk of substance use by children is found in parents with no education; the risk however increases with parents increased level of education, suggesting that parents modernism or affluence exposes children to substance abuse (NACADA, 2004).

5.3 Parents Prior Knowledge of Drug and Expectation

This study revealed that most of the parents (62.2%) never anticipated drug abuse in their children. They were not aware that their children were involved in drugs when informed about it. In addition, there was a high percentage (71.7%) of the parents who did not know when the vice started in their children. As a challenge, parents should know of the activities their children get into so as to offer help when it is still
early incase drug abuse problem arises. It also challenges the kind of knowledge they had on drug abuse if they could not detect it in their children early enough.

Most parents indicated poor awareness on help services. This was evident because there was a notable delay in seeking help services for their children as a majority (89.1%) took more than six months to seek help over drugs. This may have an association with their lack of awareness of the existing help services, which could have been made worse by lack of close family supervision. All the parents studied were not aware of the availability of drug treatment services. They all had to be introduced by another party to the centers and not by themselves. This could be a challenge to enhance parents and family strength and to mobilize community groups as their strong allies in drug prevention is therefore a priority. Although the parents and families are generally the hardest hit by the drug problems, they can also become the most radical change agents and active partners of the community and the government in drug abuse prevention efforts (UNDCP, 1996). This is because they are the people who care most about their children besides having the motivation and the courage to fight for the welfare of their children. Perhaps there should be parenting education programmes whose attempt is to strengthen families and parent groups through parenting skills and education training to enable them to have healthy and nurturing families. Important aspects of family life as positive role modeling by the parents, communication and discipline should be emphasized (UNDCP, 1996).

In this study most parents did not expect any of their children to be involved in drug abuse. Perhaps this is the reason why most of them did not know when their children started taking drugs. This in return could have caused the delay in seeking help
services. In contrast, a study done in London showed that 56% of parents studied had an expectation that their children could be involved in behaviors that are harmful to their health (Angie Rogers and McCarthy, 1999). In addition, parents studied took long to seek help for their children involved in abuse of drugs. According to Bigner (1989) they sometimes find many excuses for their teenagers altered behaviour, and most adolescents that are using drugs are happy to accept the excuses being put forth by their parents. Parents’ reaction has a direct relationship with the time taken to seek help for their children on drugs. He acknowledges that although some parents may be alert to their child’s relationship to drugs many overlook indicators of possible drug abuse because the idea is painful to them. They ignore their children’s grade changes, lack of energy, lack of interest in usual activities, changes in friends and changes in aggressive behaviour (Bigner, 1989). According to Brooks’ (1991) parental denial whereby the parents refuse to accept to look at the problem and pretend it is not there may cause delay in seeking help for their children.

Most parents were knowledgeable about the use of at least one drug e.g. some parents said that they knew that their child was on drugs by coming home drunk. A research done in Indonesia demonstrated that families and parents if given the necessary knowledge and skills and the needed support could be the most influential partners and dedicated activists in mobilizing communities for drug prevention. While drug abuse prevention is a noble goal, family and community actions however seem to lag behind in attaining this goal. Parents’ inadequate knowledge and skills on drug prevention strategies and their preventive role pose difficult problems (IDP, 2001).

Similar to a study done in London on views of 12 year olds and their parents on drugs and drug education, parents had good knowledge about drugs, their effect on
health but some of the parents had used the drugs themselves (Angie Rogers and McCarthy, 1999).

This study showed that parents spent evenings (45.7%), weekends (19.6%), end months (15.1%), holidays (17.4%) with their children. Some (2.2%) interacted with their children when time allowed. However, what parents do together with their children inform of activity was not determined in this study. According to Khant (1985), children feel loved and cared for when parents share the playful activities of life with them. In sharing interests and joyful events with children parents' love deepens and children reap the benefits. Interaction with children in routine care, in physical affection and in play brings more understanding between them and the parents.

Majority of the drug abusers either stayed with both parents (58.7%) or mother only (26.1%) before they started taking drugs. Though single parenthood and family instabilities have been blamed for the drug abuse problem (Gordon, 1990), this study revealed that even children with both parents are affected. However, the quality of time given by either parent to the children calls for further study.

5.4 Abusers Knowledge and Practice on Substance Abuse

Most of the abusers started taking drugs at 11-15 years (53.7%) of age followed by 16-20 years age bracket (31.7.6%). Most of the drug abusers (94.7%) confirmed that they were not aware of the risks involved in taking drugs before they started. Furthermore, 90.2% were not aware of the availability of help services when they got into drugs. This study did not determine the sources of knowledge by the drug abusers but it is likely that this information may have been obtained from personal experience or interaction with peers. In a study done on Israeli urban adolescents,
information based on personal experience was prominent as concerning abused substances such as alcohol, cigarette and cannabis especially among male users (Weiss, 1995). This shows clearly that youth are normally in the dark about general information concerning drugs, effects and help until they become victims. These results agree with those of Pride International in 1998 which indicated that 80% of learners in schools were aware of illicit drugs but only 6% of them knew the harmful effects of these drugs (Gacicio, 2001). Lack of awareness of risks involved at the point of initiation may have contributed to continued abuse of these substances. Most drug abusers (97.6%) had acquired some formal education up to at least primary level and only one (2.4%) without formal education. However there were cases of incomplete learning (24.4%) which could have been due to drop out cases associated with drug use among students. WHO reported in 1993 that psychoactive drugs impair the learning process. The effects of acute administration of cannabis have been extensively investigated and have been found to cause impairment of memory (WHO, 1993). Since memory and other cognitive functions are extremely essential to learning, it seems that frequent ingestion of drugs causes behavioral changes that may lead to poor academic performance, school absenteeism, and school dropout (WHO, 1995).

Students constituted the highest number of respondents for the drug abusers (65.9%) when they got into drug abuse followed by employed (14.6%), then business and unemployed which had (9.8 %) each. These findings confer with report in Kenya by UNDCP (2000) where 92% of people aged 16-26 years (school and college going age) had used drugs (UNDCP 2000). In a survey carried out by Pride International in 1998, it was found that one in every 15 learners in Kenya took illicit
drugs especially bhang (Gacicio, 2001). However, this contrasts with a survey in Kenya by NACADA in 2004 whereby non-students indicated the highest percentage of drug abusers.

Drug abuse by the youths interviewed begun mostly between 11-15 and-20 age brackets. This could be due to the developmental stage in these years that is characterized by experimentation and peer influence. Gacicio in (2001) discovered that even though most users fall in the 16-30 years age bracket, experimentation begins much earlier even at the age of four years (Gacicio, 2001). In addition drugs are introduced to 37% of the youths aged between 10-14 years and nearly 75% of the youths aged below 19 years (NACADA, 2004). This may suggest that there could be need to expose the children to knowledge about dangers of drug abuse early enough before experimentation begins.

A striking finding in this study is the higher number of first-borns and last-borns, a factor that other studies have not looked into. Of those who say it is influence that leads to drug abuse the highest number were firstborns and lastborns. However, most third-borns said that frustration led them to drug abuse. Being a first-born the parents have no prior experience in parenting. Perhaps the parents were overly protective or concerned of having a spoiled child. As a result the child may feel frustrated or misunderstood. On the other hand the first child may find tense, bewildered parents feeling inadequate in their roles as providers. In addition one could be inexperienced in parenting coupled with intense strains in child rearing which could lead to neglect of the child. The African first-born children are keenly observed as they grow and are expected to mature earlier than children in other positions. As a result they are left to make their own decisions. If this happens too
early without monitoring by the parents, it could make the first born vulnerable to
destructive behaviour by the influence of their peers who abuse drugs. The last-
borns could have come at a time when the parents have relaxed and they are given
too much freedom thus exposing them to the outside influence. According to U Khant
(1985), the oldest and the youngest child are the most prone to social problems and
that they may need the support of the whole family.

While some had proceeded to use of hard drugs, most abusers started with
social/gateway drugs (87.8%) - beer, tobacco miraa, which they are now hooked to
as addicts especially alcohol. This could be due to their social acceptance,
affordability and availability. This had been confirmed in studies done earlier by
Ong'ang'o in 2001, NACADA in 2003 where poly drug use was common especially a
combination of tobacco with other drugs. This finding was consistent with that of with
other studies (Yambo, 1993 and Kaigwa, 1998). In 2000 it highlighted that legal
marketing, affordability and social acceptance of these drugs could be the cause of
their use. (NACADA, 2000). Therefore, health education should pay attention to poly
drug use emphasizing the role tobacco may play in leading up to the use of other
drugs. There is a possibility that if the use of tobacco could be curtailed, exposure to
other drugs could be reduced. In 1993 WHO established that poly drug users
depend on the pharmacological characteristics of the substances used to produce
the desired effect in every day life (WHO, 1993).

Of the drug abusers interviewed (56.5%) said they get into drugs through influence
while 43.5% claimed that frustration led them to drugs. Ndetei in 2001 gave reasons
for drug abuse as media and peer influence transition to adulthood, 
boredom/idleness, stress, lack of social supervision and festivities among others
(Ndetei, 2001). In addition, bad parentage, easy access, peer influence, deep-seated lack of identity and self-esteem as reasons why youths abuse drugs (Kuria, 1996). For most (85.4%) drug abusers friends introduced them into the vice in this study. This confers with a survey done by NACADA in 2004, which established that the youths with the highest exposure lived with their friends (NACADA, 2004). Of those who say they started abusing drugs because of influence majority of them 90.2% were not aware of availability of any help. Similarly, of those who started abusing drugs because of frustration majority (91.7%) were not aware of availability of any form of help incase they may have wanted to quit. Thus, reason for abuse of drug points to lack of awareness of existing help. However this contrasts with a study done on high school students by Ong'ang'o (2001), which revealed that 95% of the respondents were aware of some existing help. While schools might have made some efforts through their counseling departments, it is clear that the general public is not informed on where to get help for the drug abusers.

Although most of the drug abusers (56.1%) had parents who were involved in drug use or abuse only a few had family members encouraging them into use. This may mean that the parent who is supposed to ‘preach water is already taking wine’ and would not have time to monitor movements of the child or have reasons to convince the child that drugs are bad. The guardians’ use or abuse of substances might have influenced the children’s into their use. Parents who misuse could unwittingly be setting a model, which their children follow in future. Parents’ attitude towards drugs and their own drug using behaviour can constitute strong influences. Children who are exposed to illicit consumption, production or distribution of abused substances at an early stage through adult contacts may be more likely to experiment themselves.
On the other hand, some of the drug abusers were parents. This makes their experience and reasons about factors which predispose youth to drugs are even much more interesting and important. The fact that they themselves have not managed to quit drugs while they should be playing a role in guiding their children against drugs, makes one wonder if they are really good role models or another source of frustration to their children. Parental behaviour, support and control could determine the youth’s social competence or incompetence. In a case where the parents are already abusing drugs might be a big challenge, as they cannot teach their children by example.

Similarly it had been established that several family variables are identified as antecedents. Adolescent substance abuse parallels parent use (Crany, 1986). Drug abusers come from families where parents abuse substances. Moreover, the homes were authoritative, unengaged, and lacked direction and encouragement. These families could also be disorganized and unprotective (Crany, 1986). The most serious use of substances is associated with lack of competence and psychological problems dating back to early and middle childhood (Fisher, et al., 1988). Therefore there is great importance of recognizing the long-standing nature of the substance abusers problems and the need for extensive help if the problem is to be dealt with (Brooks, 1991). In another study done in Nairobi on smoking among secondary school students, it was revealed that 24.4% of the smokers had smoking parents (Amayo, et al., 2003). Most of the respondents who were using these drugs said friends were the initial introducers. Of the abusers studied 78% were introduced to help centers by their parents. This shows the magnitude of concern the parents have in helping their children out of drugs even when they are considered old
enough to take care of themselves. It therefore demonstrates that parents are key and have a major role to play in determining the fate of drug abusers irrespective of their (abusers) age or social status. However in most cases it was the mothers that had the concern including the follow-up of the children. This brings a concern and a challenge for fathers to be co-parents even in the treatment and rehabilitation of their drug-abusing children. Those who were students felt that their parents had no time for them as most had this sentiment ‘our parents have no time for us, they are only concerned with academic affairs.

The help the drug abusers had received included medical/detoxification (14.6%), and counseling (20.2%) while others had received both (57.3%). Some claimed to have received spiritual help by prayers or going to a witchdoctor besides counseling and detoxification.

Key informants cited Christmas parties or family celebrations as examples when use of substances such as alcohol and tobacco were introduced to the young people within the family context. In their view, drug abuse and prevention is not a problem of the individual, it involves many people. Since it relates to the family and the community, the whole family must solve drug abuse problems.

The most cited way to control drug abuse by both the abusers and the parents was the government, while some cited that this could be done by strong religious authorities or educational institutions. However, in the absence of these institutions, they felt that it is the parents’ responsibility to keep their children off drugs. Even though schools and government can help, without parental guidance, these efforts are bound to fail.

According to the key informants, central to any effective prevention or treatment of drug abuse is the cooperation of parents who are aware and knowledgeable about
the drug issue. The informants' felt that the parents were third or fourth custodians of their children after the school church and peers.

The key informants felt that the awareness of the drug abuse problem among parents and schools is inadequate. This could be increased by the use of experts on the topic in seminars and in social and religious gathering as cited by the parents in the study. Video shows could couple the information given so as to actually visualize the consequences of drug use/abuse. Awareness initiatives for school children should start early enough and to include peer counseling before the children get to experiment with the drugs. They felt that more teachers could be trained in counseling and be made aware of the drug abuse issues. With these skills and knowledge they could be more helpful to the students. Parental guidance and family communication should be improved and parents should set good examples to their children. They suggested that the Kenya law should include drug rehabilitation to the sentences the drug victims are serving so that, apart from punishment, the victims are also helped out of the problem. If this is not done, the victims when released from prisons will continue influencing the youth with the drug abuse problem.

Finally, just like the abusers and the parents they suggested that there should be more government commitment in solving this problem because it is an issue affecting everybody.
CHAPTER 6: CONCLUSIONS AND RECOMMENDATIONS

6.1. Conclusions

1) The abusers had knowledge about the drugs but they did not realize the potential consequences of drug abuse on their behaviour and their effects on health when they started using the drugs.

2) Though parents had knowledge about drugs knowledge their preparedness to handle this problem was wanting. It is justified to state that some of the parents had approval to use of the drugs because they were also abusing drugs. Thus, there were poor examples from families who are involved in drug use. However, influence of their children which could have been from peers, advertisements in the print and electronic media is sometimes beyond the parents' control. The availability and affordability of drugs could also be a contributing factor in drug abuse.

Based on the above conclusions, it can be recommended that:

6.2 Recommendations

1) Dangers of and prevention of drug abuse should be taught in schools as both are closely related to behaviour. The topic drug abuse should be taught emphatically with appropriate subjects like Biology, Religious Education, Home Science, and Social Education and Ethics. This should be introduced early enough so as to influence the children's attitude and behaviour before adolescence when experimentation with drugs mostly begins.

2) Train parent educators to train parents on effective parenting and drug prevention. Extensive programmes targeting parents should be started to empower them with information on drug abuse and handling drug abuse cases
among adolescents. This would aid in the early treatment of such cases so as to avoid progressing to addiction. In addition it would increase knowledge and skills of parents and community groups on drug problem and its prevention strategies.

3) There should be a firm commitment at the highest political level. The government should start up drug abuse treatment and rehabilitation centers in government hospitals that are affordable to the common man. This is because most off the existing centers are expensive thus inaccessible to average Kenyans. In addition it should give policy guidelines on the running of these centers for proper performance.

4) A drug treatment center should be established separately from Mathare National Mental Hospital as many shy away from seeking help due to the stigma attached to it as a mental hospital.

5) Peer education and counseling should be instituted in schools as well as places of social and religious gatherings such as churches. This would be one of the most popular and therefore helpful strategies in assisting the young people. In addition, the peers should be encouraged to form clubs or support groups through which they could be trained to train others to help in counseling. Such education should also include ways of developing skills that help one to avoid drug abuse.
REFERENCES


Education, 2001 (pp 2-6).


APPENDICES

APPENDIX 1: A MAP SHOWING THE SAMPLING STATIONS (INSET: MAP OF KENYA SHOWING THE LOCATION OF NAIROBI)

NAIROBI PROVINCE

[Map of Nairobi Province showing sampling stations such as Kitisuru, Kabete, Kasarani, Mathare Hospital, Embakasi, City Centre, Starehe, Dagoretti, Langata, and Nairobi.]
APPENDIX II

QUESTIONS TO BE ADDRESSED TO PARENTS

INTERVIEW GUIDE QUESTIONNAIRE FOR THE PARENTS.

INTRODUCTION

My name is Mercy Gikonyo; I am a Post graduate student the Department of Pathology at Kenyatta University.

I am conducting a research on youths and parents' knowledge on factors predisposing the youths to drug abuse. This can be attained if you are honest with the information you give. Please do not give your name(s) to maintain confidentiality. The information you give will be confidential and will be used for the purpose of this study only.

SECTION A

Demographic Information

(Please tick where appropriate)

1. Sex: Male /___/ Female /___/

2. Age in years /___/

3. Highest level of education:
   - No formal education ( )
   - Primary Completed ( ) Not completed ( )
   - Secondary Completed ( ) Not completed ( )
   - Post Secondary Completed ( ) Not completed ( )
4. What is your occupation?

Salaried /___/ Businessman/woman /___/ not employed /___/

Others (specify)______________________________

5. What is your marital status? Single /___/ Single parent /___/

Married /___/ Divorced /___/ separated /___/

ii. If married what is your spouse’s occupation?

Salaried /___/ Business person /___/ Others (specify)______________________________

(iii) What other sources of finance are there in the family?

__________________________________________________________________________

6. a. Where is your residence?

Is your house;

Owned __________________ or rental ________________?

7. Which of the following items do you own as a family?

Car /___/ t/v /___/ video /___/ radio /___/ bicycle /___/ Motor

bike /___/ ________________________________________________

8. What is your religion?

Christian _______ (a). Catholic /___/ (b) Protestant /___/

Muslim ________

Hindu___________

Others (specify)________________________
(a) Does the religion have herbs/substances that are sacred though termed by other people as substances of abuse? Yes /----/ No /----/

(b) If it does, which ones? List them below

i. __________________________

ii. __________________________

iii. __________________________

c). Does your religion allow the use of social drugs such as tobacco/cigarette and beer?

Yes /----/ No /----/

9. (a) How many children do you have?

(b) What are their ages?

SECTION B

ASSESSMENT OF PARENTS' KNOWLEDGE ON DRUG ABUSE.

1. List any 3 symptoms you know of one abusing drug.

a. __________________________

b. __________________________

c. __________________________

2. (a) Name any 3 substances you know that are abused?

i. __________________________

ii. ____________________________

iii. ____________________________
3. Which of the signs below did you observe in your child that suggested to you that he/she was taking drugs? Give at least three.

i. 
ii. 
iii. 

4(a) Did you associate the signs (in 3 above) with drug abuse? Yes / ___ / No / ___ /

(b) If you did not associate the signs with drugs, what did you associate them with?

1. Inheritance / ___ /
2. Growth changes as found in adolescence / ___ /
3. Any other (specify) __________________________

5. List any 3 health effects you know about drugs abused.

i. 
ii. 
iii. 

(b) Other than health effects indicate 3 other dangers/social problems posed by drugs to the individual or the society.

i. 
ii. 
iii. 

6. At what age in years was your child when he/she began using drugs?
Not known /___/  below 10/___/  10-15/___/  16-20/___/  21-25/___/  above 25/___/

b. How did you know that your child is using drugs?
   i. Observed / recognized the signs of drug abuse /___/
   ii. Told by siblings /friends /____/
   iii. Informed by a social health worker /___/
   iv. Others________________

c). For how long had he/she used drugs before you discovered?
   i. Do not know________________
   ii. Less than 6 months __________
   iv. 12 months_______________
   v. more than 12 months__________

7. Did you have any knowledge relating to drug abuse? Yes /___/  No /___/
   (b) How had you acquired that knowledge?
   i. Attended seminar /_____/
   ii. Listened over the radio /____/
   iii. Discussed it with other parents /____/
   iv. From teachers in PTA meetings /____/
   v. Discussed it with spouse /____/
   vi. Discussed it in religious gathering /____/

8. At what level of schooling was your son/daughter when she/he started using drugs?
   i. Lower primary__________
   ii. Upper primary__________
iii. Secondary  
iv. Post secondary  
b. Were you aware of available services dealing with treatment of drug abuse?  
   Yes /___/ No /___/  
9. (a) Who else in the family uses substances on abuse?  
   i. Sibling(s)  
   ii. Father  
   iii. Mother  
   iv. Relative  
(b) Which one’s?  
   i. Tobacco /___/  
   ii. Alcohol /___/  
   iii. Miraa /___/  
   iv. Any other (specify)  
10. (a) Had your child, experimented with any of the above substances before engaging into other substances?  
    Yes /___/ No /___/  
(b) Do you think the above family member could have influenced your child?  
    Yes /___/ No /___/  
c. Is there any other child in your family who have been involved with drugs?  
    Yes /___/ No /___/  
11. What are some of the family problem or challenges do you know that can predispose the children to use drugs? (Give three)  
   i.  
   ii.  
   iii.  

ATTITUDE ASSESSMENT OF PARENTS  
1). In the following put a zero (0) if totally unacceptable to you and (1) if totally acceptable to you.  
(a) A seven-year-old has a small glass of wine with the family over Sunday lunch.  
   /___/  
(b) A 17-year-old boy smokes cannabis at a friend’s house.  
   /___/
(c) A 14-year-old smoke inhales an aerosol in the park with some friends. __/

(d) A 17 year-old comes home drunk after going to a Christmas Disco. __/

(e) A 19 year-old college student drinks alcohol, has fun and dances with friends till the early hours of the morning. __/

(f) A 23 years-old man smokes 3 cigarettes a day. __/

(g) A 16 year-old drinks at least 10 cups of coffee a day. __/

1. (a) Had you ever thought any of your children could be involved with drugs?
   Yes /__/ No /__/ 

(b) Which type of children had you associated with drugs?
   i. Orphans /__/  ii. Street children /__/  iii. Children from well to do homes
   iv. children from very poor backgrounds /__/  v. others (specify) /__/ 

2a. Are there drug(s) which are socially acceptable to you?
   Yes /__/  No /__/ 

b). Which gender should use they? Male /__/  female /__/  both male and female /__/ 

c) .In your opinion at what age in years should they start using the drugs?
   i. Any age /__/  i. below 10 years /__/  ii. 10-15 years /__/ 
   iii. 16-20years /__/  iv. Above 20 years /__/ 

3. How, as parents, do you think we can help or prevent our children them from being initiated into drugs? (Give one way)

__________________________________________________________________________
4(a) Who in the society do you think could be most effective to control the drug problem?

i. Government

ii. Teachers/School

iii. Family

iv. Friends

v. Any other (specify) ________________________________

Why?

_________________________________________________________________

_________________________________________________________________

PRACTICE ASSESSMENT OF PARENTS

1(a) What was your immediate reaction when you learnt that your child was on drugs?

i. Anger __________

ii. Denial __________

iii. Both denial and anger __________

iii. Any other __________

(b) What was the reaction/response of other family members?

i. Anger __________

ii. Denial __________

iii. Both denial and anger

iv. Any other __________

b) Did you seek help immediately after discovery? Yes______ No______

c). If not why? Lack of finances / ___ / Denial / ___ / Any other ________
d). How long did you take before seeking professional help?

3months _____ 6months ______ 9months ______ more than a year____

e ). Who assisted you/advised you to seek professional help?

Friend ______ health worker______ child on drugs ______

Any other (specify)________

2. How have you as a parent or family helped him/her get out of the problem?

By acceptance____ supportive counseling _____ any other (specify)____

3. Give one way in which your prior knowledge helped you when you discovered that your child was abusing drugs?

i. Helped me to seek counseling /____/

ii. Helped me in giving supportive counseling at home /___/

iii. Helped influence other family members in handling the child with drug abuse problem

iv. Any other________

4(a). How often do you spend time with your children? Evenings /____ / Weekends /____/

End months /____ / School Holidays /____ / Any other (specify) _____________

(b) Give at least three activities you do when you spend time with your children?

1. __________________________________________________________

2. __________________________________________________________

3. __________________________________________________________

(c) Did you ever discuss or talk about drugs with your children? Yes( ) No ( )

(a) According to your own assessment, did they have prior knowledge on drug abuse? Yes( ) No ( )
5. Do you think the mass media can influence the youths into taking drugs? Yes ( )
No ( )

If yes in what ways. List them below:

ii. ________________________________

iii. ________________________________

iv. ________________________________

v. ________________________________

vi. ________________________________
APPENDIX III

QUESTIONS TO BE ADDRESSED TO THE DRUG ABUSERS

INTRODUCTION

My name is Mercy Gikonyo; I am a Postgraduate student the Department of Pathology at Kenyatta University.

I am conducting a study on youth and parents' knowledge on factors predisposing the youths to drug abuse. This can be attained if you are honest with the information you give. Please do not give your name(s) to maintain confidentiality.

The information you give will be confidential and will be used for the purpose of this study only.

(Please tick appropriately where possible)

Demographic Information.

1. Sex Male /__/ Female /__/  
2 Age in years? /__/  
3 Highest level of education

No formal education

Primary Completed /__/ Not completed /__/  
Secondary Completed /__/ Not completed /__/  
Post Secondary Completed /__/ Not completed /__/  
4 (a) what was your occupation before you got into drug abuse?

Salaried /__/ Businessman /woman /__/ Not employed

Others (specify)__________________

(b) What is your occupation now?

Salaried /__/ Businessman /woman /__/ Not employed

Others (specify)__________________
4a. Are you married?

Yes /___/ No /___/

If married what is your spouse's occupation

Salaried /___/ Businessman/woman /___/ Not employed

(iii) What other sources of finance are there in the family?

4. Where is your residence? ________________________________

5. What is your religion?

a. Christian/___/ Catholic/___/ Protestant/___/

b. Muslim/___/

c. Hindu/___/

d. Others (specify) _______

Does the religion term some substances/herbs as sacred which are termed substances of abuse by other people? Yes /___/ No /___/

If it does, which one? List them below

i. ________________________________

ii. ________________________________

iii. ________________________________

9.a) How many children do you have in your family? __________

(b) What position are you in the family? ____________________

10. i. Who did you live with in your early life?

a. Father________ b. mother________ c. both-parents_______

e. Sibling(s)_______ e. relative(s)___________ f. any-other___________

(ii) Who do you live with currently?

a) Father__________ b) mother________ c.) both-parents___________
d) Sibling(s) ________ (e) relative(s)/friend(s) ____________

f. Any other ____________

KNOWLEDGE ASSESSMENT OF THE DRUG ABUSERS

1 (a). Which drugs have you used? (List them below)

I __________________________

Ii __________________________

Iii __________________________

Iv __________________________

(b). How long have you used them? ____________

(c). Had you used social drugs (alcohol and tobacco/cigarette) before indulging in other drugs? Yes / ___/ No / ___/

(d) How were you introduced to these drugs? i. By a friend / ___/ ii. relative/ ___/

iii. Parent/ ___/ iv sibling/ ___/

(e).At what age did it occur? Do not know / ___/ below 10/ ___/ 11-15 / ___/

16-20 / ___/ iv above 20 / ___/

2. (a).Which was the first drug of misuse? ________________________

(b)What was the mode of administration? a. Intravenous ______ b. ingestion ______

c. Inhalation ______ d. application ______

(c) What was the source(s) of supply? Grown at home (e.g. miraa, tobacco, bhang) / ___/ Bought from a kiosk/shop / ___/ Bought from a peddler

Any other ________________________
(d). What are some of the reasons why people indulge in drug? Give at least three.

(a) ____________________________

(b) ____________________________

(c) ____________________________

3.a. Were you aware of risks involved? Yes /__/ No /__/

b. Are you now aware of the risks? Yes /__/ No /__/

(Name 3 in each case)

<table>
<thead>
<tr>
<th>Health risks</th>
<th>Legal risks</th>
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<td>1.</td>
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4. (a) Were you aware of available help services? Yes _______ No_____

(b) Were the help services accessible? Yes /__/ No /__/

5. Estimate the number of your friends who are acquainted with using drugs__________

(b). Are you aware of any connection between drug abuse and HIV/AIDS and other sexually transmitted infections?

Yes /__/ No /__/

If yes give at least two ways you know.

Does any of your parent or guardian use any of the social drugs (alcohol and tobacco/cigarette), bhang or hard drugs?

Yes /__/ No /__/

Please list them below.

1. 
ATTITUDE ASSESSMENT OF DRUG ABUSERS

1. Why did you use or try the drugs?

b) Did you enjoy the drugs when you started using them? Yes / _ _ _ _ / No / _ _ _ _ /
If so in what ways?

c). Overall, has your use of drugs been a good or bad experience?

2. What is your view/opinion on one of social drugs i.e. alcohol and tobacco? Indicate if you agree or disagree

I. Should not be taken at all____

ii. Should be taken by both men and women at a certain age ______

iii. Should be taken by men only ______

iv. Should be taken only on certain occasions _____________

3. How do you think other parents can be involved in preventing their children from engaging with drugs? (Give one way)

4. Do you think mass media can influence the youth into taking drugs? Yes( )
   No ( )
   If yes in what ways? List them below.
   i.
PRACTICE ASSESSMENT OF DRUG ABUSERS.

1. (a) How long did you take to seek help?

Do not know /__/ 3 months /__/ 6 months /__/

iv. More than 12 months _______________

(b) Who introduced you to the help and treatment services?

Parent __________

Friend __________

Teacher

Health worker __________

Any other (specify) __________

(c) What kind of help/treatment have you been receiving or received?

i. Medical/Detoxification /__/

ii. Counseling /__/

iii. Both Medical and counseling /__/

iv. Others (indicate) _______________

2a). For how long have you received the help services?

i. Less than 3 months /__/

ii. 6 months /__/

iii. 9 months /__/

iv. Above a year

b. How have they been helping you?

I. Recover from the effects of drugs __________

ii. Gain back my self esteem __________

iii. Gain acceptance by peers and family members __________
iv. No help at all

c). If you have received no help, what advice can you give to the people giving you the help so as to improve their services?

________________________________________________________________________

________________________________________________________________________

3. (a) How often do you spend time with your parents?

   Evenings /___/ Weekends /___/ End months /___/ School Holidays /___/

   Any other (specify) ________________

b). Give three activities you do together with your parents.

   i. ___________________________

   ii. ___________________________

   iii. ___________________________

(c) Have you ever discussed or talked about drugs with your parents?  Yes/___/

   No /___/

ii.) How can you describe your relationship between you and your parents?

   (a) We have been friends/___/

   (b) I have not liked the way they handle me /___/

   (c) They don't love me /___/

   (d) Any other ________________

How can you advice them to treat you so as to improve on your relationship with them? ___________________________________________________________________
4. a. Who in the society do you think would be the most effective to control the drug problem? 

Why? 


APPENDIX IV

Key informants (Rehabilitation Center managers and Treatment Specialists).

(a) What do you believe would be the most effective way to curb substance abuse?
(b) How can the parent's be involved as key people in the primary prevention of drug abuse?
(c) According to your own assessment, what social factors in the family predispose the youths to drugs?
(d) Give comments on drug abuse in the contest of STIs & HIV prevention.
(e) What kinds of adverse health consequences do drug abusers experience?
(f) What is the misuse pattern?