FACTORS INFLUENCING ADOLESCENT DRUG USE IN SECONDARY SCHOOLS IN BAHARI DIVISION, KILIFI DISTRICT, KENYA

BY:

OMBIMA WILLIS AYUB
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DECLARATION

This research project is my original work and has not been presented for any of the study programmes in any other university.

[Signature]
OMBIMA WILLIS AYUB

Date: 12/10/2005

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

[Signature]
PROF. AUGUSTINE NWOWE
CHAIRMAN
DEPARTMENT OF PSYCHOLOGY
KENYATTA UNIVERSITY

Date: 12/10/05
DEDICATION

I dedicate this work to my beloved wife Eddah, and our loving and wonderful sons Wynes and Winston: my family, friends, teachers and mirror of confidence and persistence.
ACKNOWLEDGEMENTS

My special and sincere thanks go to my lecturer and supervisor Professor Augustine Nwoye for his selfless support, guidance and assistance to me towards the production of this work, and for his inspiration to me in facing challenges in order to be a good and adorable “pot-maker” like him.

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TABLE OF CONTENTS

TITLE PAGE ................................................................. i
DECLARATION ............................................................... ii
DEDICATION ................................................................. iii
ACKNOWLEDGEMENT ....................................................... iv
TABLE OF CONTENTS ..................................................... v
ABSTRACT ................................................................. ix
LIST OF TABLES ............................................................ xi
LIST OF FIGURES ........................................................... xii

CHAPTER ONE: INTRODUCTION

1.1 Background of the study .............................................. 1
1.2 Statement of the problem .............................................. 4
1.3 Objectives of the study ............................................... 6
1.4 Research questions ................................................... 6
1.5 Significance of the study .............................................. 7
1.6 Scope and delimitations of the study ............................... 7
1.7 Assumptions of the study ............................................. 8
1.8 Definition of terminologies ......................................... 8
1.9 List of abbreviations .................................................. 10

CHAPTER TWO: REVIEW OF RELATED LITERATURE

2.1 Introduction ............................................................ 11
2.2 Theoretical Framework ................................................................. 11
2.2.1 The Psychosocial Theory .......................................................... 11
2.2.2 The Social Learning Theory (SLT) ............................................. 13
2.2.3 The Theory of Reasoned Action (TRA) ....................................... 14
2.2.4 The Health Belief Model (HBM) ................................................ 15
2.2.5 The Problem Behaviour Theory (PBT) ....................................... 17
2.3 The Conceptual Framework .......................................................... 18
2.4 Review of related studies (local and foreign) ................................. 22
2.4.1 Factors influencing adolescent drug use ...................................... 22
2.4.2 Summary of the review ............................................................ 33

CHAPTER THREE: RESEARCH DESIGN AND METHODOLOGY

3.1 Introduction .................................................................................. 35
3.2 Research design ........................................................................... 35
3.3 Locale ............................................................................................ 36
3.4 Population and Target population ................................................ 37
3.5 Sampling techniques ...................................................................... 37
3.5.1 Selecting the study universe ...................................................... 37
3.5.2 School selection procedure ....................................................... 38
3.5.3 Student selection procedure ..................................................... 39
3.6 Research instruments ................................................................... 40
3.6.1 The questionnaires ................................................................. 41
CHAPTER FOUR: RESULTS OF THE STUDY

4.1 Introduction .............................................. 44
4.2 Descriptive statistics ....................................... 44
4.2.1 Research question one ................................. 44
4.2.2 Research question two ................................. 47
4.2.3 Research question three ............................... 48
4.2.4 Research question four ................................. 52
4.2.5 Research question five ................................. 53
4.2.6 Research question six ................................. 55
4.2.7 Research question seven ............................... 57

CHAPTER FIVE: CONCLUSION

5.1 Introduction .............................................. 60
5.2 Discussion .................................................. 60
5.3 Summary and conclusion .................................. 71
5.4 Recommendations .......................................... 75
5.4.1 Recommendations for counselling .................. 75
5.4.2 Recommendations for further research .............. 77
REFERENCES .................................................................78
APPENDIX I: STUDENTS' QUESTIONNAIRE .................................84
APPENDIX II: TEACHERS' QUESTIONNAIRE ...............................87
APPENDIX III: LIST OF REGISTERED SCHOOLS ..........................90
APPENDIX IV: RESEARCH AUTHORIZATION ...............................91
APPENDIX V: RESEARCH PERMIT ........................................92
ABSTRACT

Drug use problem in Kenya is a near catastrophe, and researches done variously indicate an increase especially among the adolescent abusers, with boys generally tending to abuse it more than girls. In this study the researcher focussed on determining the peculiarity of the factors influencing adolescent drug use in a coastal setting in Kenya; an aspect that tends to be generalised together with factors from up-country Kenya. The study also assessed the impact of other factors such as the family and peer relations that might influence adolescent behaviour in an interactional social environment.

The study was conducted among the secondary school going adolescents in Bahari division, with the form three students forming the target population of the study. Also the guidance and counselling teachers, drafted into the study sample, responded to the questionnaires, and their answers were intended to assist the researcher in verifying the contributions from among the student respondents as well as determining the extent of success of the interventive measures already in place in the secondary schools. These teachers were identified for the study because they are in constant touch with these adolescents over various institutional, developmental and societal issues.

The research design for this study was a descriptive survey with a probability sample size of 213 composed of 207 students and 6 teachers in charge of the guidance and counselling departments in their respective schools. The researcher used stratified
random sampling in identifying the 6 schools to be included in the study, and used both stratified and systematic sampling in identifying students to form part of the study.

In order to ensure content validity and reliability of the research instruments used, the questionnaires were pre-tested using a sample from within Kilifi district but outside the sampled target population for the study, under the expert guidance of the supervisor.

The answered questionnaires were analysed manually, using descriptive statistics including percentages, averages and frequencies, and employed different forms of data representation techniques such as tabulation, graphs and charts.

The findings show that more boys use drugs than girls, with the family and the context being the major influences; and the father and the elder brother having the biggest influence towards the behaviour in the family with a strong gender relationship.

Implications of the results wee drawn and some recommendations were made to improve public policy and counselling practice as strategies for curbing students’ abuse of drugs in the coastal region.
LIST OF TABLES

Table 1  Population characteristics  40
Table 2  Drugs of abuse in secondary schools  45
Table 3  Current drugs of abuse in secondary schools  45
Table 4(a)  Drugs abused by boys  46
Table 4(b)  Drugs abused by girls  46
Table 5  Contextual factors influencing drug use  47
Table 6  Distribution of drug use among the respondents  47
Table 7  Perception-prevalence on adolescent drug use  48
Table 8  Gender-age group drug use variations  50
Table 9  Drug use frequency disparities  51
Table 10  Factors influencing adolescent drug use  53
Table 11  Family influence in adolescent drug use  54
Table 12  Relationship between drug use and family segmentation  56
Table 13  Parental/caregivers' influence on adolescent drug use  58
Table 14  Religious drug use patterns among adolescents  59
# LIST OF FIGURES

<table>
<thead>
<tr>
<th>Figure</th>
<th>Description</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Figure 1</td>
<td>Interaction of factors influencing adolescent drug use</td>
<td>21</td>
</tr>
<tr>
<td>Figure 2</td>
<td>Distribution of drug use among the student respondents</td>
<td>48</td>
</tr>
<tr>
<td>Figure 3(a)</td>
<td>Perception-prevalence on gender drug use patterns</td>
<td>49</td>
</tr>
<tr>
<td>Figure 3(b)</td>
<td>Boy-girl ratio in adolescent drug use patterns</td>
<td>50</td>
</tr>
<tr>
<td>Figure 4</td>
<td>Gender-age group drug use variations</td>
<td>51</td>
</tr>
<tr>
<td>Figure 5</td>
<td>Drug use frequency disparities</td>
<td>52</td>
</tr>
<tr>
<td>Figure 6</td>
<td>Family influence in adolescent drug use</td>
<td>55</td>
</tr>
<tr>
<td>Figure 7</td>
<td>Relationship between drug use and family segmentation</td>
<td>57</td>
</tr>
<tr>
<td>Figure 8</td>
<td>Parental/caregivers’ influence on adolescent drug use</td>
<td>58</td>
</tr>
<tr>
<td>Figure 9</td>
<td>Religious patterns in adolescent drug use</td>
<td>59</td>
</tr>
</tbody>
</table>
CHAPTER ONE

INTRODUCTION

1.1 Background of the study

Adolescents abuse psychoactive drugs that may eventually lead them into a state of dependency, both physiological and psychological, after a period of prolonged use, a condition that will hamper their effectiveness in the performance of their social tasks. They abuse both licit drugs that are readily available and affordable such as alcohol, tobacco (nicotine), “miraa”, solvents/inhalants, caffeine and prescriptive drugs; and illicit drugs such as the opiates, marijuana, and cocaine among others (Rice, 1996; Walucho, 1996), depending on several factors such as availability, affordability, tolerance, personal risk threshold and motivation. Comparatively more boys than girls abuse drugs, with the latter mainly abusing prescriptive drugs (Winkley, 1996; Gichuru, 1996).

The trend shows that one may begin by taking a single drug, but subsequently turns into polydrug use that mainly involves alcohol, nicotine, marijuana and tranquillisers. Polydrug use is a risky behaviour because of the multiple effects of the drugs in the body (Spence, 1989), and is common among adolescents who have been on drugs for fairly some time, due to the increased tolerance to certain intoxication levels (Plant and Plant, 1992). This comes as a result of individuals developing a craving for more of the drugs to satiate their physiological and psychological demands.
Adolescents get into drug use through experimentation, social-recreational or circumstantial-situational use (Rice, 1996), and gradually get into dependency depending on the pre-existing risk factors that include contextual, psychological and interrelational factors. This was confirmed by Brooks et al. (Weiner, 1982:459) who identified one’s personality, peer and parental influences as independent factors that separately can lead into drug use.

With the passage of time, adolescents’ vulnerability to drug use has become a glaring reality, prompting researchers, including me, to look into the factors that influence this condition, while bearing in mind the temporal uniqueness, contextual, and interrelationship patterns, so as to exhaustively cover its entirety by looking at the causal factors, and growth, and designing appropriate interventive programmes towards the problem.

Drug use and abuse problem is of transitory nature which mostly can be resolved by the onset of adulthood (Steinberg, 1999:401), and it is a universal concern since the historical times, with various people, laymen and professionals alike trying to confront it. For example, King James I of the United Kingdom who in 1604 likened tobacco smoke to the “horrible vapours exhaling from hell” (Orford, 1985:56), and the Chinese government which in the 19th century declared a war on opium (Spence, 1989) due to its adverse social-economic implications to the Chinese society. However, the problem has continually experienced a sustained growth especially among the adolescents worldwide.
(Plant and Plant, 1992; Nielsen, 1987; Murimi, 1996; Walucho, 1996), despite the efforts at trying to stamp it out through deliberate researches to demystify its ambiguities and the colossal financial commitments by individuals, governments and NGO’s alike, towards it.

Traditionally, however, most of these psychoactive drugs currently causing panic amongst the populace were socially approved, and were ceremonially used in important social functions such as harvest ceremonies and peace meetings, for example tobacco among the American Indians (Miller et. al., 1981), and traditional brews among the Luhyia, Miji Kenda, Kikuyu and Luos, without fears of either physiological or psychological dependence. This then triggers the question “what went wrong?” so as to try and identify both psychological and social-environmental variables that have left a former noble and “wished –for” practice a dangerous venture in modern times.

In contemporary Kenya, adolescent drug use and abuse has been on the rise to threatening levels, a deduction mostly done through causal association technique by looking at the levels of status offences and property crimes amongst adolescents (Waihenya, 2000). However, some researches to confirm the rise have also been undertaken. This prompted the government to invest heavily in drug education programmes through formation of agencies such as NACADA to educate the adolescents and the general population about the dangers of drug use. The government has also established other preventative organs such as the Anti-Narcotics Police Unit, as well as
adopted prohibitive laws to make the current and potential drug users and dealers change
their drug use habits.

In Kenya’s coastal province, many have raised concern over increased drug use especially in areas such as Mombasa, Mtwapa, Kilifi, Watamu and Malindi, associating it with declining adolescent morals and persistent interruptions in school programmes through strikes in situations awash with a myriad of positive alternatives to it, and increased property crimes that have contributed immensely to a decline in educational performance in schools in the area, as well as straining parents in the rehabilitation of the physical damages involved (Ngari, 2000; Nyassy, 2000; Oketch, 2000; Thatiah, 2005).

For example, Kilifi Township Secondary School in Bahari division has experienced 6 arson incidences blamed on students between 1995 and 2005, and several interruptions to school programmes within the same period.

Therefore, due to the increased adolescent involvement in drug use in Bahari division of Kilifi district, I felt the need to investigate the peculiarity of the factors in the division towards the initiation and sustenance of this behaviour in the area, bearing in mind its spatial and temporal uniqueness to the rest of Kenya.

1.2 Statement of the problem

Despite the aggressive drug education campaigns country wide supported by empirical data collection and analysis for validation of these campaigns as well as for the
facilitation of policy making and strategy formulation towards the campaign, drug use problem still lingers on especially among the adolescents, with the resultant costly consequences such as loss of life (Obonyo, 2005), property destruction, increased medical costs and disruption of quality family life amongst others.

Due to the prevalence of the problem, therefore, several researchers previously have undertaken studies to identify factors that lead into this behaviour in different parts of the world. However, most of these studies were done in upcountry Kenya (Murimi, 1996; Njiru, 1996; Gichuru, 1996; Walucho, 1996), while others in Europe (Plant and Plant, 1992; Smith, 1990) and America (Rutter, 1998; Nielsen, 1991; Spence, 1989), all areas with different social-environmental characteristics from Kilifi district.

Therefore, the major problem of the present study is to at determine if there are any peculiar instigative factors that lead into secondary schools’ adolescent drug use in Bahari division, while bearing in mind the geographical and psychosocial factors unique to the area such as the coastal location which enhances interactions with foreign cultures through the many entry points by sea, land or air; as well as internal religious and racial diversities. Therefore, the uniqueness of the study lies on its striving to identify factors influencing adolescent drug use with the full appreciation of the heterogeneity of the social-environmental variables in the area and its geographical location.
1.3 Objectives of the study

The following were among the major objectives of the study:

1. To identify the types of drugs used by secondary school adolescents in Bahari division, Kilifi district.
2. To investigate the specific influence of the coastal location on drug use in Bahari division.
3. To determine gender differences in drug use in Bahari division.
4. To investigate factors influencing adolescent drug use in the area.
5. To find out the nature of the influence of parental drug use on the adolescents.
6. To determine the effect of family segmentation on adolescent drug use.
7. To determine if the parental religious affiliation influences an adolescent's drug use behaviour.

1.4 Research questions

The following research questions were explored in this study:

1. Which drugs do adolescents in Bahari division of Kilifi district abuse?
2. In which way does the coastal location influence adolescent drug use patterns?
3. Which gender among the adolescents is more prone to drug use than the other?
4. What factors influence adolescents' drug use behaviour in Bahari division?
5. Do adolescents with drug taking parent(s) also take drugs?
6. Does family segmentation influence adolescent drug use behaviour?
7. What is the influence of parental religious affiliation to adolescent drug use behaviour?

1.5 Significance of the study

This study is important in that:

1. It will help identify the key factors influencing adolescent drug use patterns in a coastal setting, thus equipping the drug educators with knowledge on how to improve and integrate their approaches towards maximum success in their programmes in a similar setting.

2. It will help the stakeholders in this field to appreciate the importance of the family both in initiating and controlling this behaviour, therefore, adopting an integrative approach as opposed to the dominantly intra-psychic approach.

3. It will inspire more researches on area-specific factors towards this problem and help design more appropriate interventive measures.

1.6 Scope and Delimitations of the study

This study was geographically confined to Bahari division of Kilifi district in Kenya’s coast province, which boarders the Indian ocean to the east, Mombasa to the south, Kaloleni and Ganze divisions to the west and northwest, respectively, and Malindi district to the north, and has a total of thirteen registered secondary schools (APPENDIX III).
The study targets both the secondary school adolescents as well as the guidance and counselling teachers in the sampled public schools.

1.7 Assumptions of the study

1. Adolescents in Form 3 are fully aware of their social environment and can give accurate information on various issues related to drug use.

2. Both boys and girls in secondary schools are equally exposed to drugs.

3. Drug use among secondary school adolescents is widespread in Bahari division.

4. Guidance and counselling teachers will give an objective analysis of their students concerning this problem.

1.8 Definition of terminologies

Adolescence: A transitional developmental stage in human beings between childhood and adulthood, it covers ages 12 to 24 years. Herein also used interchangeably with boys, girls and teenagers.

Drugs: Substances which when swallowed, injected into the body or inhaled, causes chemical changes into the body.

Drug abuse: Any use of drugs to appoint where some harm may be done to the individual or society.

Drug use: Any instance of non-medical use of drugs

Experimenters: those who use drugs far in between e.g. once in a month or on certain occasions only.
Family segmentation: A family where one or more of its members live(s) away from the others.

Frequent drug users: Those who use drugs at least once a week.

Habitual users: Those who use drugs on a daily basis.

Illicit drugs: Drugs whose use is prohibited by law such as marijuana and cocaine.

Licit drugs: Drugs whose use is not prohibited by law such as alcohol and cigarettes.

Middle adolescence: This is the period of an individual’s life between ages 15 and 17 years.

Not religious: They do not identify with any religious faiths or their teachings and they seem not to follow any religious life patterns.

Physiological dependence: This refers to the use of drugs in which any sudden withdrawal from it will lead into physiological distress.

Polydrug abuse: This is the abuse of more than one drug/ multiple drug abuse

Prescriptive drugs: drugs that are prescribed by the qualified medical staff.

Property crimes: These are offences committed towards objects e.g. theft and arson.

Psychological dependence: This refers to the compulsive and frequent use of drugs.

Religious: They confess a particular religion and participates in the relevant rituals but allow some degree of permissiveness to modernity.

Status offences: These are behaviours that are not against the law for adults but that nevertheless violate established codes of conduct for juveniles e.g. alcohol taking, truancy and runaways (Steinberg, 1999).
Too religious: They are strictly religious and every life aspect follows a strict religious
definition.

Unconventional environments: These are environments where a large number of
individuals share the same attitudes.

1.9 List of abbreviations

BB: Boys’ Boarding Secondary School
GB: Girls’ Boarding Secondary School
HBM: Health Belief Model
MD: Mixed Day Secondary School
MDB: Mixed Day and Boarding Secondary School
MP: Member of Parliament
NACADA: National Agency for the Campaign Against Drug Abuse
NGOs: Non-Governmental Organisations
NR: No Response
SES: Social Economic Status
SLT: Social Learning Theory
CHAPTER TWO

REVIEW OF RELATED LITERATURE

2.1 Introduction

This chapter contains the theoretical framework underlying my research work, the conceptual framework and the literature review that looks into the findings of previous investigators on the subject of the present study.

2.2 Theoretical framework

In understanding the ubiquity of this problem, this research will use several theories to explain the genesis, growth and maintenance of drug use behaviour. The theories concerned include the psychosocial theory, the social learning theory, the theory of reasoned action, the health belief model and the problem behaviour theory.

2.2.1 The Psychosocial Theory

This theory, credited to Erik Erikson emphasizes the importance of the social environment in developing a stable ego. It divides the lifelong developmental process into stages based on epigenetic principle of motivation in which at every stage, the society is structured to meet the psychological readiness and help the individual realize
the potentialities of that stage (Smith and Vetter, 1982:63) failure of which causes an individual's maladaptation to the social environment.

An individual is viewed to be in active interaction with the social environment, represented at the initial stage by the family, which is the matrix of identity (Minuchin, 1974:47). At each of the developmental stages up to adolescence, appropriate conflict resolution helps an individual develop feelings of hope, self-restraint, courage, self-confidence and self-identity which enables them deal with their feelings of conflict, indecisiveness, loneliness and anxiety that makes them confused and unpredictable.

During adolescence, the conflict is that of identity crisis, and if the adolescents resolve the crisis adequately, they develop fidelity which is a clear sense of self-identity that helps them to develop the ability to understand and abide by standards and mores of the society, but failure to realise full resolution or adequate resolution will lead into the adolescents developing "totalism" which is the belief that they know what is absolutely and undeniably right (Smith and Vetter, 1982:65).

The development of "totalism" at this stage, therefore, makes this theory relevant to the study of adolescents' drug use behaviour due to its implication in shaping adolescent behaviour, as well as due to increase in drug use among adolescents, a situation that makes us be interested in the ritualization process in order to be able to understand further the causal factors to the drug use problem.
2.2.2 The Social Learning Theory (SLT)

This theory, credited to Bandura (1969) puts emphasis on the importance of the interaction between individuals and the society through models from whom they learn vicariously. The theory assumes that the occurrence of observational learning is contingent upon reinforcement of imitative behaviour (Bandura, 1969:121). A model in this case could be a living person or merely symbolic as those in stories and television programmes.

Learning, according to this theory, occurs because of the individual's possession of cognitive processes namely attention, symbol formation and memory (Lerner, 1986).

Viewed in terms of commencement and sustenance of drug use behaviour, an adolescent may identify him/herself with a given individual in the society as his/her model and will imitate the model's behaviour that is positively rewarded. If the model after drug use appears more confident, draws attention of significant others and appears to be brilliant, courageous and acceptable, of which all are positive attributes individuals look forward to, then this outcome will positively reinforce the adolescent, making him form a positive attitude towards the behaviour which will thence motivate the adolescent into imitating it (Weiner, 1982).

Group-approval, in a peer group, could be the major reinforcer towards the adolescent learning the behaviour so as to avoid isolation and loneliness. Therefore, the adolescent
will learn the positively reinforced behaviour shown by the model vicariously, and this behaviour can be reproduced in the absence of direct reinforcement (Bandura, 1969:123).

But, if after taking the drug the adolescent observes the model experiencing aversive reinforcement such as rejection, isolation and contempt, he/she will be discouraged from taking up the habit for the anticipated fear of experiencing similar negative reinforcers, therefore, the result here negatively reinforce the adolescent into dropping the urge to imitate the model.

2.2.3 The Theory of Reasoned Action (TRA)

This theory that emphasizes the rational cause of behaviour is credited to Ajzen and Fishbein, who designed it to explain all human behaviour under voluntary control (Kaplan et. al., 1993:53). It states that intentions are the most immediate influence on behaviour, and assumes that people are usually rational and make predictable use of information available to them.

The two identified attitudes, which are determined by the most prominent belief about what would happen as a consequence of the behaviour, and the subjective norms that are mainly affected by the pressures from the significant others as the factors that influence intentions. Only the most remembered consequence really affects attitudes.
In the context of adolescent drug use, this theory is vital because it emphasizes the beliefs adolescents hold towards the drug use behaviour, and the importance of the family, the peers and the society at large, in their developing the intention to get into the habit. Their feeling that many “cool guys” smoke, as is normally shown in adverts in the mass media, and so the practice is not harmful to health will make them perceive that the societal norms favour smoking and so he/she will form a positive belief about the practice and subsequently an intention to smoke, which will eventually translate into the actual smoking behaviour.

According to the theory of reasoned action, therefore, intention formation is the prerequisite for adoption of behaviour. This phenomenon makes the theory of reasoned action to be crucial and practical in explaining the commencement and maintenance of drug use among adolescents.

2.2.4 The Health Belief Model (HBM)

This theory was developed by Rosenstock (Kaplan et. al., 1993) and it mainly focuses on cognitive influences on behaviour. It deals with beliefs that are directly related to the health behaviour. Rosenstock contended that behaviour is a function of beliefs held by an individual that pushes him/her towards action or inaction. He identified these beliefs as

(a) Susceptibility: people are motivated to take action if they perceive themselves to be at risk;

(b) Severity: perceived seriousness of a condition is more influential on behaviour than
the actual severity,

(c) Benefits: this is how effective the behaviour will produce a specified effect;

(d) Barriers: these are hindrances towards adoption of behaviour, for example, the feasibility or availability of the behaviour.

For behaviour to be performed, a cost-benefit-analysis of perceived benefits verses perceived barriers is conducted and if the former outweighs the latter, then the likelihood of action is increased. Similarly, a likelihood of action is highest when the perceived threat of the condition is high, but the perceived benefits of the health behaviour outweigh the barrier (Kaplan et. al., 1993:53).

In the context of contemporary adolescent drug abuse, this explains why they start and maintain the habit despite concrete dangers ahead. They are indifferent towards drug use because of the belief that they are out of danger for they have only smoked for a shorter time hence the health risk does not face them, instead, drugs will make them more relaxed. This is further enhanced by the availability of some of the drugs readily and legally in the environment. Therefore, this model explains the starting and maintenance of drug use behaviour among adolescents.
2.2.5 The Problem Behaviour Theory (PBT)

This theory is credited to Richard Jessor et al. (Steinberg, 1999) who were trying to explain the origin of the Problem Behaviour Syndrome, in which problems are always intercorrelated.

The problem behaviour theory asserts that the fundamental cause of adolescent externalising problems lies in the unconventionality in their personality and the social environment, whereby, unconventional individuals in unconventional environments are more likely to engage in a variety of risk-taking behaviour (Steinberg, 1999:403).

This explanation, therefore, shows that an individual's disposition to engage in "problem behaviour" is influenced by biographical and socio-psychological variables such as personality, beliefs and the behaviour approved of by significant others (Plant and Plant, 1992:117). In relation to drug use and abuse, this theory explains that interpersonal, the context and the individual's psychology can jointly influence an adolescent into drug use.

An adolescent with a higher tolerance to deviance and not highly connected to the social institutions, or who is very liberal in his/her social views, when they stay in an environment where the availability and use of drugs is commonplace, with the peers and family members using them too, then such an adolescent will also take to the behaviour because of the perceived psychological support and approval from the unconventional environment he/she is in.
For example, in Bahari division, due to a considerably large number of people taking the local palm wine (mnazi) freely, this gives a feeling of acceptance towards it by the community, and so adolescent use of the same does not constitute a status offence. With this scenario, therefore, majority of them will turn to its use due to the absence of a perceived aversive consequent.

PBT tries to explain the initiation and the maintenance of the drug use behaviour within individuals.

2.3 The conceptual framework

Many researches have been done to determine the factors influencing drug use inception, development and effects to individuals and the society during this time of high drug consumption rates, especially among the adolescents.

In identifying the factors influencing this phenomenon, therefore, efforts have to commence from the understanding of the adolescents’ vulnerability from both the intra-psychic (psychoanalytic) perspective which views an individual as an object reacting to the environment, to the interpersonal (psychosocial) perspective which views one as interacting with the environment. An adolescent’s presence in the society places him/her in direct contact with other players in it such as the family, peers, societal norms and the geographical exclusivity of the area.
Therefore, an interaction of several factors influences an individual into drug use. Each individual possesses inner qualities of the “self” that determine how one reacts to social environmental challenges and anxieties, and these qualities include self-worth, self-confidence, assertiveness and self-acceptance amongst others. The development of a “mature” and “effective” self is not solely an innate predisposition but it draws from personal experiences that either injures it thus weakening its functions, or adequately nurtures it into a mature personality, which comprises of a stable and rational ego.

Development of a weak or dictatorial ego could lead into behavioural maladaptations that place one at the risk of drug abuse. Therefore, an appropriate social environment is a strong variable towards effective ego development.

Another variable with a strong influence on an individual and which can contribute significantly to drug abuse is the family which is the “comfort zone” (Rutter, 1998), through such experiences as parenting, discipline procedures and family cohesiveness which provide the needed psychological support. A dysfunctional family system yields a bruised and weak ego, with the consequent low self-worth and self-esteem. This will make the adolescent less assertive and have low confidence in dealing with peers and the outside challenges thus making him/her vulnerable to external control and maladaptive lifestyles (Steinberg, 1999).
Since an individual is an interactional being in the social environment, a weak ego will make him/her develop irrational and maladaptive environmental assessment capacities, and therefore, easy accessibility, affordability and less severe penalties to drug users will be misinterpreted as societal acceptance of the behaviour. This, therefore, means that in the high prevalence areas, comparatively more adolescents will be influenced into the habit, than in the less prevalent areas.

Less severe penalties and even reluctance of the law enforcers to enforce the law, and support of opinion leaders in the society and the other people towards use of a particular drug, reinforces the habit and so enhances the accessibility of drugs to people, a phenomenon that makes the drug appear “socially acceptable”. This is the scenario in Kilifi district where several opinion leaders and locals alike, have been calling openly for the use of mnazi uninhibitedly, for example former MPs Karisa Maitha and Jembe Mwakalu, amongst others.

Thus, it is important to view the adolescent as an interactive being and so factors that influence him/her into drug use may not always be personal, but might often be familial, peer-oriented and contextual, and so, interventive measures have to take all these variables into consideration for effective behavioural changes among adolescents. The interrelatedness of these factors are summarised in the diagram overleaf.
Figure 1
INTERACTION OF FACTORS INFLUENCING ADOLESCENT DRUG USE

Society
- Models
- Punishment/rewards
- Societal/religious norms
- Legal framework
- Problem definition

Family
- Parenting styles
- Familial norms
- Parental harmony
- Family type
- Familial SES
  etc.

Peers
- Orientation
- Group cohesion
- Group demands

Geographical location
- Drug prevalence
- Affordability
- Types of drugs

Self/individual
Self worth
Assertiveness
Self-esteem
Self-confidence
  etc.

BEHAVIOUR
Drug use
Avoidance
2.4 Review of related studies (Local and Foreign)

2.4.1 Factors influencing adolescent drug use

Alcohol is commonly the first drug to be used (Steinberg, 1999; Gichuru, 1996; Kamonjo, 1997) because of the variability of its strengths (from low alcoholic content to those with higher alcoholic contents) that allow the adolescents to take according to their physiological ability, and also due to their availability and affordability. Locally produced alcoholic drinks, though lethal, are readily available at cheaper prices such as “chang’aa”, “kumi kumi”, “busaa” and “mnazi”, thus making the drinks more accessible even to the unemployed adolescents (Obonyo, 2005).

Most cultures, however, embrace alcohol and so its use has continued to be licit despite the changing social environments that has led into the dependence problem which many still consider as the “disease-of-the-will” (Orford, 1985), thus making it difficult to formulate effective interventive measures towards it. Most adolescents take alcohol as a “drug-of-choice” (Rice, 1996).

Generally, drug taking commences with liquors with low alcoholic content such as beer and wine, and as tolerance increases, they get into “hard liquor” such as whisky and spirits, as well as cigarettes; thence into marijuana, before getting into the “strong drugs” such as cocaine, hashish and heroine (Steinberg, 1999). However, the transformation of a drug taker does not rigidly follow such a linear pattern for exceptions occur due to
availability and affordability of the drug, as well as an individual's cognitive preparedness.

In most cases, adolescents who use drugs at one stage will most likely use it at the next stage and this phenomenon is called the "Stepping-stone Hypothesis" (Weiner, 1982:455). For example, in my current locale of residence, Bahari division, majority of the drug-taking adolescents seem to begin with taking the traditional palm wine ("mnazi") that is readily available, affordable and with almost no legal restrictions, and then move into cigarette use and other drugs as a result of increased tolerance in their bodies.

As Marlatt (Miller and Foy, 1981) observed, adolescents' cognitions are instrumental in providing the energy for drug-taking behaviour because of the "Abstinence Violation Effect" in which one cognitively "convinces" him/herself after the first experience that he/she is addicted, and thus carries on the act to eventually graduate into dependency. Adolescents' positive attitude towards drug use influences them into the behaviour, since the latter follows logically from cognitive constructs (Ansbacher, 1977:45).

If one views smoking as good, he/she will form a positive attitude towards it and will consequently use it by virtue of viewing it as being positive, a standpoint that will reinforce one's belief that drug use is inevitable. Weinstein (Ogden, 2000) confirmed this through his view of Unrealistic Optimism in which he observed that people practice
unhealthy behaviours due to their inaccurate perceptions of risk and susceptibility. This, he further explains that is brought into place with their egocentrism.

Therefore, any information that do not target the adolescents' attitudinal change will only help them to be more knowledgeable in drug matters, rather than change their behaviour (Weiner, 1982).

Adolescents' drug use has increased tremendously by their vicariously learning it from their models. In their quest for freedom and autonomy, adolescents identify themselves equally with other "adorable freedom fighters" that thence become their models thus leading into their aping of their lifestyle, in order to appear "like them". This explains why the adolescents readily embrace movements like Rastafarianism and personalities as Bob Marley whom they view as 'a world-over-respected' fighter for human emancipation from bondage, and therefore, a symbol of successful liberation struggle that they assume they are fighting for from the unresponsive adults.

The Rastafarian movement targeted emancipating of the Africans from colonial rule both in Africa and in the diasporas, so as to give them their identity, a goal viewed to be similar to the adolescents' in the moratorium, who define their struggle as that for identity, respect and freedom from the "domineering" and "unrealistic" adults. Modelling is also blamed on TV viewing which mainly depicts drug users as high social
achievers and respectable personalities. This gives the notion of the behaviour being socially acceptable.

Peer pressure is another important factor that influences adolescents into drug use as viewed from the Eriksonian viewpoint that adolescents are victims of developmental conflicts of identity crisis, in which one strives to attain an identity in spite of the separation anxieties from their controlled past (Freedman, 1972). During this time, an adolescent experiences separation anxieties from his/her family and seeks comfort, protection and identity in the group that defines the goals and behaviour patterns for its membership, in return for the group protection and acceptance. It is against such a psychological background that if a group is oriented towards excessive appetitive behaviour, including drug abuse, then it becomes inevitable for the poorly individuated member to embrace the group’s sub-cultural demands in order to enjoy the group’s recognition, identity and acceptance, for fear of isolation (Glick and Hebding, 1980; Rice, 1996; Castillo, 1986).

In a study by Njiru (1996), of the total 102 respondents he had, 58.8% learnt drug use from peers and relatives, a finding that proves the vulnerability of the adolescents to peer influence, as well as the importance of the family that reinforces by showing acceptance to the drug user as is explained by the PBT.
The family, which is the immediate biosocial unit to an individual, provides the most influential learning context to the individual behaviourally, emotionally and in life coping skills, thus, it determines the advent and perpetuation of drug use problem among the adolescents today (Jackson, 1970; Ackerman, 1970; Rutter, 1998; Richter, 1974).

A dysfunctional family immensely influences an adolescent into drug use by creating a feeling of low self-esteem in them, a common characteristic of drug takers and a key factor in the aetiology and development of the habit (Spence, 1989; Weiner, 1982; Miller and Foy, 1981). Some factors in a dysfunctional family that leads into this problem are parental conflict in child rearing practices, inconsistent discipline, maternal rejection and parental physical and sexual abuse (Rice, 1996; Ansbacher, 1977).

Adolescents are more likely to use drugs when the caregiver(s) is/are involved in its use (Spence, 1989; Weiner, 1982; Gichuru, 1996; Murimi, 1996), for they intrinsically interpret it to mean it is rewarding and is socially acceptable to do it. Spence (1989) identifies key familial figures as the parent(s), elder brother and elder sister. This phenomenon is pertinently described in the traditional native wisdom of the Swahili people at the Kenyan coast in their saying that, "mtoto umleavyo mako dhiavyo", meaning child rearing practices determines the child's future behaviour. Adolescents learn this behaviour vicariously from their significant others and see it as acceptable to the family, and by extension the society. Adolescents anticipate positive rewards out of
the habit for example acceptance, admiration and respect, a situation that sustains the habit into dependence.

Adolescents also get into drug use as a result of their physical separation from their parents (Plant and Plant, 1992; Steinberg, 1999) whose presence provide a medium for value training, and a standard for them to identify with as well as to learn from because they give the crucial psychological and material support to assist them in their development. Weiner (1982:461) decried lack of close family relationships as a strong influence into drug use because when adolescents stay away from their parents, the poorly individuated and “anxiety-filled” adolescents are left vulnerable to the whims of the aggressive peers in their search for group protection, identity and approval, and this partly explains the higher incidences of drug use in boarding schools. This situation is aggravated by the fact that the frequency of adolescent drug use increases with age (Weiner, 1982:452). Peer influence susceptibility increases between pre-adolescence and middle adolescence (Steinberg, 1999:417).

Parental level of education, which together with parental occupation are often used as indices for SES, influences adolescent drug use with those with low educated parents tending to be involved more in the use of drugs than those with more educated parents. Poverty and no or low levels of education, is a major contributor to drug use because it tempers with the social system that is expected to buttress one against drug use. It reduces parental nurturing and monitoring abilities on their children and repeatedly exposes the
adolescents to incidences of drug use in the neighbourhood from those who use them to block out their problems, and this breeds drug use among the very adolescents (Steinberg, 1999:414). However, different studies touching on this subject give conflicting deductions, some supporting this view whilst others oppose it (Kamonjo, 1997).

Religion is an important factor that influences drug use because of the prohibitions and tolerance of the religious teachings to a particular behaviour. Drug use is expected to be high among the less religious, and low among the conservatives due to the latter’s total prohibition of its use which helps in maintaining low drug use rates due to the fear of societal isolation, as is the case with the Muslims (Orford, 1985; Kamonjo, 1997).

But the irreligious and those in less strict religions will indulge into the practice almost indiscriminately because of the absence of the fear of the social repercussions of the practice from their religious compatriots. The social control theory observes that an individual without strong bonds to society’s institutions which include religious institutions too, are more inclined to drug use than those with strong bonds (Steinberg, 1999).

When an individual lives in a social context that makes drug use easier, he/she will move into using and even abusing it. Vital contextual factors in this case include availability of drugs, community’s norms regarding drug use, degree of drug laws enforcement and ways through which drug use is presented in the media (Steinberg, 1999:411). Increased
accessibility to drugs enhances drug use in the area. Bahari division being in constant interaction with the rest of the country and the world through the roads, air and ocean ports, this ensures that influx of drugs into the area is high, as well as easy accessibility to locally available drugs.

The local community’s acceptance of traditional palm wine taking for almost all categories of persons has given the acceptance and the lethal nod to its indiscriminate taking, at the time when the law enforcers seem to take it as an acceptable practice too. The social context also allow for a wider variation of drugs used in the area.

Adolescents’ poor coping skills to environmental stressors can also make them to adapt this behaviour. When one is faced with an anxiety-provoking situation, he/she feels helpless and resorts to drug use in order to “block out” the problem. This can be attributed to a low sense of self-esteem and self-confidence, therefore, an individual may opt to use drugs rather than tackle the anxieties through effective decision-making. This is very apparent in adolescents from “conflict-habituated-homes”, where they feel worthless and lacking in self-confidence and therefore, resorts to drug use on a defensive turn, rather than face the anxieties and challenges of realising self-confidence, self-esteem and redefining one’s destiny.
Several personalities (Winkley, 1996; Freedman, 1972; Glick and Hebding, 1980; Rice, 1996; Walucho, 1996; Smith, 1990; Spence, 1989; Castillo, 1986) further identified factors influencing adolescent drug use as

i. Curiosity,

ii. To rebel or shock the adults/people,

iii. A depressed mood,

iv. Normlessness,

v. Need for sensual pleasure/fun,

vi. Being involved in drug selling,

vii. Underlying serious personality problems.

Therefore, factors influencing adolescent drug use are not only intra-psychic, but have tentacles into the social-environment, and thus need to be viewed from a multi-faceted perspective, in order to realise any form of success.

Due to the magnanimity of the problem, several scholars have tried to undertake studies in order to establish the genesis, growth and consequences of this socially debilitating behaviour both locally and internationally, and these researchers have proved immensely invaluable in revealing the intricate nature of the contributory factors and showing the direction to follow in handling this problem. These researchers have provided the launching grounds for the drug education campaigns and provision of appropriate counselling services.
In a study conducted in Britain by Jansen and his colleagues and cited by Rice (1996), inhalants/solvents (glue, shoe polish, petrol fumes etc) have been identified as chemicals of abuse despite the law being silent over them. Inhalants have severe physiological and psychological consequences on its users such as impairment and permanent damage of the brain tissue function, disinhibition, hallucinations, fits, coma, depression, weight loss and their highly addictive nature will make them socially discriminated against due to the behaviour they will exhibit. Sniffing is an extensive problem especially among urban youths with the peak age between 13-14 years, and it begins as a group activity (Rice, 1996; Winkley, 1996). The “legal vacuum” concerning its definition just like other drugs of abuse, however, curtails its control both in Britain and Kenya (Obonyo, 2005).

In his study in Kikuyu division, Murimi (1996) deducted that familial factors are very strong in influencing adolescents into drug use by observing that factors like single parenthood, SES and other family members using drugs contribute 72.6%, 87.2% and 52%, respectively, to adolescent drug use. This confirms the viewpoint of Ackerman and Kempster (1972), Plant and Plant (1992) and Steinberg (1999).

Njiru (1996) in his study conducted in Runyenjes division covering a sample of 102 students, further confirmed this deduction by observing that peers and/or relatives influence 58.8% of students getting into drug use.
In Gichuru's study in Kabete location (Gichuru, 1996), 72% of students who use drugs, have parents who use them too, whilst 54% who use, have parents who do not use drugs. This observation vividly brings to the fore the aspect of observational learning by the adolescents from their significant others in the family, especially the parents. Gichuru further observed that 91% of those using drugs have parents who approve the behaviour, but 55% who use have parents who oppose it. This shows the effect of parental attitude towards adolescent drug use. If parental approval is present, then the behaviour is acceptable and one will take to it, but the reverse is true if the approval is lacking.

Alcohol's use as a "drug-of-choice" by adolescents is a common phenomenon in various parts of Kenya. For example, in Runyenjes division (Njiru, 1996), alcoholic beverages account for 30.4% and cigarettes 22.6% of adolescent drug use. However, regional differences in Kenya exists as in a study by Murimi (1996) who deduced that the leading drug used in Kikuyu division by school going adolescents is cigarettes at 43.8%, followed by alcohol at 10.4%. These studies reveal that both single and polydrug use is present in Kenya, and compose of drugs such as alcohol, cigarettes, marijuana, "miraa", and inhalants (Njiru, 1996; Murimi, 1996; Gichuru, 1996).

Murimi (1996) and Njiru (1996) showed in their studies that some adolescents get into drug use as a result of academic pressure. They observed that 13.3% and 14.7%, respectively, get into drug use because of this reason. This, therefore, calls for a detailed study to identify the real impact of the curriculum load on the adolescents' mental health.
Kamonjo (1997) observed that the SES of the family of origin of the adolescent also impacts on the drug use behaviour, with those from low SES families leading (153) and the high SES the least (36) while the middle SES stood at 112.

Kamonjo also deduced that adolescents from conservative religious backgrounds use drugs least compared to the less conservatives. She observed that most drug addicts were Christians. From her sample, Protestants led by 202, followed by Catholics (103) and lastly Muslims (8).

2.4.2 Summary of the review

Researches globally, on adolescent drug use, have revealed major trends towards the development of this behaviour, in terms of the factors influencing it.

One of the trends is that adolescent drug use is not solely a function of a single factor, but interplay of several factors simultaneously. This is because an individual is an active participant in his/her social environment, and so one interacts with several factors at once, a phenomenon that negates the view that solely one factor is responsible for the behaviour.

Another trend is that modern adolescents learn more from their models and the mass media rather than their parents. This enables them to get information “unedited”, without sieving that is characteristic of the traditional information acquisition in the family. This has greatly affected their cognitions and their general perception of life issues.
Enormous researches done have tried to demystify this problem by explaining probable reasons for its emergence, spread, patterns and how it can be challenged. However, gaps which need answers remain, such as

a. The role of the context in influencing this behaviour in terms of prevalence, costing, problem definition and societal norms.

b. Why more adolescents get into drug use at an early age.

c. What are the differences in drug use among adolescents in terms of age, types, and patterns in a coastal setting?

d. Which personality attribute is core in determining an individual’s entry into drug use?

This study, therefore, is to determine the factors influencing adolescent drug use in a coastal context in Kenya, and identify their uniqueness.
CHAPTER THREE

RESEARCH DESIGN AND METHODOLOGY

3.1 Introduction

This chapter gives a description of the design and methodology of the study. It discusses the population, sampling procedure, instrumentation and its administration, pre-testing for the instruments and the procedure used for data analysis.

3.2 Research design

The design of this research was a sample survey study because it aimed at among other issues to compare different groups in the society and assessing their opinions and feelings too (Shaughnessy, et. al., 2003; Eysenck, 1994). It was a descriptive study conducted at the ordinal level of measurement, with the independent variables being the factors influencing drug use such as gender, parental drug use, and family's segmentation, religion and context, whilst the dependant variable was the drug use behaviour by the adolescent.

The study aimed at identifying the factors influencing secondary school adolescents' drug use behaviour in Bahari division in order to enable drug educators to effectively work out strategies to ensure the success of the programmes.
Being a sample survey study, data collection was done using questionnaires (Eysenck, 1994; Shaughnessy, et al., 2001) both for students and teachers in charge of guidance and counselling departments in the respective sampled schools. Guidance and counselling teachers were included in the study because they interact and assist adolescents with drug use and other interrelationship problems and so could provide information vital to the study.

3.3 Locale

The study was conducted in Bahari division of Kilifi district, among the form three adolescents, in the 6 sampled schools, as well as the heads of departments of the guidance and counselling departments of the 6 schools.

The division has two main urban centres which include Kilifi, which is also the district headquarters, and Mtwapa, a resort town, separated from Mombasa by the Mtwapa Creek, and joined to it by the Mtwapa bridge.

The division has a total of thirteen registered secondary schools (11 public and 2 private), but the study exclusively covered only the public schools that compose of 1 exclusive for boys, 1 exclusive for girls, and 9 mixed schools (APPENDIX III).
3.4 Population and target population

Though it aimed at studying the adolescent drug use behaviour, this study was restricted to adolescents currently in secondary schools. The Form 3 adolescents in the sampled public secondary schools were identified as the target population because at their average age (middle adolescence) that is when the adolescents tend to be more susceptible to peer influence with a marked dilemma of conformity to parental instructions (Steinberg, 1999), and this is the time they tend to be more involved in drug taking behaviour. At this age also, the adolescents are more aware and critical of their social contexts.

3.5 Sampling techniques

3.5.1 Selecting the study universe:

Kilifi district has five divisions namely Bahari, Kaloleni, Ganze, Chonyi and Kikambala, however, the researcher identified Bahari division purposively as the study universe because he has lived and worked in schools in the division for a long time and has witnessed many strikes, interruption to school programmes and property and status crimes by students, blamed on rampant drug use, as well as seeing adolescents dropping out of school and wasting their lives away, all associated with drug use prevalent in the division. This created an interest in the researcher to study the problems in more details (Shaughnessy, et. al., 2003).
3.5.2 School selection procedure:

After getting information from the local DEO’s office on the number of registered schools in the division (Appendix III), probability sampling techniques were used for sample identification in the study. In identifying the schools to form the study sample, stratified random sampling was used, in which the schools were first categorised into gender based strata as boys only, girls only and mixed secondary schools. This was to give equal chance to schools in all the categories to be selected for the study and thus remove the sampling biasness due to over- or under-representation of any of the categories.

After the stratification process, simple random sampling was done amongst schools in each stratum in order to identify the schools that represented each stratum in the study sample because this technique ensured that each school had an equal opportunity of being included in the sample, thus reducing the sampling bias.

Two schools, Kilifi Township and Bahari Girls’ secondary schools, automatically formed part of the sample for being the only exclusively single-sex schools for boys and girls, respectively, in the division. Two schools from each stratum were randomly identified through the lottery method from the remaining two strata: mixed day and boarding and mixed day secondary schools, and formed part of the sample.
Using the stratified random sampling technique, therefore, 6 schools representing 54.5% of the registered public secondary schools in the division were identified for the sample, which is well above the 10% recommended for a descriptive study.

However, private schools were not included in the sample because their enrolment largely was biased towards those who scored low marks in their final primary exams or had been expelled from the public schools and so it could not give a clear representation of all categories of adolescents in the division.

3.5.3 Student selection procedure:
The form three students were purposively identified to form the sample of the study primarily because their average age, middle adolescence, makes them be psychologically more vulnerable, and also they could have a more clearer understanding of their social environments including the schools.

In identifying the respondents (students) to fill in the questionnaires, different techniques were used depending on the category of the school, that is, whether mixed or single sex school. In single sex schools, simple systematic sampling was used whereby every third subject in the official class register was picked, starting from the first entrant in the class register. But in mixed schools, stratified sampling was done based on gender, thereafter, simple systematic sampling was done to identify the respondents, with every third entrant in the class register becoming part of the sample.
These sampling approaches were used to ensure that all the form three students in the sampled schools had an equal opportunity of forming the sample in order to allow future generalisations and objectivity, and removal of the sampling biasness.

A total of 207 students were identified as respondents from the sampled school, and a total of 6 teachers in charge of guidance and counselling departments each from the sampled schools, who answered the questionnaires. This put the total number of respondents at 213, as is indicated in table 1 below.

Table 1

<table>
<thead>
<tr>
<th>NAME</th>
<th>CATEGORY</th>
<th>NO. STREAMS</th>
<th>TEACHER RESPONDENTS</th>
<th>BOYS</th>
<th>GIRLS</th>
<th>TOTAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>Kilifi Township</td>
<td>BB</td>
<td>3</td>
<td>1</td>
<td>42</td>
<td>43</td>
<td></td>
</tr>
<tr>
<td>Bahari</td>
<td>GB</td>
<td>2</td>
<td>1</td>
<td>36</td>
<td>37</td>
<td></td>
</tr>
<tr>
<td>Majaoni</td>
<td>MD</td>
<td>2</td>
<td>1</td>
<td>22</td>
<td>16</td>
<td>39</td>
</tr>
<tr>
<td>Takaungu</td>
<td>MD</td>
<td>1</td>
<td>1</td>
<td>5</td>
<td>5</td>
<td>11</td>
</tr>
<tr>
<td>Dzitsoni</td>
<td>MDB</td>
<td>2</td>
<td>1</td>
<td>21</td>
<td>20</td>
<td>42</td>
</tr>
<tr>
<td>Chumani</td>
<td>MDB</td>
<td>2</td>
<td>1</td>
<td>19</td>
<td>21</td>
<td>41</td>
</tr>
<tr>
<td>TOTAL</td>
<td></td>
<td>6</td>
<td>109</td>
<td>98</td>
<td>213</td>
<td></td>
</tr>
</tbody>
</table>

3.6 Research instruments

The research instrument used during this study was the questionnaire for it allows collection of data from many respondents cost and time effectively, and reliably (Shaughnessy, et. al., 2003; Coolican, 1996).
3.6.1 The questionnaire:

Two types of questionnaires, one for students (Appendix I) and the other for guidance and counselling teachers (Appendix II), formed the major data collection instruments of the study. They contained both open and closed ended questions, and divided into two sections. Section A for background information and Section B for research information.

The students' questionnaire contained 22 items, whereas the teachers' questionnaire contained 14 items. In each sampled school, only the teacher in charge of the guidance and counselling department was given a questionnaire to answer.

Areas covered in the students' questionnaire included:

(a) Background information;
(b) Types of drugs used;
(c) Gender differences in drug use;
(d) Factors influencing adolescent drug use;
(e) Parental influence on adolescent drug use;
(f) Influence of family's segmentation on drug use;
(g) Religious influence on drug use.

The teachers' questionnaire covered:

a) Background information;
b) Duration of serving in the school;
c) Level of professional training in counselling;
d) Types of drugs used in the school;

e) Religious patterns in adolescent drug use in the school;

f) Severity of the problem in the school.

3.7 Pre-testing research instruments

The questionnaires were pre-tested to detect any weakness and ensure clarity of the questions in March 14th and 15th 2005. The tool was pre-tested among form three students at Lutsangani Secondary School, and form two students of Kilifi Township Secondary School. Two teachers, members of the guidance and counselling department each from either school, also responded to the questionnaires.

This enabled the researcher to detect problems in clarity, ambiguity and wording with the items before actual administration, and thus reframed the items, omitted as well as merged others to ensure objectivity, validity and reliability of the research instrument used.

Content validity was established by expert judgement of my supervisor who checked and approved of the instruments.

3.8 Data collection procedures

Data was collected between March 21st and 29th 2005. The researcher administered the questionnaires in person by getting the respondents only identified through the
probability sampling techniques used, in one area and giving them the questionnaires to fill in, and collected them immediately on completion. Using this approach, the response rate was 100%.

This method of administering the questionnaires increased confidence among the students that the teachers or the school administration will use none of the information given against them.

Before the respondents began the actual filling in of the questionnaires, the researcher defined the meaning of some terminologies as used in the questionnaire and this research work such as drugs, drug abuse, type of school, too religious, religious and not religious amongst others; and also re-affirmed to the respondents on the confidentiality of their answers, and requested them not to indicate their identities anywhere on the questionnaire.

3.9 Data analysis

Data was analysed manually using descriptive statistics such as percentages, averages and frequencies, and was represented using tables, graphs and charts.
CHAPTER FOUR

RESULTS OF THE STUDY

4.1 Introduction:

This chapter contains findings of the study from the research questions investigated on the factors influencing adolescent drug use in secondary schools in Bahari division, Kilifi district, and data representation.

In the presentation of the findings, tables and figures are organised in the sequence of the research questions investigated by the study. The tables show data presented in frequencies, percentages, mean and ranks where applicable, while figures show visual presentation of the same data where necessary.

4.2 Descriptive statistics:

4.2.1 Research question one: Which drugs do adolescents in Bahari division of Kilifi district abuse?

This question aimed at identifying the various types of drugs being used by adolescents in secondary schools in Bahari division, and the results are tabulated in Tables 2, 3, 4(a) and 4(b).
### Table 2:

**DRUGS OF ABUSE IN SECONDARY SCHOOLS**

<table>
<thead>
<tr>
<th>DRUG</th>
<th>FREQUENCY</th>
<th>%</th>
<th>RANK</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bhang</td>
<td>78</td>
<td>38</td>
<td>1</td>
</tr>
<tr>
<td>Alcohol</td>
<td>63</td>
<td>30</td>
<td>2</td>
</tr>
<tr>
<td>Caffeine</td>
<td>38</td>
<td>18</td>
<td>3</td>
</tr>
<tr>
<td>Cigarettes</td>
<td>33</td>
<td>16</td>
<td>4</td>
</tr>
<tr>
<td>Prescriptive drugs</td>
<td>29</td>
<td>14</td>
<td>5</td>
</tr>
<tr>
<td>Miraa</td>
<td>27</td>
<td>13</td>
<td>6</td>
</tr>
<tr>
<td>Cocaine</td>
<td>7</td>
<td>3</td>
<td>7</td>
</tr>
<tr>
<td>Heroine</td>
<td>6</td>
<td>3</td>
<td>8</td>
</tr>
<tr>
<td>Solvents</td>
<td>4</td>
<td>2</td>
<td>9</td>
</tr>
<tr>
<td>Kuber</td>
<td>1</td>
<td>0.5</td>
<td>10</td>
</tr>
</tbody>
</table>

Table 2 above shows that bhang is the most abused drug followed by alcohol, and "kuber" is the least used drug.

### Table 3:

**CURRENT DRUGS OF ABUSE IN SECONDARY SCHOOLS**

<table>
<thead>
<tr>
<th>DRUG</th>
<th>FREQUENCY</th>
<th>%</th>
<th>RANK</th>
</tr>
</thead>
<tbody>
<tr>
<td>Caffeine</td>
<td>15</td>
<td>42</td>
<td>1</td>
</tr>
<tr>
<td>Alcohol</td>
<td>8</td>
<td>22</td>
<td>2</td>
</tr>
<tr>
<td>Bhang</td>
<td>7</td>
<td>19</td>
<td>3</td>
</tr>
<tr>
<td>Prescriptive drug</td>
<td>6</td>
<td>17</td>
<td>4</td>
</tr>
<tr>
<td>Miraa</td>
<td>2</td>
<td>6</td>
<td>5</td>
</tr>
<tr>
<td>Cocaine</td>
<td>2</td>
<td>6</td>
<td>6</td>
</tr>
<tr>
<td>Cigarettes</td>
<td>1</td>
<td>3</td>
<td>7</td>
</tr>
<tr>
<td>Heroine</td>
<td>1</td>
<td>3</td>
<td>8</td>
</tr>
</tbody>
</table>

This shows that the leading drugs of abuse are caffeine, alcohol and bhang, with the presence of strong drugs also apparent.
TABLE 4:

(a) DRUGS ABUSED BY BOYS

<table>
<thead>
<tr>
<th>DRUGS</th>
<th>FREQUENCY</th>
<th>%</th>
<th>RANK</th>
</tr>
</thead>
<tbody>
<tr>
<td>Caffeine</td>
<td>11</td>
<td>58</td>
<td>1</td>
</tr>
<tr>
<td>Alcohol</td>
<td>4</td>
<td>21</td>
<td>2</td>
</tr>
<tr>
<td>Bhang</td>
<td>4</td>
<td>21</td>
<td>3</td>
</tr>
<tr>
<td>Cigarettes</td>
<td>1</td>
<td>5</td>
<td>4</td>
</tr>
<tr>
<td>Miraa</td>
<td>1</td>
<td>5</td>
<td>5</td>
</tr>
<tr>
<td>Heroine</td>
<td>1</td>
<td>5</td>
<td>6</td>
</tr>
</tbody>
</table>

Boys mostly abuse caffeine, alcohol and bhang.

(b) DRUGS ABUSED BY GIRLS

<table>
<thead>
<tr>
<th>DRUGS</th>
<th>FREQUENCY</th>
<th>%</th>
<th>RANK</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prescriptive drugs</td>
<td>6</td>
<td>35</td>
<td>1</td>
</tr>
<tr>
<td>Alcohol</td>
<td>4</td>
<td>24</td>
<td>2</td>
</tr>
<tr>
<td>Caffeine</td>
<td>4</td>
<td>24</td>
<td>3</td>
</tr>
<tr>
<td>Bhang</td>
<td>3</td>
<td>18</td>
<td>4</td>
</tr>
<tr>
<td>Cocaine</td>
<td>2</td>
<td>12</td>
<td>5</td>
</tr>
<tr>
<td>Miraa</td>
<td>1</td>
<td>6</td>
<td>6</td>
</tr>
</tbody>
</table>

Girls mostly abuse prescriptive drugs, alcohol and caffeine, with miraa being the least abused.
4.2.2 Research question two: In which way does the coastal location influence adolescent drug use patterns?

This question aimed at identifying the various aspects of the coastal context that influence the adolescent drug use patterns in the area.

Table 5:

<table>
<thead>
<tr>
<th>CONTEXTUAL FACTOR</th>
<th>FREQUENCY</th>
<th>%</th>
<th>RANK</th>
</tr>
</thead>
<tbody>
<tr>
<td>Climatic factor for drug growth</td>
<td>4</td>
<td>67</td>
<td>1</td>
</tr>
<tr>
<td>Tourism</td>
<td>4</td>
<td>67</td>
<td>2</td>
</tr>
<tr>
<td>Local traditions/customs</td>
<td>2</td>
<td>33</td>
<td>3</td>
</tr>
<tr>
<td>Unsupervised fishing ports</td>
<td>1</td>
<td>17</td>
<td>4</td>
</tr>
<tr>
<td>Poverty</td>
<td>1</td>
<td>17</td>
<td>5</td>
</tr>
<tr>
<td>Government reluctance to drug controls</td>
<td>1</td>
<td>17</td>
<td>6</td>
</tr>
</tbody>
</table>

Table 5 shows that climatic factors favouring the growth of the drugs (67%) is the leading instigative factor to drug use in the area, with the government reluctance at controlling it being the least (17%).

TABLE 6:

<table>
<thead>
<tr>
<th>HOME CONTEXT</th>
<th>TOTAL USING</th>
<th>BOYS USING</th>
<th>BOYS TRIED</th>
<th>GIRLS USING</th>
<th>GIRLS TRIED</th>
<th>TOTAL USING</th>
<th>TOTAL TRIED</th>
</tr>
</thead>
<tbody>
<tr>
<td>URBAN</td>
<td>77</td>
<td>5</td>
<td>9</td>
<td>9</td>
<td>11</td>
<td>14</td>
<td>20</td>
</tr>
<tr>
<td>RURAL</td>
<td>127</td>
<td>14</td>
<td>29</td>
<td>8</td>
<td>11</td>
<td>22</td>
<td>42</td>
</tr>
<tr>
<td>NR</td>
<td>3</td>
<td>—</td>
<td>—</td>
<td>—</td>
<td>—</td>
<td>—</td>
<td>—</td>
</tr>
</tbody>
</table>

More adolescents have tried out drugs in the rural areas (42%) compared to those in the urban areas (20%).
4.2.3 Research question three: Which gender among the adolescents is more prone to drug use than the other?

The results to this question are represented in Table 7, 8, and 9 and Figure 2(a), 2(b), 3 and 4.

TABLE 7:

<table>
<thead>
<tr>
<th>GENDER</th>
<th>TOTAL</th>
<th>BOYS PRONE</th>
<th>GIRLS PRONE</th>
<th>BOTH PRONE</th>
<th>USING DRUGS</th>
<th>TRIED DRUGS</th>
</tr>
</thead>
<tbody>
<tr>
<td>BOYS</td>
<td>109</td>
<td>73</td>
<td>11</td>
<td>3</td>
<td>19</td>
<td>40</td>
</tr>
<tr>
<td>GIRLS</td>
<td>98</td>
<td>71</td>
<td>10</td>
<td>1</td>
<td>17</td>
<td>22</td>
</tr>
</tbody>
</table>
Table 7 shows that the majority of boys and girls perceive boys to be at a greater risk of drug use than girls, although more boys use drugs than girls.

Figure 3:
(a)
Table 8:

GENDER-AGE GROUP DRUG USE VARIATIONS

<table>
<thead>
<tr>
<th>AGE-GROUP</th>
<th>TOTAL USING</th>
<th>BOYS USING</th>
<th>BOYS TRIED</th>
<th>GIRLS USING</th>
<th>GIRLS TRIED</th>
<th>TOTAL USING</th>
<th>TOTAL TRIED</th>
</tr>
</thead>
<tbody>
<tr>
<td>15-17</td>
<td>103</td>
<td>9</td>
<td>14</td>
<td>9</td>
<td>12</td>
<td>18</td>
<td>26</td>
</tr>
<tr>
<td>18-24</td>
<td>99</td>
<td>9</td>
<td>25</td>
<td>9</td>
<td>11</td>
<td>18</td>
<td>36</td>
</tr>
<tr>
<td>NR</td>
<td>5</td>
<td>1</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

This shows that more adolescents in the late adolescence involve themselves in drugs compared to those in the middle adolescence and this is graphically presented in the compound bar graph below.
Thus most boys are habitual drug users, but majority of the girls on drugs are experimenters and habitual users.

These results are represented graphically in the compound bar graph below.
4.2.4 Research question four: What factors influence adolescents' drug use behaviour in Bahari division?

The results to this question are summarised in Table 10.
From the above table, the need to be active is the major factor influencing adolescent drug use, whilst curiosity is the least.

4.2.5 **Research question five: Do adolescents with drug-taking parent(s) also take drugs?**

The results to this question are presented in Table 11 and Figure 5.
From these results, therefore, it is apparent that there is a strong gender influence in drug use patterns within the family.
4.2.6 Research question six: Does family segmentation influence adolescent behaviour?

This question sought to establish if there was any relationship between adolescent drug use and the person/caregiver he/she is staying with, and the results are represented in Table 12 and Figure 6.
TABLE 12:
RELATIONSHIP BETWEEN DRUG USE AND FAMILY SEGMENTATION

<table>
<thead>
<tr>
<th>PERSON STAYING WITH</th>
<th>TOTAL</th>
<th>BOYS USING</th>
<th>BOYS TRIED</th>
<th>GIRLS USING</th>
<th>GIRLS TRIED</th>
<th>TOTAL USING</th>
<th>TOTAL TRIED</th>
</tr>
</thead>
<tbody>
<tr>
<td>BOTH PARENTS</td>
<td>123</td>
<td>7</td>
<td>17</td>
<td>8</td>
<td>11</td>
<td>15</td>
<td>28</td>
</tr>
<tr>
<td>FATHER ONLY</td>
<td>13</td>
<td>1</td>
<td>3</td>
<td></td>
<td>2</td>
<td>1</td>
<td>5</td>
</tr>
<tr>
<td>MOTHER ONLY</td>
<td>39</td>
<td>6</td>
<td>10</td>
<td>6</td>
<td>6</td>
<td>12</td>
<td>16</td>
</tr>
<tr>
<td>GUARDIAN</td>
<td>29</td>
<td>5</td>
<td>13</td>
<td>1</td>
<td>1</td>
<td>6</td>
<td>14</td>
</tr>
<tr>
<td>NR</td>
<td>3</td>
<td></td>
<td></td>
<td>2</td>
<td>2</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

From the above table, therefore, in families where one or both parents do not stay with the adolescents, drug use incidences among the latter tend to be higher than when living with both parents.
4.2.7 Research question seven: what is the influence of parental religious affiliation to adolescent drug use behaviour?

This question investigated the effect of parental/caregiver’s religious values towards adolescent drug use patterns. The findings are presented in Tables 13 and 14, and Figures 7 and 8.
Table 13:

PARENTAL/CAREGIVERS' INFLUENCE ON ADOLESCENT DRUG USE

<table>
<thead>
<tr>
<th>VIEW OF PARENT/ CAREGIVER</th>
<th>TOTAL</th>
<th>USING DRUGS</th>
<th>TRIED DRUGS</th>
</tr>
</thead>
<tbody>
<tr>
<td>TOO RELIGIOUS</td>
<td>38</td>
<td>6</td>
<td>8</td>
</tr>
<tr>
<td>RELIGIOUS</td>
<td>147</td>
<td>26</td>
<td>43</td>
</tr>
<tr>
<td>NOT RELIGIOUS</td>
<td>13</td>
<td>2</td>
<td>4</td>
</tr>
<tr>
<td>NR</td>
<td>9</td>
<td>2</td>
<td>3</td>
</tr>
</tbody>
</table>

From Table 13, adolescents who view their parents/caregivers as “Too religious” least tried drugs, whilst those who viewed their parents/caregivers as “Not religious” have the highest attempts at drugs.

Figure 8:
Table 14:

<table>
<thead>
<tr>
<th>RELIGION</th>
<th>TOTAL</th>
<th>USING DRUGS</th>
<th>TRIED DRUGS</th>
</tr>
</thead>
<tbody>
<tr>
<td>CATHOLIC</td>
<td>48</td>
<td>5</td>
<td>15</td>
</tr>
<tr>
<td>PROTESTANT</td>
<td>87</td>
<td>14</td>
<td>22</td>
</tr>
<tr>
<td>MUSLIM</td>
<td>31</td>
<td>6</td>
<td>9</td>
</tr>
<tr>
<td>NOT SPECIFIC (CHRISTIANS)</td>
<td>36</td>
<td>10</td>
<td>12</td>
</tr>
<tr>
<td>NO RELIGION</td>
<td>2</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>NR</td>
<td>3</td>
<td></td>
<td>2</td>
</tr>
</tbody>
</table>

Figure 9:

**RELIGIOUS PATTERNS IN ADOLESCENT DRUG USE**

- MUSLIMS 15%
- OTHERS 3%
- CHRISTIANS 82%
CHAPTER FIVE

CONCLUSION

5.1 Introduction:
This chapter contains the main findings of the study, their discussion and interpretation, the summary and conclusion of the study, and the recommendations for counselling and further research.

5.2 Discussion:
The discussion of the study findings are presented in the order of the major research questions as presented in chapters one and four.

Research question one: Which drugs do adolescents in Bahari division of Kilifi district abuse?
Table 2,3 and 4(a) and (b) summarises student responses to this question which aimed at identifying the types of drugs abused by adolescents in secondary schools in Bahari division of Kilifi district.

Caffeine (42%) is the most abused drug, followed by alcohol (22%), bhang (19%) and prescriptive drugs (17%), thus confirming regional differences in drug use patterns in Kenya (Gichuru, 1996; Njiru, 1996; Murimi, 1996). Majority of the respondents using caffeine approved of its stimulating effects and its full "social
acceptable label", regardless of its short and long-term medical or psychological implications (Robbins, et. al., 1997: 278).

Gender disparities in types of drugs used was apparent with boys largely abusing caffeine (58%), alcohol (21%), bhang (21%) and cigarettes (5%); and girls largely abusing prescriptive drugs (35%), alcohol (24%), caffeine (24%), and bhang (18%) (Table 4(a) and (b)). Polydrug use is common and it involves alcohol, bhang, miraa and cigarettes.

However, there is a wide range of drugs abused in secondary schools in Bahari division (Table 2) with bhang (38%) being the leading followed by alcohol (30%) and caffeine (18%), with the least being “kuber” (0.5%), according to the deductions from the responses of the 207 student respondents, and confirmed by the teacher respondents, which also revealed the use of strong psychoactive and illicit drugs such as cocaine and heroine.

The traditional palm wine (“mnazi”) is the single largest alcoholic drink taken by adolescents because it is readily available, as it had been mentioned by Steinberg (1999) on the importance of context, and its second rank in usage confirms the viewpoint of Rice (1996) and Njiru (1996) that it is the drug-of-choice.
Spatial infiltration of drugs can be seen through the presence of “kuber” in this area, a stimulant previously associated with Kisumu town.

Research question two: In which way does the coastal location influence adolescent drug use patterns?

The responses to this question are summarised in Table 5 and 6, with Figure 2 representing the data graphically.

Majority of the teacher respondents (67%) view the coastal climate which is part of the physical context and which favours the growth of palm trees and bhang crop as the major factor leading into the genesis and development of drug use behaviour, because it enhances availability, accessibility and affordability of the drugs (Steinberg, 1999) to the adolescents.

67% of the teacher respondents also identified the coastal context as a major factor because it favours the development of tourism which enhances interactions between drug using tourists and other seamen who pass on the habit to local teenagers in such areas as points of entry, fishing ports or resort towns such as Takaungu, Mnarani and Mtwapa all in Kilifi (Nyassy, 2000).

At Takaungu secondary school, the guidance and counselling teacher identified interaction with fishermen as the sole instigative factor to drug use. This deduction
gives credence to the fact that the leading drugs of abuse in this area are locally produced (palm wine and bhang), as well as illicit drugs commonly associated with tourists such as heroine and cocaine, and the widely used caffeine mainly in the form of coffee (Table 2).

33% of the teacher respondents view cultural permissiveness as an instigative factor towards adolescent drug use for it exposes adolescents to alcohol use at a very young age, thus explaining why 33% of adolescents residing in rural areas having tried drugs, with only 26% in urban areas (Table 6).

Similarly, local traditions' less strict stance on the boys' use of alcohol probably has contributed to more boys in rural areas (23%) having tried out drugs, compared to 9% of the girls in the same locality (Table 6). This viewpoint corroborates that of Steinberg (1999:411) that easy access to drugs and the belief that there is ample room to use them will make adolescents turn into drug use.

Unconventional environment has also been identified as a factor in the fact that legal framework and law enforcement agents seem to be rather indifferent in tackling this problem.

**Research question three:** Which gender among the adolescents is more prone to drug use than the other?
This question aimed at establishing if the adolescents’ perception on drugs affected their intake of the same, and the responses received are summarised in Table 7, 8 and 9, and Figure 3(a), 3(b), 4 and 5.

Majority of the boys (67%) and girls (72%) respondents believed that boys were more inclined to drug use than girls, although this perception did not match with the subsequent behaviour because more boys (37%) had tried drugs than girls (22%), and 53% of the drug using adolescents were boys compared to 47% girls. This deduction corroborates the view that more boys abuse drugs than girls (Spence, 1989; Winkley, 1996; Gichuru, 1996).

There are no gender differences in current drug use levels for each stand at 17% thus implying that both genders are equally threatened by this problem behaviour.

The dissonance between the boys’ perception of themselves vis-à-vis the real risk lurking can be attributed to the low perception of personal risk and susceptibility to the problem behaviour towards the self, as was explained by Weinstein (Ogden, 2000) in his view on “Unrealistic Optimism”. This therefore, makes them to have a “faulty belief” and intent and so engage in the self-destructive behaviour (Kaplan, et al., 1993).
In both age groups, the current rate of drug abuse is similar in both sexes, although more boys have tried drugs in both age groups compared to girls, 14% against 12% in middle adolescence, and 25% against 11% in late adolescence (Table 8).

There is negligible difference between male and female respondents between middle and late adolescent drug use (17% and 18%, respectively). Fewer adolescents have tried drugs in middle adolescence (25%) compared to 36% of the late adolescence, which is in variance with the view of Steinberg (1999) that identifies pre-adolescence and middle adolescence as the most critical period for the aetiology of the behaviour.

Majority of the adolescents taking drugs are habitual users (42%), followed by experimenters (36%) and frequent users (17%), thus denoting the urgency needed to contain the behaviour before they degenerate into actual dependence. The situation is more challenging because the experimenters on drugs, who are the second largest among the drug users, could easily transcend into habitual users and complicate the situation through what Weiner (1982) referred to as the “Stepping-stone Hypothesis”.

Majority of the girls taking drugs are experimenters (35%) and habitual users (35%), with 24% frequent users. However, majority of the boys on drugs are habitual users (47%), 37% experimenters and 11% frequent users (Table 9).
Research question four: What factors influence adolescents’ drug use behaviour in Bahari division?

Responses to this question are tabulated in Table 10.

The psychological pressure to be seen as active/alert in various activities is the leading factor (21%), followed by peer pressure (18%) which remains one of the important influences towards adolescent drug use (Rice, 1996; Murimi, 1996; Njiru, 1996), and it underscores the importance of peers and an individual’s intentions in adopting this behaviour as that which will make him/her accepted by his/her peers as explained by Ajzen and Fishbein (Kaplan, et. al., 1993) in their Theory of Reasoned Action.

However, deductions from among the teacher respondents identify peer influence (50%) and curiosity (50%) as the key factors influencing adolescent drug use.

The need to gain courage out of drug use is also a key deduction because (6%) of the student respondents argued that courage is needed in participating in strikes, and for boys in mixed schools, in “facing” girls. This raises the paradox on whether drug use leads to strikes, or on whether drugs are only but “safe camouflage” among the desperate and overwhelmed administrators.

Significantly, 2% of the student respondents observed that girls use prescriptive drugs to procure abortion, an issue that raises concern over the practice of both protected
and safe sex among adolescents. The fact that majority of the girls on drugs (35%) abuse prescriptive drugs, signals a problem in the way adolescents handle their sexual lives in the light of the current HIV/AIDS pandemic.

Drug availability (1%) and affordability (1%) are among the factors that least influence drug use behaviour among adolescents according to the deductions made from the responses received.

These factors therefore indicate that interrelations between an individual and his/her human, social and physical environment largely determine one’s response behaviour (Steinberg, 1999; Smith and Vetter, 1982) and therefore limiting interventive measures to solely intra-psychic will be an approach in futility.

**Research question five: Do adolescents with drug taking parent(s) also take drugs?**

Answers to this question are presented in Table 11 and Figure 6.

The parents, elder brother and elder sister significantly influence the drug use behaviour of adolescents in a family. 42% and 45% of those who have tried drugs, have fathers and elder brothers respectively, using drugs, whilst 31% of them have no family member on drugs. The latter can be attributed to among other factors, strong peer influence.
There is a strong gender influence on drug use patterns within the family, with the father and elder brother largely affecting boys (34% and 30%, respectively) and the mother and elder sister largely affecting girls (38% and 40%, respectively). However, the elder brother has more influence on his siblings than the rest (45%) because of the cultural "alternate-father-figure" position he holds in the family, as well as his constant free interaction with his siblings.

Therefore, in the family which plays the pivotal role in adolescent development, family members immensely influence adolescent drug use by creating an enabling environment for an adolescent to indulge in drug use behaviour by either copying others or by creating anxieties through developmental roadblocks that encumber the individuation process in the adolescents (Minuchin, 1974; Jackson, 1970; Ackerman, 1970; Rice, 1996; Bandura, 1969; Weiner, 1982; Spence, 1989).

Research question six: Does family segmentation influence adolescent drug use behaviour?

This question aimed at establishing the effect of the parent(s) staying away from their adolescent children on the aetiology of drug use behaviour, and the responses to the question are summarised in Table 12 and Figure 7.
48% of those living with guardians have tried drugs with 21% on drugs, whilst 41% of those staying with their mothers only have tried drugs with 31% on drugs. Those staying with both parents have 23% who have attempted drugs and 12% on drugs.

This therefore means that adolescents staying away from their parents use drugs most, with least incidences recorded among those staying together with both parents and this is because those staying away from their parent(s) miss the strong family relationships and the positive contact (Rutter, 1998), which ensures both psychological and material support to the adolescents in order to keep them off the drugs by weakening the aggressive peer pressure and building a strong sense of self-esteem and a positive self-concept (Steinberg, 1999; Plant and Plant, 1992; Weiner, 1982; Richter, 1974; Rutter, 1998).

Physical separation of adolescents from their parents exposes them to aggressive peer pressure and anxieties in the moratorium, a consequent that questions the psychological merits of boarding schools.

Research question seven: What is the influence of parental religious affiliation to adolescent drug use behaviour?

Responses to this question are summarised in Table 13 and 14 and Figures 8 and 9.
31% of the respondents who view their parents/caregivers as “Not religious” have tried out drugs, although few (15%) have continued with the behaviour. However, those who view their parents/caregivers as “Religious” have the highest percentage on drugs (18%) and ranks second among those who have tried out drugs (29%).

Those viewing their parents/caregivers as “Too religious” have the least attempts at drugs (21%), with 16% of them taking drugs.

Therefore, an adolescent’s perception of the parent’s/caregiver’s religious disposition is crucial in one’s decision to or not to try out drugs, with those perceiving them as “Not religious” having the highest attempts on drugs, whereas the “Too religious” ones have the lowest attempts on drugs probably because of the strictness of their parents/caregivers towards observing their religious teachings.

Notwithstanding drug use, 98% of the student respondents were religious, with 83% (171) Christians, 15% (31) Muslims, 1% (2) Pagans and 1% (3) who never responded to the research item. Comparatively, more Christians (81%) than Muslims (17%) have tried out drugs, thus confirming deductions by Orford (1985) and Kamonjo (1997) that more Christians use drugs compared to their Muslim counterparts. However, this situation is on edge because 19% of the Muslim student respondents are on drugs compared to 17% of the total Christian population in the study.
In conformity with the views of Kamonjo (1997) and Orford (1985), more Protestants are on drugs compared to Catholics (16% and 10%, respectively). However, more Catholics have tried out drugs than Protestants (31% and 25%, respectively).

Thus, parental values are pivotal in creating an environment worth trying out and deterring drug use through impartation of positive religious values to the young since it is apparent that religious teachings are vital in orientating an adolescent’s life (Steinberg, 1999).

5.3 Summary and conclusion:

This study explored the factors influencing adolescent drug use in secondary schools in Bahari division of Kilifi district, and the factors explored included

(1) Types of drugs used by adolescents in secondary schools in the division;

(2) The specific effect of the coastal context on drug use in the area;

(3) Gender differences in adolescent drug use;

(4) Factors influencing adolescent drug use in the division;

(5) Parental influence on drug use by adolescents;

(6) Effect of family segmentation on adolescent drug use;

(7) Parental religious affiliation's effect on adolescent drug use.

The study yielded the following findings
There is a wide range of drugs used by adolescents in secondary schools, with marked gender disparities in the types of drugs used;

There is polydrug use, with several of the adolescents being habitual users;

There are marked regional differences in the types of drugs used and the instigative factors for their use;

The leading drugs of abuse are caffeine, alcohol (palm wine) and bhang, with a proliferation of strong drugs such as heroine and cocaine evident;

The physical and social context is vital in the genesis, development and eventual dependence on drugs through such key contributory factors as climatic conditions favouring widespread growth of plants used in the production of drugs such as palm wine and bhang, the availability, accessibility and affordability of the drug, the traditions that encourages adolescent drug use, flawed legal system and the ease of interaction between the drug users and the adolescents in the absence of thorough controls at points of entry into the country as well as in tourist designated areas;

Both boys and girls are almost equally threatened by this self-destructive behaviour;

Among boys, there is a marked disharmony between their perception of risk against themselves, and the subsequent problem behaviour exhibited;
viii. Although the psychological need to be active/alert and peer pressure are the leading factors into drug use, these deductions reveal that adolescent drug use behaviour is not a function of a single factor (Miller and Foy, 1981), but it is a result of a complex matrix of factors, with the individual having a dual role of an "active actor" and an "interacting object";

ix. There is a strong familial influence in adolescent drug use with the father and the elder brother being the most influential, with a strong gender-influence pattern in the family; male significant members largely affecting the boys and the female ones largely affecting the girls;

x. More adolescents from segmented families use drugs, compared to those staying together with both parents;

xi. Adolescent perception of parental values is key in initiating or avoiding drug use behaviour, with those who view them as "Not religious" having the highest incidences of drug use, and those viewing them as "Too religious" having the least incidences;

xii. More Christian adolescents use drugs than Muslims, although the difference is deceptively negligible. Therefore, irrespective of their religious backgrounds, all adolescents are vulnerable to this behaviour;

xiii. Religious teachings are vital in stopping drug use behaviour.

Based on this study, therefore, the researcher made the following conclusions:
a) There is widespread drug use in secondary schools in Bahari division, with more boys having tried drugs than girls (37% and 22%, respectively). However, current drug use levels stands at 17% for both sexes.

b) Drug use is more prevalent in mixed schools than in single sex schools.

c) Cultural permissiveness has immensely contributed to boys’ involvement in drug use than girls, with 24% of the former and 11% of the latter having tried out drugs.

d) Drug education should, among other things, aggressively strive to harmonize “perception” and “exhibited behaviour” by skilfully re-orienting the “intention-formation process” of the adolescent, in order for the drug education programmes to succeed.

e) There is need for a multi-faceted and multi-dimensional approach in resolving this problem effectively by including among other players, the adolescents (the primary target), families (including parents and siblings), religious institutions, cultural and opinion leaders, educationists, the civil society and the relevant government departments and organs.

f) An adolescent has internal capacities to perceive, interpret, and relate to various environmental stimuli as drug availability, flawed legal system, drug use by family members, family’s religious
inclination and physical and emotional separation from the parents, before making a belief, proceeded by a decision and an intention of getting involved in the behaviour.

5.4 Recommendations:

In order to put to check the adversities of this problem to the adolescents, the researcher identified the following recommendations both for making counselling effective in secondary schools, as well as areas for future research.

5.4.1 Recommendations for counselling:

Due to the ubiquity of the problem, the researcher has identified several recommendations aimed at improving delivery of counselling services in secondary schools in the division, in order to contain this problem that is spreading "infectiously" among the adolescents. These include

(a) Effective, qualitative and "need-driven" counsellor training and posting in schools with special consideration of the students' genders. Female counsellors should be posted as a priority to girls and mixed schools to allow female students access gender-specific counselling from a fellow female.

(b) Guidance and counselling departments in schools should be made functional, professional and comprehensively non-administrative by observing strict
counselling principles in order for them to be effective in containing such like problem behaviour among the adolescents.

(c) Widening of the scope of drug education programmes by governmental organisations and NGOs, to include youth programmes as well as parental/family drug education programmes among others simultaneously, to ensure empowering of every sector of the society in this course, and making explicit the implications of parenting styles to adolescent involvement in drugs.

(d) Inculcation of religious principles and virtues in social living should take a prominent role in the institutions of learning through the relevant agencies and persons, in order to facilitate positive reception of socially acceptable and progressive values, thus augmenting the work of the school counsellor.

(e) Strengthening and ensuring impartiality of the various organs involved in the regulation and controlling the use of different types of drugs in the society such as the judiciary and the police, as well as in the private sector.

5.4.2 **Recommendations for further research:**

As a result of financial constraints among other factors, the scope of this study and the variables studied in this study were restricted to the divisional level. However, the researcher makes the following recommendations for further research:
(a) A similar study to cover a larger part of the coast province so as to ensure adequate generalisations can be made, and more variables studied too.

(b) The direction of influence in drug use patterns in the family between an individual and his/her younger siblings.

(c) The impact of boarding schools in encouraging anti-social behaviours, including drug use, among adolescents.

(d) What is the effectiveness of the current drug education programmes to the adolescents?

(e) Modalities of approach in converting guidance and counselling departments in schools into more functional and professional departments in order to curb the adolescent problem behaviour.

(f) The role of religious organisations/institutions in curbing this problem, and how effective their activities have been so far, in Bahari division.
REFERENCES


APPENDIX I

STUDENTS' QUESTIONNAIRE

NOTE: Please do not write your name or admission number anywhere on this questionnaire.

The responses you put on this questionnaire will be treated with utmost confidentiality.

SECTION A: BACKGROUND INFORMATION

1. Type of school: .................................................................
2. Location of your school
   (a) Rural
   (b) Urban
3. Gender: Male ............... Female ..........................................
4. Your age: ..........................
5. Religion: Christianity .............. (Specify whether catholic or protestant)
   Muslim ......................
   Others, specify ..........................

SECTION B:

6. After school/ during school holidays, where do you stay?
   (a) Urban area
   (b) Rural area
7. Do you stay with both of your parents? Yes... No....
   If no, state whom you stay with and give reason(s) ........................................
   ........................................................................................................
   ........................................................................................................
8. How would you rate your parent(s)/guardian(s) in religion?
   Too religious ......... Religious ......... Not religious ........
9. What is the level of your parent(s)/guardian's education? (Tick the appropriate space)
<table>
<thead>
<tr>
<th>Level</th>
<th>Father</th>
<th>Mother</th>
<th>Guardian</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Secondary</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Middle level College</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>University</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Others (specify)</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

10. What is your parent(s)'/guardian's occupation?
11. Do students in your school abuse drugs? Yes... No...
   If yes, mention drugs they commonly abuse...
12. Mention reasons that make students in your school to abuse drugs...
13. Between boys and girls, whom do you think abuse drugs more?
14. Do any of your family members abuse drugs? Yes... No...
   If yes, identify him/her and name the drug(s)
   a. Father
   b. Mother
   c. Elder brother
   d. Elder sister
   e. Younger brother
   f. Younger sister
   Any other, specify...
15. Do you have close friends? Yes... No...
   If yes, how many?
16. Does any of your close friends abuse drugs? Yes... No...
   If yes, how many of your friends abuse drugs?
   Name the drug(s) they abuse...
17. Have you ever abused drugs before? Yes..... No.....
   If yes, name the drug(s) you abused.

18. Do you abuse drugs now? Yes..... No.....
   If yes, name the drug(s) you are abusing (in order of preference)

19. How often do you take this/these drug(s) of abuse?
   (a) At least once a week
   (b) At least once a month
   (c) On a daily basis
   (d) Others (specify)

20. Mention reasons why you abuse drugs.

21. Do you think you can stop abusing drug(s)? Yes..... No.....
   If no, state some of the reasons for that.

22. Give any comment or personal view you have on this subject.

Thank you very much for taking part of your precious time to fill in this questionnaire.
APPENDIX II

TEACHERS' QUESTIONNAIRE

NOTE: Please do not write your name or employment number anywhere on this questionnaire.

The answers you give on this questionnaire will be treated with utmost confidentiality.

SECTION A: BACKGROUND INFORMATION

1. Type of school (Tick the appropriate category):
   (a) Boys' boarding .........
   (b) Girls' boarding ..........
   (c) Mixed day and boarding ......
   (d) Mixed day ..................
   (e) Others (Specify) ........................................

2. Gender: ..................................................

3. Your age: ..................................................

4. Duration of serving in this station: ..........................

5. How many streams does your school have? .................

6. Your religion: Christianity (Specify whether protestant or catholic) ..................
   - Islam ..........................
   - Others (specify) ..........

7. Are you trained as a counsellor? Yes .... No ......
   If yes, to what level?
   i. Workshops/seminars .......... ..
   ii. Certificate ..................
   iii. Diploma ..................
   iv. Degree ...........
   v. Others (Specify) .............

87
SECTION B:

8. How serious is the drug abuse problem in your school?
   Very serious...... Serious...... Not serious........ Non-existent......

9. Which drugs do students in your school mainly abuse? (In order of prevalence)

10. Mention common reasons why some students use drugs in your school.

11. How does the coastal location impact on students' drug use in your school?

12. How many drug-related matters have you dealt with in the last two months in your school?

13. Rank the factors below which influence adolescent drug use (if you think one is not a problem, tick the appropriate space against it).
<table>
<thead>
<tr>
<th>Factor</th>
<th>Rank</th>
<th>Not a factor</th>
</tr>
</thead>
<tbody>
<tr>
<td>Poor academic performance</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Congested curriculum</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Curiosity</td>
<td></td>
<td></td>
</tr>
<tr>
<td>To rebel/shock the adults</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Need for sensual pleasure</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Being involved in selling drugs</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Underlying personality problems</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Single parenthood (mother only)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Single parenthood (father only)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mass media</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Weak religious affiliations</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Students from divorced families</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Peer influence</td>
<td></td>
<td></td>
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<tr>
<td>Familial SES</td>
<td></td>
<td></td>
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<tr>
<td>Easy availability of the drugs</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other family members using drugs</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Coastal location</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

14. Give any comment or personal view you have on this subject

Thank you very much for taking part of your precious time to fill in this questionnaire.
### (A) REGISTERED PUBLIC SECONDARY SCHOOLS IN BAHARI DIVISION, DECEMBER 2004

<table>
<thead>
<tr>
<th>NAME OF SCHOOL</th>
<th>TYPE OF SCHOOL</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Kilifi Township</td>
<td>Boys’ boarding</td>
</tr>
<tr>
<td>2. Bahari Girls’</td>
<td>Girls’ boarding</td>
</tr>
<tr>
<td>3. Chumani</td>
<td>Mixed day and Boarding</td>
</tr>
<tr>
<td>4. Lutsangani</td>
<td>Mixed day and Boarding</td>
</tr>
<tr>
<td>5. St. Teresa</td>
<td>Mixed day and Boarding</td>
</tr>
<tr>
<td>6. Dzitsoni</td>
<td>Mixed day and Boarding</td>
</tr>
<tr>
<td>7. Katana Ngala</td>
<td>Mixed day school</td>
</tr>
<tr>
<td>8. Majaoni</td>
<td>Mixed day school</td>
</tr>
<tr>
<td>9. Takaungu</td>
<td>Mixed day school</td>
</tr>
<tr>
<td>10. Shariani</td>
<td>Mixed day school</td>
</tr>
<tr>
<td>11. Msumarini</td>
<td>Mixed day school</td>
</tr>
</tbody>
</table>

### (B) REGISTERED PRIVATE SECONDARY SCHOOLS IN BAHARI DIVISION, DECEMBER 2004

<table>
<thead>
<tr>
<th>NAME OF SCHOOL</th>
<th>TYPE OF SCHOOL</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Mtwapa North</td>
<td>Mixed day</td>
</tr>
<tr>
<td>2. Coral</td>
<td>Mixed day</td>
</tr>
</tbody>
</table>

Source: D.E.O's office, Kilifi
APPENDIX IV: Research Authorisation

KENYATTA UNIVERSITY
GRADUATE SCHOOL

Our Ref: E55/5075/03

Date: 11th March 2004

The Permanent Secretary,
Ministry of Education, Science & Technology,
P.O.Box 30040
NAIROBI.

Dear Sir/Madam,

RE: RESEARCH AUTHORIZATION:

I write to introduce Mr. Ombima W.A. who is a Postgraduate Student of this University. He is registered for a M.Ed. degree programme in the Department of Psychology.

Mr. Ombima intends to conduct research for a project entitled, "Factors Influencing Adolescent Drug Use in Secondary Schools in Bahari Division, Kilifi District, Kenya", a partial fulfillment of the requirement for his degree programme.

Any assistance given to him will be highly appreciated.

Yours faithfully,

P.K. MUCHEME
FOR: AG. DEAN, GRADUATE SCHOOL

C.C. Registrar (Academic)
Dean, Graduate School - to see on file
Dean, School of Education
Chairman, Psychology Department
PKM/mb
APPENDIX V

CONDITIONS

1. You must report to the District Commissioner and the District Education Officer of the area before embarking on your research. Failure to do so may lead to the cancellation of your permit.

2. Government Officers will not be interviewed without prior appointment.

3. No questionnaire will be used unless it has been approved.

4. Excavation, mining and collection of biological specimens are subject to further permission from the relevant Government Ministry.

5. You are required to submit at least two (2) bound copies of your final report for Kenyans and non-Kenyans respectively.

6. The Government of Kenya reserves the right to modify the conditions of this permit including its cancellation without notice.

(REPUBLIC OF KENYA
RESEARCH CLEARANCE PERMIT

KENYATTA UNIVERSITY

CONDITIONS—see back page)

Page 2

THIS IS TO CERTIFY THAT:

Prof./Dr./Mr./Mrs./Mre. OMBIMA WILLIS AYUB

of (Address) KENYATTA UNIVERSITY
P.O. BOX 43844, NAIROBI

has been permitted to conduct research in

BAHATTI DIVISION Location,
KILIFI District,
COAST Province,
on the topic FACTORS INFLUENCING ADOLESCENT
DRUG USE IN SECONDARY SCHOOLS IN BAHATTI
DIVISION, KILIFI DISTRICT KENYA

for a period ending 31st June 2005

(PAGE 3)

Page 3

Research Permit No. MOIST 131001/35C

Date of issue 14th April, 2005

Sns. 500

MINISTRY OF EDUCATION,
SCIENCE AND TECHNOLOGY

For PERMANENT SECRETARY

MINISTRY OF EDUCATION,
SCIENCE AND TECHNOLOGY

Signature

M. K. R. ODIRO

MINISTRY OF EDUCATION,
SCIENCE AND TECHNOLOGY

Applicant

Ministry of Education
Science and Technology

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