REPUBLIC OF KENYA

NACADA
FOR A NATION FREE FROM ALCOHOL AND DRUG ABUSE

NATIONAL GUIDELINES ON ALCOHOL AND DRUG USE PREVENTION

2021

NATIONAL GUIDELINES ON ALCOHOL AND DRUG USE PREVENTION

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FOREWORD

The success and failures of coronavirus management have set a precedent for how countries should approach future outbreaks and public health challenges- as a precaution, not as a reaction.

It is over one year since COVID-19 caused disruption in most of our lives and programs approach. At NACADA, we have embraced this time of change to make a difference in our own way.

Previously, our approach to prevention has been one off activities, development and dissemination of information, education and communication materials on myths and facts the negative effects of alcohol and drug abuse. The introduction and implementation of scientific approach research is relatively new in Kenya.

One of the greatest milestone that we have achieved during this unprecedented time is the development of the National Guidelines on Alcohol and Drug Use Prevention. The Guidelines aim to improve delivery of programs, interventions and policies in Kenya to produce positive outcomes for the targeted populations. This accentuates our commitment to Evidence-Based Interventions (EBIs) in combating alcohol and drug abuse challenges in Kenya.

The Guidelines are anchored on the International Standards on Drug Use Prevention (UNODC, 2015) that summarizes the science that underlies evidence-based prevention interventions and policies for preventing or reducing substance use. They will provide a framework for state and non-state actors to effectively carry out prevention programs and policies that are applicable to our Kenyan context.

It is my sincere hope and expectation that all state and non-state institutions will implement these Guidelines in an effort to enhance prevention of substance use.

Victor Okioma, EBS

Chief Executive Officer

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Yvonne Olando,

Director Public Education, Advocacy & Rehabilitation

ABBREVIATIONS & ACRONYMS

ADHD — Attention Deficit Hyperactivity Disorder

CBO — Community Based Organization

EAP — Employee Assistance Program

ECDE — Early Childhood Development Education

FBO — Faith Based Organization

KICD — Kenya Institute of Curriculum Development

MoE — Ministry of Education

MoH — Ministry of Health

NACADA — National Authority for the Campaign against Alcohol and Drug Abuse

NHIF — National Hospital Insurance Fund

SDGs — Sustainable Development Goals

TSC — Teachers Service Commission

UNODC — United Nations Office on Drugs and Crime

DEFINITION OF TERMS

Adaptation	Modification of program content to accommodate the needs of a specific consumer group
Brief Interventions	Systematic, focused processes that aim to investigate potential substance use and motivate individuals to change their behaviour. The goal is to reduce risky substance use before the individual becomes dependent or addicted
Drug	Any chemical capable of altering the mind, body, behaviour or character of an individual and includes both lawful drugs (alcohol, tobacco, miraa, prescribed medications) or narcotic and psychotropic substances
Drug /Substance abuse	The harmful or hazardous use of psychoactive substances, including alcohol and illicit drugs
Drug testing	Chemical analysis of biological samples (including blood, urine, hair, and sweat) to detect the presence of a drug or their metabolites
Drug / Substance use	The use of psychoactive substances regardless of their controlled status. The term includes the use of alcoholic beverages; all forms of tobacco
Employee Assistance Programs	An employer sponsored service designed for personal or family problems, including mental health, substance abuse, various addictions, marital problems, parenting problems, emotional problems, or financial or legal concerns
Evidence based practice	Systematic decision-making processes or provision of services which have been shown, through available scientific evidence, to consistently improve measurable client outcomes

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Evidence based/ informed programs	Practices that have shown to be effective in preventing substance use or impacting known protective or risk factors for substance use when targeting given program participants
Indicated population	A subset of the population identified as being at particular risk for substance use or for substance use disorders
Intervention	This is a group of activities of a specific kind. This could be a programme that is delivered in a specific setting in addition to the normal activities delivered in that setting
Policy	A documented regulatory approach or guidelines either within a setting or in the general population that facilitates specific actions
Prevention interventions	Activities Focusing on altering trajectories by promoting positive developmental outcomes and reducing negative behaviours and outcomes
Prevention science	The science behind preventive interventions that are based on research and practice. It is the foundation for health education and health promotion
Protective factors	Factors that directly decrease the likelihood of substance use and behavioural health problems or reduce the impact of risk factors on behavioural health problems
Psychoactive substances	Drugs or medicines that affect the body's central nervous system and change how people behave or perceive what is happening around them
Risk factors	Factors that increase the likelihood of beginning substance use, of regular and harmful use, and of other behavioural health problems associated with use
Selective population	A subset of the population that are at an increased risk of substance use

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Substance use disorders	A general term used to describe a range of problems associated with substance use (including alcohol, illicit drugs and misuse of prescribed medications), from substance abuse to substance dependence and addiction
Substance use prevention	Substance use programs and policies aimed at preventing and delaying substance use and the transition to substance use disorders
Universal population	The entire population without regard to individual or group risk factors

1.0.   INTRODUCTION

Globally, there has been tremendous growth in the field of prevention science over the past two decades. Initially, programs implemented were based on the realization that most people had little or no knowledge about the harmful effects of alcohol and illicit drugs. This led to the development and dissemination of public information campaigns designed to replace myths with facts. Over time, the field has increasingly become oriented with approaches that are based on theories and research. Currently, prevention strategies provide a good basis for evidence-based interventions for targeted populations aiming at positive lifestyle outcomes.

These National Guidelines on Alcohol and Drug Use Prevention summarize the current available scientific evidence and describe interventions and policies that have been found to result in positive prevention outcomes. They are anchored on the International Standards on Drug Use Prevention (UNODC, 2015).

Background

Psychoactive substance use and substance use disorders (SUDs) continue to be major problems around the world, taking a toll on global health, social and economic functioning. This challenge has particularly adversely affected young persons, families, workplaces and communities. Some of the social effects of psychoactive substance use include emotional dysregulation, anti-social behaviours, and poor relationship formation patterns. Economically, individual productivity and potential is adversely affected which exacerbates poverty.

The United Nations Office on Drugs and Crime (UNODC) reports that, in 2018, about 275 million people between ages 15 and 64 used illicit substances at least once. Of those who use psychoactive substances, 10-14% will develop SUDs. SUDs contribute significantly to global disease burden, disability, and death. Therefore, the prevention of substance use and other social problems is a goal that can significantly improve the health and well-being of populations around the world.

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Kenya recognizes alcohol and drug abuse as a major threat to life and national development. Due to its adverse negative impact, the Government of Kenya has established the National Authority for the Campaign against Alcohol and Drug Abuse (NACADA). NACADA is the lead agency mandated to coordinate a multi-sectoral response to the alcohol and drug abuse situation in the country.

NACADA survey reports indicate that the most commonly abused drugs and substances in Kenya are alcohol, tobacco, cannabis (bhang), glue, miraa (Khat) and psychotropic substances. The Rapid Situation Assessment of Drug and Substance Abuse in Kenya (NACADA, 2017) indicates that 12.2% of persons aged between 15 and 65 are active users of alcohol, with 10.4% of them suffering from alcohol use disorders. This survey also indicates that other substances of abuse included: tobacco (8.3%); miraa (4.1%) and cannabis at 1.0%. In addition, findings of a National Survey on the Status of Drugs and Substance Abuse among Primary School Pupils in Kenya (NACADA, 2019) showed the average age of onset of at least one drug or substance of abuse was 11 years; and lowest age of onset of at least one drug of abuse was 4 years.

Further, a National Survey on Alcohol and Drug Abuse among Secondary School Students in Kenya (NACADA, 2016) showed secondary schools are not drug free environments. Among this age group, alcohol had highest prevalence at 3.8%, prescription drugs recording 3.6%, miraa 2.6%, tobacco 2.5%, cannabis 1.8% and heroin and cocaine having the lowest prevalence at 0.2%.

Although tremendous efforts have been made to mitigate the growing problem, through awareness and sensitizations, drug education, counselling and rehabilitation, less attention has been given to evidence based programs that are cost effective and with large effect size. The World Bank has pointed out that several low-cost interventions can have large-scale effects not only on population health but also on productivity especially in countries with low resources such as Kenya.

The United Nations General Assembly Special Session on Drugs (UNGASS) 2016 recommends that member states increase the

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availability, coverage and quality of scientific evidence-based measures and tools that target relevant age and risk groups in all relevant settings.

The African Union Plan of Action on Drug Control and Drug prevention (AUPA 2019-2023) has committed to development and implementation of prevention campaigns and programs that aim at raising awareness of the dangers associated with abuse of all drugs. In addition, involvement of parents, care service providers, teachers, peer groups, health professionals, religious communities, community leaders, social workers, sports associations, media professionals, entertainment industries as appropriate, in their implementation.

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2.0. RATIONALE

The primary objective of psychoactive substances use prevention is to help people, particularly but not exclusively of younger age, to avoid or delay the initiation of the use of psychoactive substances, or, if they have started already, to avert the development of substance use disorders. Effective prevention contributes to the positive engagement of children, youth and adults with their families, schools, workplace and community.

Available scientific evidence shows what works for families, schools, workplaces and communities in addressing risk factors and enhancing protective factors for various age groups. Risk factors contribute to increased vulnerability to initiation of substance use while protective factors reduce individual vulnerabilities. These risk and protective factors differ according to age.

2.1. Prevention of Alcohol and Drug Abuse

Prevention is one of the main components of a health-centred system to address drugs as mandated by the three International Drug Control Conventions: The Single Convention on Narcotic Drugs of 1961 as amended by the 1972 Protocol, the Convention on Psychotropic Substances of 1971 and the United Nations Convention against Illicit Traffic in Narcotic Drugs and Psychotropic Substances of 1988

Prevention of alcohol and drug use aims at healthy and safe development of children and youth to realize their talents and potential becoming contributing members of their community and society. It is an integral part of a larger effort to ensure children and youth are less vulnerable and more resilient.

2.2. Prevention Science

The science of prevention involves the study of human development and social ecology as well as the identification of factors and processes that lead to positive and negative health behaviours and outcome.

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To improve public health by identifying malleable risk and protective factors, assessing the efficacy and effectiveness of preventive interventions and identifying optimal means for dissemination and diffusion. Risk factors include lack of knowledge about substances and consequences of their use, genetic predisposition, personality traits (e.g. impulsivity, sensation seeking), the presence of mental and behavioural disorders, family neglect and abuse, poor attachment to school and the community, social norms and environments conducive to substance use (including the influence of media) and growing up in marginalized and deprived communities.

On the flip side, protective factors that have been established to reduce individual vulnerabilities include: psychological and emotional well-being, personal and social competence, a strong attachment to caring and effective parents, attachment to schools and communities that are well resourced and organized.

2.3.   National Guidelines

The National Guidelines on Alcohol and Drug Use Prevention aims to improve delivery of programs, interventions and policies in Kenya in order to produce positive outcomes for the targeted populations. Interventions and policies are grouped by the settings in which programs are implemented and major developmental stages in the life of an individual from pregnancy, infancy and early childhood, middle childhood, adolescence and adulthood.

The Guidelines do not address secondary and tertiary prevention interventions, including treatment of substance use disorders and the prevention of health and social consequences of substance use and substance use disorders. They do not address law enforcement efforts in drug control.

2.4.   Development Process

The document has been developed with the technical assistance of national representatives drawn from state and non-state organisations. The technical working group met in February 2020 to review the terms of engagement, the scope of the development process and develop the zero draft.

Owing to the coronavirus outbreak, the technical working group held three virtual meetings from September to December 2020. This was followed by an internal validation and presentation of the draft to NACADA management and staff.

The national validation workshop was held in April 2021 and the technical working group retreated in June 2021 to incorporate proposals from stakeholders as well as finalize the document.

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3.0.   GOAL, OBJECTIVES AND SCOPE

3.1.   Goal

The goal of this document is to establish minimum requirements for conducting effective alcohol and drug use prevention programs in schools, families, workplaces, communities and media in Kenya.

3.2.   Objectives

The objectives of this document are to:

a)   Advise on the best practices in prevention interventions and policies;

b)   Ensure professionalism in planning and implementation of prevention interventions;

c)   Provide guidelines and minimum requirements for service providers to ensure recipients of prevention interventions are protected;

d)   Foster development of a national prevention system that will support children, youth and adults in different settings to lead positive, healthy and safe lifestyles.

3.3.   Scope

This document is intended for use by all stakeholders in Kenya involved in the development and implementation of alcohol and drug use prevention interventions. These include relevant government institutions, county governments, development partners, Civil Society Organizations (CSOs), Faith Based Organizations (FBOs), private sector and individuals.

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4.0. PREVENTION STANDARDS AND GUIDING PRINCIPLES

Standard 1: Primary Settings for Prevention Programs

Description: Prevention programs are designed to reach target populations in their primary settings. For the purpose of this document, the primary settings shall include family, school, workplace and community. In addition to setting, prevention programs can also be described by the audience for which they are designed, namely:

- *Universal* programs that are designed for the general population, such as all students in a school;

- *Selective* programs that target groups at risk or subsets of the general population, such as poor academic achievers or children of drug abusers; &

- *Indicated* programs that are designed for people already experimenting with drugs.

This would mean that a program developed or chosen for a particular setting could further target any of the audience indicated above.

a) Family Programs

Family prevention programs can strengthen protective factors among young children by teaching parents/guardians better family communication skills, age-appropriate discipline styles, firm and consistent rule enforcement, and other family management approaches.

Guiding Principles

Principle 1.1: Family-based prevention programs should be based on scientific theory; that is how the problem develops and how a program will change the behaviors, it intends to.

Principle 1.2: The programs should enhance family bonding and relationships and include parenting skills; practice in developing, discussing, and enforcing family policies on substance use; and training in drug education and information.

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Principle 1.3: Family programs are most enduring in effectiveness if they produce changes in the ongoing family dynamics and environment. It must consider the characteristics of the families to be served and the unique design differences in family interventions.

Principle 1.4: The chosen programs should meet the cultural and socio-economic needs of the target population.

Principle 1.5: The programs should match the level of risk in the target population.

Principle 1.6: The programs should match the specific needs of the family.

Principle 1.7: The chosen programs should be age and developmentally appropriate (for parents with children of different ages).

Principle 1.8: The programs should contain adequate intensity and sufficient dosage i.e. enough sessions for parents and children.

Principle 1.9: The programs should be interactive and contain no more than 8-12 families as a general guideline.

Principle 1.10: The program should be delivered by adequately trained personnel.

Principle 1.11: The programs should include strong and systematic monitoring and evaluation components.

b)   **School Programs**

Prevention programs in schools focus on children's social and academic skills, including enhancing peer relationships, self-control and drug-refusal skills. If possible, school-based prevention programs should be integrated into the school's academic program, because poor performance is strongly associated with drug use.

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Integrated programs strengthen students' bonding to school and reduce their likelihood of dropping out. Most school prevention materials include information about correcting the misperception that many students are using drugs. Other types of interventions include school-wide programs that affect the school environment as a whole. All of these activities can serve to strengthen protective factors against drug use.

Guiding Principles

Principle 1.1: School-based prevention programs should be age-specific targeting specific developmental stage and their risk factors.

Principle 1.2: Prevention programs should be designed to intervene as early as preschool to address risk factors for drug use, such as aggressive behaviour, poor social skills, and academic difficulties.

Principle 1.3: Prevention programs for elementary school children should target improving academic and social-emotional learning to address risk factors for drug use, such as early aggression, academic failure, school dropout and academic support, especially in reading.

Principle 1.4: Prevention programs for middle, junior and senior school students should increase academic and social competence, self-efficacy, assertiveness and drug use refusal among other skills.

Principle 1.5: Prevention programs targeting learners should utilize interactive techniques.

c) **Community Programs**

Prevention programs work at the community level with civic, religious, law enforcement and other government organizations to enhance anti-drug use norms and pro-social behaviours. Many programs coordinate prevention efforts across settings to communicate consistent messages through school, work, religious institutions, and the media. Community-based programs also typically include development of policies or enforcement of regulations, mass media efforts, and community-wide awareness programs.

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Guiding Principles

Principle 1.1: Prevention programs aimed at general populations at key transition points, such as the transition to middle school and junior school can produce beneficial effects even among high-risk families and children. Such interventions do not single out risk populations, therefore, reduce labelling, and promote bonding to school and community.

Principle 1.2: Community prevention programs that combine two or more effective programs, such as family-based and school-based programs, can be more effective than a single program alone.

Principle 1.3: Community prevention programs reaching populations in multiple settings—for example, schools, clubs, faith-based organizations, and the media—are most effective when they present consistent, community-wide messages in each setting.

d) **Workplace Programs**

Workplace substance use prevention programs focuses on workplace (on-the-job) and workforce (off-the-job) substance use. This is a transition point from home/school to work where employees are exposed to different risk factors that predispose them to substance use. The programs can be designed to meet the different populations at the workplace namely universal, selective or indicated.

Guiding Principles

Principle 1.1: Program content should be based on proven prevention theory and research.

Principle 1.2: Program should include comprehensive approaches that address multiple risk and protective factors.

Principle 1.3: Provide material that is relevant during important transitions in an employee's life and career.

Principle 1.4: Program should be sensitive to the culture of the workplace and community.

Principle 1.5: Program should provide sufficient dosage and follow-up.

Principle 1.6: Program should make use of interactive teaching techniques.

Principle 1.7: Program should incorporate training for prevention program providers.

Principle 1.8: Program should incorporate monitoring and evaluation to know that the intervention had the desired effect on behaviour.

Standard 2: Risk Factors and Protective Factors

Description: The risk of becoming a substance user involves the relationship among the number and type of risk factors (e.g. deviant attitudes and behaviours) and protective factors (e.g. parental support). The potential impact of specific risk and protective factors changes with age. For example, risk factors within the family have greater impact on a younger child, while association with substance-using peers may be a more significant risk factor for an adolescent.

Early intervention with risk factors (e.g. aggressive behaviour and poor self-control) often has a greater impact than later intervention by changing a child's life path (trajectory) away from problems and toward positive behaviours. While risk and protective factors can affect people of all groups, these factors can have a different effect depending on a person's age, gender, ethnicity, culture, and environment. It is therefore prudent for prevention programs to target risk factors affecting each target group. Baseline assessment helps to identify the needs of the community.

Guiding Principles:

Principle 2.1: Prevention programs should enhance protective factors and reverse or reduce risk factors.

Principle 2.2: Prevention programs should address all forms of substance use, alone or in combination, including the underage use of legal drugs (e.g. tobacco or alcohol); the use of illegal drugs (e.g. marijuana or heroin); and the inappropriate use of legally obtained substances (e.g. inhalants), prescription medications, or over-the-counter drugs.

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Principle 2.3: Prevention programs should address the type of substance use problem in the local community, target modifiable risk factors, and strengthen identified protective factors within the given setting or target group.

Principle 2.4: Prevention programs should be tailored to address risks specific to population or audience characteristics, such as age, gender, and ethnicity, in order to improve program effectiveness.

Standard 3: Age Appropriate Prevention Program and Policies

Description: Prevention programs should be adequate for and tailored to the developmental needs of the specific target/group. They should aim to enhance protective factors and reverse or reduce risk factors for various developmental stages.

Guiding Principles

Principle 3.1: The program content should aim at addressing the specific target group's needs with age specific messages.

Principle 3.2: The program should provide a clear structure that stipulates its duration, length of sessions and frequency of implementation.

Principle 3.3: The method of delivery should bring out appropriate language, and activities relevant to the specific target group.

Principle 3.4: The program should ensure physical and emotional safety of the participants.

Principle 3.5 Programs providing referral for other individualized services should be to child or youth friendly centres.

Standard 4: Professional Ethics in Prevention Programs

Description: All substance use prevention programs should be guided by professional judgement about what is "good" or "bad". Moral values governing the practice cut across all areas and apply to programs

targeting different settings and target groups. Professionals should not assume that drug prevention activities are per definition ethical and beneficial for participants. The standards outline principles of ethical substance use prevention, which focus on different aspects.

Guiding Principles

Principle 4.1: Competence-prevention practitioners should be properly trained and skilled in provision of prevention programs in compliance with ethical standards to avoid misrepresentation in terms of credentialing in the relevant area and licensure where applicable.

Principle 4.2: Confidentiality-should be observed at all times while handling participants' and/or institutions data or information. The practitioner should address issues of confidentiality before initiating the program and further address its limitations such as legal requirement; if a participant is a danger to self or others and in case of abuse of a minor or an elderly person by the participant. This will help to avoid stigma and discrimination.

Principle 4.3: Informed Consent -prevention practitioners should adequately inform the participants of the program objectives, benefits, process, duration and frequency of sessions before implementation. Participation should be voluntary. Adult participants should give their consent to participate in the program. Children/minors should assent while their parents or guardians provide consent for their participation.

Principle 4.4: Beneficence- prevention programs shall be tailored to address risks specific to population or audience characteristics, such as age, gender, and ethnicity in order to improve program effectiveness. Ethical substance use prevention activities may not require physical or clinical intervention, but they represent a form of intervention in people's lives nevertheless. Moreover, prevention is typically targeted at young people, and in the case of selective and indicated prevention, these young people can be among the most vulnerable in society.

Principle 4.5: Non-maleficence- prevention programs shall not cause more harm than good to participants. Harm may be intentional or unintentional. Either way, practitioners should refrain from taking actions that may harm others.

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Principle 4.6: Respect- this calls for unconditional acceptance of participants and being aware of any personal or cultural differences. The practitioner should consider and uphold participants' rights and autonomy as well as dignity.

Principle 4.7: Honesty- prevention practitioners should provide truthful information about the program or research to the target group before implementation, while avoiding misleading information or misrepresentation. It calls for the practitioner to be candid, forthright and worthy of trust.

Standard 5: Inclusivity and Non-discrimination

Prevention programs shall promote active participation of the community in multiple settings e.g. schools, workplaces, membership clubs, places of worship, faith based organizations and the media with consistent, community-wide messages in each setting. In non-discrimination, no prevention services shall be withheld from anyone or anyone be treated differently based on physical or mental ability, education level, economic status, religion, age or gender.

Standard 6: Prevention Program Delivery

Description: Delivery includes program selection or adaptation and implementation. The process starts with baseline or needs assessment and selecting a program that meets the needs of the target population.

Guiding Principles

Principle 6.1: Adaption of programs to match community needs, norms or differing cultural requirements should retain core elements of the original research-based intervention that include:

• Structure (how the program is organized and constructed);

• Content (the information, skills, and strategies of the program); and

• Delivery (how the program is adapted, implemented, and evaluated).

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Principle 6.2: Prevention programs should be long-term with repeated interventions, rather than a single event, to reinforce the prevention goal.

Principle 6.3: School based prevention programs should include teacher training on good classroom management practices, such as rewarding appropriate student behaviour. Such techniques help to foster students' positive behaviour, achievement, academic motivation, and school bonding.

Principle 6.4: Prevention programs are most effective when they employ interactive techniques, such as peer discussion groups and parent role-playing, that allow for active involvement in learning about substance use and reinforcing positive parenting skills.

Standard 7: Monitoring and Evaluation of Prevention programs

Description: Monitoring and evaluation is a crucial component of a program. Monitoring is a continuous process of collecting and analysing information about a program. It addresses the question: "What are we doing?" It tells how well the intervention or program is being implemented. On the other hand, evaluation addresses the question: "What have we achieved?" It is the process that systematically and objectively assesses all elements of the program (design, implementation and results achieved) to determine its overall worth and significance.

Guiding Principles

Principle 7.1: Prevention programs should start with a baseline survey or a needs and resource assessment in the community.

Principle 7.2: Prevention programs should have indicators and expected outcomes.

Principle 7.3: Monitoring and evaluation (M&E) should be linked to the specific program objectives that were designed through the appraisal and program planning process.

Principle 7.4: Monitoring information should be used in decision-making.

Principle 7.5: M&E should respect principles of participation and involve all program stakeholders including implementers and beneficiaries.

Principle 7.6: M&E should respect and protect the rights, welfare and confidentiality of all those involved in the program.

Principle 7.7: M&E should use multiple methods of data collection/gathering to answer the same question.

Standard 8: Effective Prevention Programs

Description: Effectiveness of a program relates to the level by which the activities of a program produce the desired results. The program must be implemented in a given context or setting.

Guiding Principles

Principle 8.1: Program should address multifaceted areas of an individual. Prevention programs shall address all forms of substance use, alone or in combination, including the underage use of legal drugs (e.g. tobacco or alcohol); the use of illegal drugs (e.g. cannabis or heroin); and the inappropriate use of legally obtained substances (e.g. inhalants), prescription medications, or over-the-counter drugs.

Principle 8.2: Comprehensive Services-programs and strategies should include multiple components and affect multiple settings to address a wide range of risk and protective factors of the target problem.

Principle 8.3: Programs should include multiple teaching methods, including some type of active, skills-based component.

Principle 8.4: Sufficient Dosage-participants need to be exposed to enough of the activity for it to have an effect.

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Principle 8.5: Theory Driven-preventive strategies should have scientific or logical rationale.

Principle 8.6: Positive Relationships-programs should foster strong, stable, positive relationships between children and adults.

Principle 8.7: Appropriately Timed-program activities should happen at a time (developmentally) that could have maximum impact in a participant's life.

Principle 8.8: Socio-culturally Relevant-programs should be tailored to fit within cultural beliefs and practices of specific groups, as well as local community norms.

Principle 8.9: Outcome Evaluation-a systematic outcome evaluation is necessary to determine whether a program or strategy worked.

Principle 8.10: Well-Trained Staff- programs need to be implemented by staff members who are sensitive, competent, and have received sufficient training, support, and supervision. Follow up (booster) training and technical assistance to staff are critical.

5.0.   ALCOHOL AND DRUG USE PREVENTION INTERVENTIONS AND POLICIES

5.1.   Family Programs

These prevention programs target children at the family setting. They include:

a)   Prenatal, infancy and early childhood

Pregnancy and motherhood are periods of major and sometimes stressful changes that may make women receptive to address their substance use and substance use disorders. Alcohol and substance use during pregnancy poses potential health risks to pregnant women and to their babies, even in the absence of substance use disorders. All pregnant women should be advised of the potential health risks to themselves and to their babies.

On the other hand, children's earliest interactions occur in the family before they reach school. They may develop vulnerabilities when they experience interaction with parents or caregivers who fail to nurture them. Such circumstances may hinder children from reaching significant developmental competencies and make a child vulnerable and at risk for behavioural disorders later on. The key developmental goals for early childhood are the development of safe attachment to the caregivers, age-appropriate language skills, and executive cognitive functions such as self-regulation and pro-social attitudes and skills. The acquisition of these is best supported within the context of a supportive family and community.

Programs conducted in Kenya for this developmental stage include:

i.   Prenatal care where mothers-to-be visit health care facilities and receive educational sessions on a range of services on health, nutrition and child care;

ii. Postnatal care where mothers visit health care facilities and receive growth monitoring, nutrition, and other health care services;

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iii. Home visits by community health workers where each health worker is assigned a number of households within which they make follow-ups for a range of health-related issues and make referrals to health facilities.

<u>Characteristics associated with positive prevention outcomes</u>

- Delivered by trained health workers;
- Regular visits up to two years of age of the baby, at first every two weeks, then every month and less towards the end;
- Provision of basic parenting skills;
- Supporting mothers to address a range of socio-economic issues.

b) Family skills programs

Family skills programs involve training parents to improve and strengthen parenting skills, training children in personal or social skills. They also involve direct training and practice of skills together as a family. The emphasis here extends beyond parenting to how the parents and children influence each other and function together as a family.

Examples of interventions include Universal Prevention Curriculum, Family Based Prevention Interventions, and Strong Families Program.

<u>Characteristics associated with positive prevention outcomes</u>

- Teach parents to be responsive, provide structure, and be involved in the child's school life;
- Help children build life skills but also help parents reinforce them;
- Help youth to develop an orientation toward the future;
- Children and youth develop effective problem-solving skills;
- Children and youth learn about how to take care of themselves in a healthful way;

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- Teach youth how to interact positively with other people and reinforce values such as respect;

- Youth learn to communicate effectively through active listening and clearly expressing ones needs;

- Teach youth peer resistance skills;
- Characteristically include activities for the parents, the children and the whole family;
- Usually include a series of sessions;
- Delivered by trained individuals, in many cases without any other formal qualification.

Characteristics associated with no or negative prevention outcomes

- Undermine parents' authority;

- Only targets children;

- Delivered by poorly trained staff.

c) Parenting skills programs

Parenting skills programs support parents in being better parents in very simple ways. A warm child-rearing style, where parents set rules for acceptable behaviours, closely monitor free time and friendship patterns, help to acquire personal and social skills, and are role models, is one of the most powerful protective factors against substance use and other risky behaviours. These programs can be delivered also for parents of early adolescents.

Programs conducted in Kenya:

In Kenya, various parenting skills programs have mainly been held by faith-based organizations. However, they have not been evaluated for effectiveness.

Characteristics associated with positive prevention outcomes

- Enhance family bonding, i.e. the attachment between parents and children;

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- Support parents on how to take a more active role in their children's lives, e.g. monitoring their activities and friendships, and being involved in their learning and interactions;

- Support parents on how to provide positive and developmentally appropriate discipline;

- Support parents on how to be a role models to their children;

- Organised in a way to make it easy and appealing for parents to participate (e.g. out-of-office hours (weekends), meals, childcare, transportation, small prize for completing the sessions, etc.);

- Usually include a series of sessions;
- Delivered by trained individuals, in many cases without any formal qualification.

Characteristics associated with no or negative prevention outcomes

- Undermine parents' authority;

- Only provide information to parents about drugs so that they can talk about it with their children;

- Delivered by poorly trained staff.

5.2.   School Programs

The institutions covered in school programs include Early Childhood Development Education (ECDE), primary, secondary and middle/tertiary colleges as well as all technical institutions. Interventions and policies in this section focus on learners in the institutions. The interventions and policies that have been found to yield positive outcomes are grouped according to the age of the target group that represents a major developmental stage in the life of an individual. These stages include early childhood, middle childhood, early adolescence, adolescence and early adulthood.

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a) Early childhood education

In Kenya, early childhood education programs target children from conception to six years and are mainly offered in the formal and informal school settings. The early childhood care and education has been a community effort since independence and the challenges of this approach are still evident in the education sector.

Early childhood care and education centres are under the jurisdiction of county governments. The county government is responsible for infrastructure and employment of teachers while the national government is in charge of policy and curriculum related to ECDE. The formal education for ECDE begin between 4-5 years old subdivided into 2 categories - PP1 composed of 4 year olds and PP2 composed of 5 year olds.

Characteristics associated with positive prevention outcomes

- Improving the cognitive, social and language skills of children;
- Daily sessions;
- Delivered by trained teachers;
- Provision of support to families on other socio-economic issues.

b) Middle childhood

This stage includes Grade 1-6 which comprise of 6 – 11 years who are in primary schools. During middle childhood, increasingly more time is spent away from the family, most often in school and with same age peers. Family remains a key socialization agent. However, the role of school and peer groups start to grow. In this respect, factors such as community norms, school culture and quality of education become increasingly important for safe and healthy emotional, cognitive, and social development. The role of social skills and prosocial attitudes grows in middle childhood and they become key protective factors, influencing the extent to which the school-aged child will cope and bond with school and peers.

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Among the main developmental goals in middle childhood is the continued development of age specific language and numeracy skills, impulse control and self-control. The development of goal directed behaviour, together with decision-making and problem-solving skills, starts. Mental disorders that have their onset during this period (such as anxiety, attention deficit hyperactivity and conduct disorders) may also hinder the development of healthy attachment to school, cooperative play with peers, adaptive learning, and self-regulation. Children of dysfunctional families often start to affiliate at this time with peers involved in potentially harmful behaviours, thus putting themselves at increased risk of alcohol and drug use.

Programs

i.   Life Skills Training Program

Life-Skills Training (LST) is a multi-component substance use prevention curriculum addressing social, psychological, cognitive, and attitudinal factors that are associated with the use of various legal and illegal psychoactive substances. Its primary objective is to enhance the development of basic life skills, personal competence, and skills related to resistance to social influences that promote substance use especially amongst young people.

Characteristics associated with positive prevention outcomes

- Teach learners the necessary skills to resist social (peer) pressures to smoke, drink, and use drugs;

- Help students to develop greater self-esteem and self-confidence;

- Enable learners to effectively cope with anxiety;

- Increase their knowledge of the immediate consequences of substance abuse;

- Enhance cognitive and behavioural competency to reduce and prevent a variety of health risk behaviours.

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ii. Personal and social skills education

During these programs, trained teachers engage learners in interactive activities to give them an opportunity to learn and practice a range of personal and social skills. These programs are normally delivered to all children via a series of structured sessions. They provide opportunities to learn skills to be able to cope with difficult situations in daily life in a safe and healthy way and support the development of general social competencies, including mental and emotional wellbeing.

Programs comprise mostly of developmental components, i.e. they do not include content with regard to specific substances, as in most communities' children at this young age have not initiated use. This is not the case everywhere and programs targeting children who have been exposed to substances (e.g. inhalants) at this very young age might want to refer to the substance specific guidance included for "prevention education based on personal and social skills and social influence" under "adolescence".

Programs conducted in Kenya for this developmental stage include:

i.   Currently the life skills subject/ lesson is mainstreamed into different learning subjects from grade 1-6. In grade 4, the lesson is infused in the following subjects: English, Kiswahili, Kenyan sign language and Music.

ii.   The Government of Kenya has also developed a number of policies that seek to provide a framework for equipping learners with life skills so that they can make responsible choices and avoid various problem behaviours e.g. National Guidelines for Alcohol and Substance Use Prevention and Management in Basic Education Institutions (2021).

iii. A number of civil society organizations and faith-based organizations are implementing various programs in learning institutions that seek to equip learners with relevant life skills so that they can make responsible choices.

Characteristics associated with positive prevention outcomes

- Improves a range of personal and social skills;
- Delivered through a series of structured sessions, often providing booster sessions over multiple years;
- Delivered by trained teachers or facilitators;
- Sessions are primarily interactive.

Characteristics associated with no or negative prevention outcomes
- Using non-interactive methods, such as lecturing as main delivery method;
- Providing information on specific substances including fear arousal;
- Focus only on the building of self-esteem and on emotional education.

iii. Classroom environment improvement programs

These programs strengthen the classroom management abilities of teachers and support children to socialize in their role as students, whilst reducing early aggressive and disruptive behaviours. Teachers are supported to implement a collection of non-instructional classroom procedures in the day-to-day practices with all students for the purposes of teaching pro-social behaviour as well as preventing and reducing inappropriate behaviour. These programs facilitate both academic and socio-emotional learning. They are universal as they target the whole class with a developmental component.

Policies/Programs conducted in Kenya to address this area include:

i. The Ministry of Education through the Teachers Service Commission (TSC) and Kenya Institute of Curriculum Development (KICD) conducts capacity-building programs for teachers on various aspects including classroom management.

ii. The Government of Kenya has also developed a number of policies and guidelines that seek to ensure that the school environment is conducive for learning such as:

- Child Friendly Schools Manual, 2006

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- Safety Standards Manual, 2008

- Sector Policy for Learners and Trainees with Disabilities, 2018

Characteristics associated with positive prevention outcomes

- Often delivered during the first school years;

- Include strategies to respond to inappropriate behaviour;

- Include strategies to acknowledge appropriate behaviour;

- Include feedback on expectations;

- Active engagement of learners.

iv. Policies to retain children in school

School attendance, attachment to school, and the achievement of age-appropriate language and numeracy skills are important protective factors for substance use among children of this age. Various policies has been implemented to support the attendance of children and improve their educational outcomes.

The Government of Kenya has collaborated with key stakeholders to implement various programs and policies that seek to enhance the learner's language and numeracy skills.

Programs conducted in Kenya to address this area include:

i.   Tusome Program by RTI-USAID focusing on boosting literacy skills at early years of learning (Grade 1-3);

ii. Kenya Primary Education Development (PRIEDE) Project focusing on numeracy skills for primary school students for grade 1-3;

iii. Spelling Bee competition focusing on literacy skills for learners on writing and speaking and confidence building;

iv. Sanitary towels programs focusing on provision of sanitary towels by the Ministry of Education (MoE) and National Government Affirmative Action Fund (NGAAF);

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v.   Secondary Education Quality Improvement Project (SEQIP) focusing on improving infrastructure in schools and other targeted interventions in specific counties that are in the hard-to-reach areas;

vi. School Bursary programs implemented by Equity Bank (Wings to Fly), Cooperative Bank, County Governments and National Government Constituency Development Fund (NG-CDF);

vii. Conditional Cash transfer programs which can be used to buy uniforms and bags to address barriers to education;

viii. School Based Deworming Programme by Ministries of Health and Education;

ix. Free day secondary education whereby learners in day secondary school fees is paid for by the government;

x.   Free primary education that calls for affordability of and equitable access for education for all in Kenya;

xi. Textbook supply for core subjects in secondary and for all subjects in primary schools;

xii. School meals - mainly in arid and semi-arid lands where children are provided with free meals by the ministry while other schools the meals are provided by parents.

c) Adolescence

Adolescence is a developmental period when youth are exposed to new ideas and behaviours through increased associations with people and organizations beyond those in childhood. It is a time to "try out" adult roles and responsibilities. It is also a time when the "plasticity" and malleability of the adolescent brain suggests that interventions can reinforce or alter earlier experiences.

The desire to assume adult roles and more independence at a time when significant changes are occurring in the adolescent brain also creates a potentially opportune time for poorly thought-out decisions and

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involvement in potentially harmful behaviours. Such behaviours may include risky sexual behaviours, smoking of tobacco, consumption of alcohol, risky driving behaviours, and drug use.

The substance use (or other potentially harmful behaviours) of peers, as well as rejection by peers, are important influences on behaviour, although parental influence remains significant. Healthy attitudes and social normative beliefs related to psychoactive substance use are also important protective factors against alcohol and drug use. Good social skills, resilient mental and emotional health remain key protective factors throughout adolescence.

In Kenya, adolescence includes children in Grades 7-9 (ages 12-14 years) which is Junior Secondary as well as Grades 10-12 which is senior secondary (ages 15-17 years).

Programs conducted in Kenya include:

i)   Addressing mental health disorders

Emotional disorders (e.g. anxiety, depression) and behavioural disorders (e.g. ADHD, conduct disorder) are associated with higher risk of substance use later in adolescence and in life. Supporting children, adolescents and parents to address emotional and behavioural disorders as early as possible is an important prevention strategy.

Kenya Mental Health Policy 2015-2030 provides for a framework on interventions for securing mental health systems reforms. It proposes that every level 4-5 health facility should provide services on mental health disorders and psychological vulnerabilities. Currently, programs targeting the adolescent are limited.

ii)   Prevention education based on social competence and influence

In skills-based prevention programs, trained teachers engage students in interactive activities to give them the opportunity to learn and practice a range of personal and social skills (social competence). These programs focus on fostering substance use and peer refusal

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abilities that allow young people to counter social pressures to use substances and in general cope with challenging situations in a healthy way.

In addition, they provide the opportunity to discuss in age-appropriate settings, the different social norms, attitudes, and positive and negative expectations associated with substance use, including the consequences of substance use. They also aim to change normative beliefs on substance use addressing the typical prevalence and social acceptability of substance use among the peers (social influence).

Programs conducted in Kenya include

i.   Life Skills Training (LST) as described in earlier sections;

ii.   Policy guiding substance use prevention programs such as the National Guidelines for Alcohol and Substance Use Prevention and Management in Basic Learning Institutions, 2021;

iii. Programs by non-government organizations and actors implemented in education institutions.

Characteristics associated with positive prevention outcomes

- Use interactive methods;

- Delivered through a series of structured sessions (typically 10-15) once a week often providing booster sessions over multiple years;

- Delivered by a trained facilitator (also including trained peers);

- Provide opportunity to practice and learn a wide array of personal and social skills including coping with anger and anxiety, decision making and resistance skills and particularly in relation to substance use;

- Impact perceptions of risks associated with substance use emphasizing immediate consequences;

- Dispel misconceptions regarding the normative nature and expectations linked to substance use.

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<u>Characteristics associated with no or negative prevention outcomes</u>

- Utilise non-interactive methods such as lecturing as the primary delivery strategy;

- Information-giving alone, particularly fear arousal;

- Based on unstructured dialogue sessions;

- Focus only on the building of self-esteem and emotional education;

- Address only ethical/ moral decision making or values;

- Use ex-alcohol and drug users as testimonials.

iii)   **School policies and culture on substance use**

School policies on substance use dictate that both students and staff should not use on school premises and during school functions and activities substances. Policies also create transparent and non-punitive mechanisms to address incidents of use transforming it into an educational and health promoting opportunity. These interventions and policies are universal, but may also include indicated components such as screening, brief interventions and referral. They are often implemented jointly with other prevention interventions such as skills-based education and/or school-wide policies to promote school attachment and/or supporting parenting skills and parental involvement.

Programs conducted in Kenya include:

A number of policy documents are in place to provide a framework for addressing positive school environment and incident management in schools such as the:

i.   Kenya School Health Policy, 2018;&

ii.   National Guidelines for Alcohol and Substance Use Prevention and Management in Basic Learning Institutions, 2021.

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<u>Characteristics associated with positive prevention outcomes</u>

- Supports normal school functioning not disruption;

- Policies developed with the involvement of all stakeholders (students, teachers, staff, parents);

- Policies clearly specifying the substances that are targeted, as well as the locations (school premises) and/or occasions (school functions) the policy applies to;

- Applies to all in the school (student, teachers, staff, visitors, etc) and to all psychoactive substances (alcohol, tobacco, other drugs);

- Addresses violations of policies with positive sanctions by providing or referring to counselling, treatment and other health care and psycho-social services rather than punishing;

- Enforce consistently and promptly including positive reinforcement for policy compliance.

<u>Characteristics associated with no or negative prevention outcomes</u>

- Inclusion of random drug testing not linked to any comprehensive program.

iv)   **School-wide programs to enhance school attachment**

School-wide programs are aimed at enhancing school attachment, support student participation, positive bonding and commitment to school. These interventions and policies are universal. They are often implemented jointly with other prevention interventions such as skills-based education and/or school policies on substance use and/or supporting parenting skills and parental involvement.

Programs conducted in Kenya include:

The Ministry of Education has implemented various programs that seek to enhance the learner's attachment to school. Some of these programs include:

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i.   Competency Based Curriculum (CBC) - This curriculum is learner centred and seeks to enhance the participation of learners in the education cycle (This has integrated Tusome and PRIEDE project);

ii. Student Councils - The chair of the student council is a member of Board of Management thus representing the interests of learners as per the Basic Education Act (2013).

<u>Characteristics associated with positive prevention outcomes</u>

- Support positive school philosophy and commitment to school;

- Support student participation.

v)   Addressing individual psychological vulnerabilities

Some personality traits such as sensation seeking, impulsivity, neuroticism and are associated with increased risk of substance use. Prevention programs addressing individual psychological vulnerabilities help adolescents that are particularly at-risk to deal constructively with emotions arising from their personalities instead of using negative coping strategies such as hazardous and harmful alcohol and drug use. They are mostly comprised of developmental components.

<u>Characteristics associated with positive prevention outcomes</u>

- Delivered by trained professionals (e.g. psychologist, counsellor, teacher);

- Participants have been identified as possessing specific personality traits on the basis of validated instruments;

- Programs are organized in such a way to avoid any possible stigmatization;

- Provide participants with skills on how to positively cope with the emotions arising from their personality;

- Short series (2-5 sessions).

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d) Early Adulthood

This section covers young adults in tertiary institutions. As adolescents grow, interventions delivered in settings other than the family and the school, such as the workplace, the health sector, entertainment venues and the community become more relevant.

Interventions and policies in schools for early adolescents also apply to older adolescents.

Programs conducted in Kenya include:

i.   Addressing individual psychological vulnerabilities (as described earlier);

ii. Alcohol and tobacco policies – these provide direction on production, packaging, sales and advertisement of alcoholic beverages and tobacco control; (described under community programs);

iii. Programs targeting entertainment venues.

5.3.   Workplace Programs

The vast majority of substance use occurs among working adults. Substance use disorders expose employees to health risks and difficulties in their relationship with colleagues, friends and family, as well as safety risks within the workplace. Young adults are at high risk as job strain is a risk factor to developing substance use disorders among young adults using alcohol/drugs.

Conversely, employers also bear a significant cost of substance use. Employees with substance use problems have higher absenteeism rate and lower productivity, are more likely to cause accidents, and have higher health care costs and turnover rates. Moreover, employers have a duty to provide and maintain a safe and healthy workplace in accordance with the applicable law and regulations.

Prevention programs in Kenya are multi-component, including prevention elements and policies, as well as counselling and referral to treatment. Public Sector Institutions (PSIs) in Kenya have been

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implementing workplace alcohol and drug abuse prevention programs since 2009 as a cross cutting issue. They include:

a)   Development and Implementation of Alcohol and Drug Abuse Prevention and Management Policies

These are written plans outlining goals, procedures and course of action to guide decisions regarding alcohol and drug abuse within the workplace and workforce. They address alcohol & drug prevention for all employees, the entire prevention continuum and involve all key stakeholders in their development.

Policies/Programs conducted in Kenya include:

i.   Guidelines for Developing Workplace Alcohol and Drug Abuse Prevention and Management Policies (NACADA, 2020);

ii.   Human Resource Policies and Procedures Manual for the Public Service, 2016.

b) Employee Assistance Programs (EAPs)

These are programs designed to enhance employee and workplace effectiveness through prevention, identification and resolution of personal and productivity issues. They may be stand-alone programs or integrated in other existing programs such as health and wellness programs.

Policies/Programs conducted in Kenya include:

i.   Human Resource Policies and Procedures Manual for the Public Service, 2016;

ii.   Institutional specific Employee Assistance Programs (EAPs) and/ or brief interventions.

c) Brief Interventions and Treatment Referral

Brief intervention consists of one-to-one counselling sessions that may include follow up sessions or additional take home information. Trained health and social workers should deliver them targeting people at risk because of their substance use but who would not necessarily

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seek treatment. In addition, they should target people at risk because of their substance use but do not necessarily seek treatment. The sessions identify whether there is a substance use problem and provide immediate appropriate basic counselling and/or referral services. The sessions are structured ranging from 2-6 sessions based on individual scores and levels and last between 15 to 30 minutes.

Brief interventions are offered within the primary health care system or in emergency rooms. They are also effective when delivered as part of the school-based or workplace programs, online or through telephone services.

Brief intervention sessions employ motivational interviewing techniques which are a psycho-social intervention where the substance use of a person is discussed and the patient is supported in making decisions and setting goals about his/her substance use. They are delivered in up to 6 sessions that can be up to 1-hour long. These may be integrated in Employee Wellness, EAPs or stand-alone interventions.

Employees at high risk of developing SUDs are offered short time counselling and education sessions while others are referred to treatment facilities.

Other measures in place include:

i.   Comprehensive medical cover that caters for wellness of employees including alcohol and drug abuse treatment and rehabilitation;

ii.   National Hospital Insurance Fund (NHIF) accreditation of alcohol and drug abuse treatment facilities to cater for substance use disorders;

iii. Classification of alcoholism as a disease through the Alcoholic Drinks Control Amendment Act 2010, revised in 2015.

Note: Monitoring and evaluation of intervention programs is crucial to check inclusion of universal, selective, indicated and treatment/maintenance as part of the prevention and management of alcohol and drug related problems in the workplace.

<u>Characteristics associated with positive prevention outcomes</u>

- Involvement of all stakeholders in the development process (employers, management, employees);

- Guarantee confidentiality to employees;

- Include and are based on a policy on substance abuse management in the workplace that has been developed by all stakeholders and is non-punitive;

- Provide brief interventions (including web-based) as well as counselling, referral to treatment and reintegration services to employees who need them;

- Include a clear communication component;

- Embedded in other health or wellness related programs (e.g. for the prevention of cardiovascular diseases);

- Include stress management courses;

- Trains managers, employees and health workers in fulfilling their roles in the program;

- Include alcohol and drug testing only as part of a comprehensive program with the characteristics described above.

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5.4.   COMMUNITY PROGRAMS

Community prevention programs aim to enhance anti-drug norms and pro-social behaviours. As indicated earlier in the document, many programs coordinate prevention efforts across settings to communicate consistent messages through school, work, faith-based or religious institutions, and the media. Furthermore, community-based programs also include development of policies or enforcement of regulations, mass media efforts, and community-wide awareness programs.

Policies/Programs conducted in Kenya include:

a)   **Tobacco and Alcohol Policies**

These include a series of policies to be delivered at the population level to reduce the availability and accessibility of alcohol and tobacco products. Such policies include tax and pricing policies, control of access and availability, control of drunk driving, provision of alcohol-free environments for persons under the age of 18 years, control of labelling, packaging, regulation of marketing and advertising.

Kenya has enacted and implemented a range of policies to address availability and accessibility of alcohol and tobacco products. Kenya is a signatory to the World Health Organisation (WHO) Framework Convention on Tobacco Control (2003) and has the Tobacco Control Act (2007). The Act outlines various strategies that guide on accessibility and availability of tobacco and tobacco products as well as promote early intervention and treatment.

In relation to tobacco, the policies include:

i.   Tax and Price Control Policy whereby the Government annually reviews its tobacco tax rates upwards translating to an increase in tobacco and tobacco product prices;

ii.   Prohibition of sale to minors (under 18 years) and display of warning signs at points of sale. In addition, prohibition of single-stick and automated vending machine sales;

iii. Prescribed messages and a statement as on the constituent on all tobacco product packs;

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iv.   Comprehensive ban on advertising, promotion and sponsorship to restrict the use of direct or indirect incentives that encourage the purchase of tobacco products by the public;

v.   Promotion of economically viable alternatives for tobacco workers and growers to reduce the supply of tobacco;

vi.   Inclusion of tobacco effects and control programs in the school curriculum;

vii. Prohibition of smoking in public places apart from within the designated smoking zones;

viii. Multi-agency collaboration on enforcement of existing laws, policies and regulations;

ix.   With the support of like-minded stakeholders, development of guidelines to support healthcare workers in screening, assessment, offering brief interventions and intensive interventions

In relation to alcohol control, policies include:

The enactment of the Alcoholic Drinks Control Act (2010) to regulate and control manufacture, sale and consumption of alcoholic drinks. Consequently, a number of Counties have enacted County Alcoholic Drinks Control Acts. Components include:

i.   Prohibition of promotion of alcoholic beverages at any event associated with persons under the age of 18 years;

ii.   Display clear and prominent notices in English or Kiswahili stating that purchase of alcoholic drinks is prohibited for persons under the age of 18 years

iii. Public awareness about the health consequences, addictive nature and mortal threat posed by excessive alcoholic drink consumption through a comprehensive nation-wide education and information campaign conducted by the Government through the relevant Ministries, departments, authorities and other agencies including the relevant non-governmental organizations and civil society.

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iv.   Prohibition of issuance of licences to sell alcoholic drinks in or near any institution of basic education including primary and secondary schools or any residential area as have been demarcated.

Characteristics associated with positive prevention outcomes

- Increase in the price of tobacco and alcohol through taxation;

- Increase in the minimum age of sale of tobacco and alcohol products; Prevent sale of tobacco and alcohol to young people under the legal age through comprehensive programs including active and ongoing law enforcement and education of retailers through a variety of strategies (personal contact, media and information materials);

- Bans advertisement of tobacco and restricted advertisement of alcohol

b)   Community-based multi-component initiatives

At the community level, mobilization efforts to create partnerships, task forces, coalitions, action groups, etc. bring together different actors in a community to address substance use. Some community partnerships are spontaneous. However, the existence of community partnerships on a large scale is normally the product of a special program providing financial and technical support to communities to deliver and sustain evidence-based prevention interventions and policies over time. Community-based initiatives are normally multi-component, taking action in different settings (e.g. schools, families, media, enforcement etc.).

In Kenya, alcoholic beverage laws require that members of the community be involved in licensing of alcoholic drinks selling outlets to allow them protect their localities. Members of the community can object to licensing of premises if it affects their locality or where outlets are located within residential areas. Members of the communities are nominated to sit in licensing committees and boards.

Characteristics associated with positive prevention outcomes

- Support the enforcement of tobacco and alcohol policies at the local level;

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- Work in a range of community settings (families and schools, workplace, entertainment venues etc);

- Involve institutions of higher learning to support the implementation of evidence-based programs and their monitoring and evaluation;

- Adequate training and resources are provided in the communities;

- Initiatives are sustained in the medium term such as having annual consultative forums/symposium to facilitate information sharing.

c) Media campaigns

Media campaigns are often the first and/or only intervention delivered by policy makers concerned with preventing the use of drugs in a population, as they are visible and have the potential to reach a large number of people relatively easily.

Policies/Programs conducted in Kenya include:

The Ministry of Education implements radio programs for primary and secondary school children targeting specific age groups to disseminate information on drug use prevention as part of the school curriculum.

Characteristics associated with positive prevention outcomes

- Precisely identify the target group of the campaign;

- Based on a solid theoretical basis;

- Design age-appropriate messages on the basis of strong formative research;

- Strongly connect to other existing drug prevention programs in the home, school and community;

- Achieve adequate exposure of the target group for a long period of time;

- Systematically evaluated;

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- Target parents, as this appears to have an independent effect also on the children;

- Aim at changing cultural norms about substance use and/or educating about the consequences of substance use and/or suggesting strategies to resist substance use.

<u>Characteristics associated with no or negative prevention outcomes</u>

- Media campaigns that are badly designed or poorly resourced should be avoided as they can worsen the situation by making the target group resistant to or dismissive of other interventions and policies.

d) **Entertainment venues**

Entertainment venues include bars, clubs, restaurants as well as outdoor or special settings where large-scale events may occur. These venues can have both positive and negative impact on the health and wellbeing of citizens, as they provide social meeting spaces and support the local economy, but at the same time, they are identified as high-risk settings for many risky behaviours, such as alcohol and drug use, drunk driving and aggression.

Most prevention programs utilizing entertainment venues have multiple components including different combinations of training of staff and managers. The focus is on management of intoxicated patrons; changes in laws and policies, e.g. with regard to serving alcohol to minors or to intoxicated persons, or with regard to driving under influence of alcohol and/or drugs; high visibility enforcement of existing laws and policies. They also include communication to raise awareness and acceptance of the program and to change attitudes and norms; and, offering treatment to managers and staff.

Policies/Programs conducted in Kenya include:

i.   The Alcoholic Drinks Control Act of 2010 requires sellers to put up signage indicating that availing of alcoholic drinks to persons under 18 years is prohibited.

ii. Relevant government regulatory agencies undertake periodic spot checks on entertainment venues to evaluate and monitor compliance to regulations.

<u>Characteristics associated with positive prevention outcomes</u>

- Train staff and management on responsible serving and handling of intoxicated clients;

- Provides counselling and treatment for staff and management who need it;

- Includes a strong communication component to raise the awareness and the acceptance of the programme;

- Includes the active participation of the law enforcement, health and social sectors;

- Enforces existing laws and policies on substance use in the venues and in the community.

6.0.   PREVENTION ISSUES REQUIRING FURTHER RESEARCH

a) **After-school activities, sports and other structured leisure time activities**

In many communities, it is popular to organize sports and other drug or substance free leisure time activities as a way to give adolescents prosocial and healthy pursuits, preventing them from engaging in risky behaviours including drug use.

Several studies indicate that that bringing together high-risk youths may have adverse effects as is often the case where after-school programs target youths from poor socio-economic backgrounds or youths with behavioural problems. Participation in sports per se is not always associated with lower rates of substance use and it has been linked to higher rates of smoking and binge drinking.

On the other hand, there exist examples of programs where sport coaching is used as a setting to deliver personal and social skills education such as the Line Up Live Up currently being piloted by UNODC in Africa and Latin America.

In general, policy makers should exercise the utmost caution if choosing to implement this kind of intervention, including a strong research component to assess the impact.

b) **Monitoring and evaluation of prevention programs**

There are different prevention programs implemented by different stakeholders such as the NGOs, FBOs, public and private institutions among others, in different settings such as the family, schools, workplace and the community. These programs should be evaluated for effectiveness to inform further implementation or revision.

c) **Preventing the non-medical use of prescription drugs**

The non-medical use of prescription drugs controlled under the Conventions and the non-medical use of medicines sold over the counter is an increasing problem in many countries. Indeed, school-based surveys by NACADA indicate a growing problem among

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adolescents in prescription drug abuse. Other at risk groups that may be predisposed to prescription drug abuse include street families and healthcare professionals.

Further research is required to establish level of non-medical use of prescription drugs among various populations.

d) Interventions and policies targeting children and youth particularly at risk

This group includes out-of-school children and youth, street children, children and youth of displaced or post-conflict populations, children and youth in foster care, in orphanages and in the juvenile justice system.

It is highly recommended that research be conducted in this area to evaluate effectiveness of the interventions and policies.

e) Interventions and policies targeting families

Families are an important setting to reach out to parents and their children. However, research in this setting is lacking. On the other hand, faith-based organizations implement a number of programs that have not been evaluated.

It is recommended that research be conducted in this area to evaluate effectiveness of these interventions.

f) The influence of media

Exposure to media exerts a profound influence on the psychosocial development of young people. In particular, popular culture (e.g. celebrities, film and music) can strongly influence the initiation of risky behaviours such as alcohol and tobacco use. Several potential mechanisms may explain this influence, including a desire to acquire the traits that make celebrities special or the spread of behaviours throughout social networks. Due to the unique neurodevelopmental context of young people, they are particularly susceptible to the influence of popular culture and their actions are not simply a result of health illiteracy.

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Although this topic is not covered in this document, further research to examine the issue more closely would be warranted. It should be noted that the evidence available on the effectiveness of mass media campaigns is extremely limited. Hence, more research on the effectiveness of mass media campaign is imperative.

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