



**KNOWLEDGE, ATTITUDES AND PRACTICES OF
CHRISTIAN FBOs ON ALCOHOL AND DRUG
ABUSE**

By

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ABBREVIATIONS/ACRONYMS

ADA	Alcohol and Drugs Abuse
AIDS	Acquired Immuno-Deficiency Syndrome
CBO	Community-Based Organization
EAK	Evangelical Alliance of Kenya
FBO	Faith-Based Organizations
FGD	Focus Group Discussion
HCK	Hindu Council of Kenya
HIV	Human Immuno-deficiency Virus
IDI	In-Depth Interview
IEC	Information Education and Communication
KEC-CS	Kenya Episcopal Conference-Catholic Secretariat
NACADA	National Authority for the Campaign against Alcohol and Drug Abuse
NAMLEF	National Muslim Leaders Forum
NCCK	National Council of Churches of Kenya
OAIC	Organization of African Instituted Churches
SDA	Seventh Day Adventist Church
SUPKEM	Supreme Council of Kenya Muslims

EXECUTIVE SUMMARY

More than 82% of the Kenyan population is classified as Christians; these are members belonging to one of the many religious groups in the country. These religious groups have established structures across the country to help support community outreach activities – they run schools, health care facilities, community development projects, among others and are widely felt in policy circles especially in relation to health care provision and education. The voice of Faith Based Organizations (FBOs) in combating alcohol and drug use, however, is rarely felt in policy in circles.

The *primary goal* of this research was to assess the knowledge, attitudes and practices of FBOs in addressing alcohol and drug abuse related issues in the country with the following three as the guiding research questions: (i) What is the level of knowledge of FBOs regarding alcohol and drug abuse?; (ii) What is the attitude of FBOs towards alcohol and drug abuse?; and (iii) What are the practices of FBOs regarding alcohol and drug abuse? The *overall objective* was to generate data to enhance understanding of the response of Christian FBOs towards alcohol and drugs abuse. Specifically, the study addresses the following *five specific objectives*: (i) assess the level of *knowledge* of FBOs regarding alcohol and drug abuse; (ii) assess the *attitude* of FBOs towards alcohol and drug abuse; (iii) profile *practices* of FBOs regarding alcohol and drug abuse; (iv) *determine how NACADA can effectively engage* with FBOs to address alcohol and drug related problems in society; and (v) *make recommendation* to facilitate targeted response by FBOs to address alcohol and drug abuse in the community.

A total of 400 respondents (63.8% male & 36.3% female) aged between 22 to 67 years were interviewed and supplemented with data from 80 IDIs with the FBO leadership as well as 24 FGDs with members of the various church congregations. The FBOs were selected from each of the eight regions of the country and were selected to cover national, regional and local FBOs. *First*, quantitative data generated through a structured questionnaire was used to generate information on the knowledge, attitudes and practices of FBOs in relation to alcohol and drug abuse among different congregations. The questionnaire was administered face-to-face using trained research assistants. *Second*, qualitative data generated through in-depth interviews from FBO leaders and focus group discussions with members of various congregations elicited in-depth information on knowledge, attitudes and practices of FBOs on alcohol and drug abuse. FGD data provided community perspectives regarding FBOs and alcohol and drug use.

Close to three in four of the respondents were married or living with a partner while about one quarter identified themselves as single (never been married). The remaining were either widowed (4.0%), divorced or separated from their spouses (0.5%). As expected, a majority of the FBO leaders (most of them elders – 39% or pastors - 20.5%) were educated beyond secondary school and others with a college or higher education (58.8%). More than half of the leaders had served for a period of less than five years in the church.

Generally, the FBO leaders reported that they have adequate knowledge on substances of abuse to enable effective communication on issues relating alcohol and drugs. However, from the community's perspective, the FBO leaders needed more information so as to make them more

effective at their work. Further, more information on prescription drugs could complement the knowledge they already possess regarding substances of abuse. There are differences in reported levels of substance of abuse. Although the leaders tend to agree that use of heroin, inhalants and prescription drugs is low among congregants and the community in general, there is less agreement on tobacco use, alcohol consumption, marijuana and *kebat* use among the two groups, namely the congregants and the community.

The FBO leaders' attitudes towards those who are addicted to alcohol and drugs is generally positive. A majority of those interviewed supported the idea that those addicted should not be dismissed from work. However, they also indicated that the family/community did not provide an adequately supportive environment for those addicted. The clergy were clear in their message that they should be concerned about the level of substance abuse in the country. More than nine in ten of the FBO leaders disagreed with the statement that the clergy should not be concerned on a private matter such as alcohol and drug use.

Close to 90% of the FBO leaders indicated that their churches expressly prohibited church members from consumption of alcohol and drugs. Nonetheless, a large majority (87.5%) of those interviewed reported that the prohibition was not part of any vows members are made to take on formal admission into the church register while 12.5% reported that the prohibition was part of the vows taken before such admission. In terms of practice, a significant finding from this survey is that one in ten of the FBO leaders (13.5%) had never talked about alcohol and drug abuse to their congregations, thereby missing opportunities to contribute to the fight against alcohol and drugs abuse.

Based on these findings, the following conclusions are drawn: (i) The clergy are generally knowledgeable of issues of alcohol and drugs abuse within their congregations as well as in their various communities; (ii) The clergy perceive their congregational members as being at low risk of alcohol and drug abuse compared to those in the community, implying that they perceive the problem as being outside the church rather than within; (iii) The clergy have a positive disposition towards those who abuse alcohol and drugs and are willing to accept and help them get out of addiction; and (iv) A fair proportion of the clergy do not address issues on alcohol and drugs abuse to their congregations regularly. In fact among the clergy, one in four have not broached this topic to their congregations.

Consequently, the following recommendations are made: *First*, there is need for NACADA to equip these groups with IEC materials as a way of augmenting FBO leaders' knowledge so that they are better able to handle substance abuse related problems. *Second*, in order for anti-alcohol and drugs abuse campaigns to be effective, NACADA should work closely with the FBO leaders in order to sensitize them regarding the need to constantly educate their congregations about the dangers of alcohol and drugs abuse. *Lastly*, efforts towards elimination of alcohol and drug abuse should be built on a multi-pronged system imparting appropriate knowledge to the clergy through provision of IEC materials among others, enforcing of the existing legal provisions including streamlining licensing of premises and establishing and supporting structures to facilitate rehabilitation of those who abuse alcohol and drugs.

1.0 BACKGROUND TO THE STUDY

1.1 Background

More than 82% of the Kenyan population is classified as Christians leaving the remaining 18% to be shared among the other religious groups, namely Muslims (11.2%), traditional African religions (5%), and Hindu/Sikh/Baha'i/Jewish (1%)¹. Consequently, in absolute figures, one can make the argument that most of the alcohol and drug related problems might be appropriately assigned to those who profess the Christian faith. Religious groups have established structures across the country to help support community outreach activities. They run schools, health care facilities, community development projects, among others. Their presence in policy circles especially in relation to health care provision and education sector is widely acknowledged. For example, in the health care sector, FBOs own about one-quarter of the non-public health facilities consisting of clinics and dispensaries (level 2), health centers (level 3) and hospitals (level 4) (Luoma *et al.*, 2010). Unfortunately, the voice of the Faith Based Organizations² (FBOs) in combating the problems relating to alcohol and drug use is rarely felt in policy circles. In spite of the rampant nature of alcohol and drugs abuse, the church has remained largely silent for most of the time only rarely coming out to voice their concern when there is an incident grabbing national attention such as the recent methanol related deaths. The primary goal of this research was to assess the knowledge, attitudes and practices of FBOs addressing alcohol and drug abuse related issues in the country.

NACADA has previously engaged with FBOs on its various activities. The organizations it has worked with include Christian organizations – Seventh Day Adventist (SDA) Church, the Kenya Episcopal Conference-Catholic Secretariat (KEC-CS), National Council of Churches of Kenya (NCCCK), Evangelical Alliance of Kenya (EAK), and Organization of African Instituted Churches (OAIC Kenya); Muslims – Supreme Council of Kenya Muslims (SUPKEM), Kenya Muslims National Advisory Council and National Muslim Leaders Forum (NAMLEF); and the Hindu Council of Kenya (HCK).

1.2 Problem Statement and Justification

The problem of alcohol and drug use among the faithful is recognized as having a negative effect on individuals, families and communities in general. Alcohol and drugs in particular lead to many negative outcomes including high school dropouts, and low productivity within communities in general and individuals who are dependent on alcohol and/or drugs have poor outcomes on key indicators such as schooling, job retention, health and social wellbeing. To show its resolve to address the problems caused by alcohol and drugs abuse, the Government of Kenya in the financial year 2012/2013 allocated close to Kenya Shillings one billion to facilitate NACADA's activities

¹www.state.gov/md2962.htm

² Faith Based Organizations or FBOs are organizations which subscribe to the principles or teachings of specific religious groups or those that explicitly include religious identity in their mission statement. FBOs, therefore, are used in this proposal to include Church groups (both the Clergy and the Laity) as well as non-governmental organizations that subscribe to specific religious teachings of a particular religious group. For the purpose of this call, the focus will be on Christian FBOs. Thus, those that belong to the Muslim Faith, such as Muhuri and other religious groups will be excluded.

against alcohol and drugs abuse³. The amount allocated to NACADA is over and above funds allocated to other government departments such as the Police and Judiciary which play a supportive role towards the war against alcohol and drugs abuse. On its part, the church has a role to play in ensuring that the laity are well nurtured and that based on Biblical teachings the believers treat their bodies as the temple of Christ, which should be left pure and uncontaminated. In the Book of Proverbs⁴, the wise King Solomon admonishes against the consumption of wine because it makes one foolish.

One expects that with these clear Biblical positions, Christian FBOs and in particular the clergy would take the lead in addressing the problem of alcohol and drugs in order to uphold the purity of the “temple of Christ”. The laity on the other hand would be expected to ensure and maintain their bodies as the “temple of Christ”. However, the level of alcohol and drug use among the faithful and especially among Christians is high. In a recent national survey, among those aged 15-65 years 13.7% of Christians compared to 7% of Muslims reported use of alcohol while 2.4% compared to 20.1% reported use of *Khat* (NACADA, 2012a) an indication of the possible link between religion and specific aspects of current alcohol and drug use.

There is greater trust in congregations regarding the role/function of FBOs (Wuthnow, Hackett & Hsu, 2004). In fact, Francis and Liverpool (2009) have shown a higher community endorsement of the educative role of FBOs especially on matters dealing with use of alcohol or injectable drugs and substances. Due to their important role in the community and the high likelihood of influencing alcohol and drug use trends and in influencing policy, the study was designed to assess knowledge, attitudes and practices of FBOs in relation to alcohol and drug abuse. Knowledge influences attitudes and practices. The study generates data to help us understand the problem of alcohol and drug use from two perspectives, namely, from the position of the clergy and from the position of the laity.

By assessing the Christian FBO knowledge, attitudes and practices the findings from this study fills in a major gap in our understanding on how FBOs have responded to alcohol and drug related issues within their respective communities in general and their congregations in particular. Further, the study generates information to inform NACADA and other agencies in formulating appropriate strategies in order to effectively engage with the Christian FBO groups. Third, the information will help policy makers to design effective responses targeting Christian FBOs and religious congregations.

1.3 Research Questions and Objectives

The research sought to bring out Christian Faith Based Organizations’ beliefs and values regarding alcohol and drugs abuse. Consequently, the study was designed to answer the following *three research questions*: (i) What is the level of knowledge of FBOs regarding alcohol and drug abuse?; (ii) What is the attitude of FBOs towards alcohol and drug abuse?; and (iii) What are the practices of FBOs regarding alcohol and drug abuse?

³ Finance Minister Robinson Githae’s 2012-2013 Budget Speech to Parliament.

⁴ Proverbs 20:1; 23:20, 29-32

The **overall objective** of this research was to generate data to enable us understand the response of Christian FBOs towards alcohol and drugs abuse. The study highlights the barriers facing Christian FBOs in their campaigns against alcohol and drug abuse. Specifically, the study addresses the following **five specific objectives**: (i) assess the level of *knowledge* of FBOs regarding alcohol and drug abuse; (ii) assess the *attitude* of FBOs towards alcohol and drug abuse; (iii) profile the *practices* of FBOs regarding alcohol and drug abuse; (iv) *determine how NACADA can effectively engage* with FBOs to address alcohol and drug related problems in society; and (v) *make policy recommendation* to facilitate targeted response by FBOs to address alcohol and drug abuse in the community.

1.4 Literature Review

There is considerable interest in the role of faith based organizations in the services they provide to communities. The nature and depth of this interest has grown over time and proponents of the faith based organizations now argue that perhaps governments should fund the activities of FBOs because of the role they play in service provision. In the area of health care for example, faith-based organizations own 25% of the non-public health facilities at levels 2, 3 and 4 (clinics, dispensaries, health centers, other hospitals and primary hospitals). Together with other non-public health facilities, FBOs provide access to care for some of society's most underprivileged groups (Luoma *et al.*, 2010).

NACADA is partnering with faith based organizations, community based organizations and other international organizations in the prevention, control and mitigation of alcohol and drug abuse in Kenya as a move towards achieving Vision 2030 (NACADA, 2012b). This is happening through consultative forums with faith based organizations in various regions. Support of faith based programs and interventions is not new even in the international scene. Former US Vice President Al Gore, in May 1999 reaffirmed the transformative experience by faith-based organizations and religious service providers aimed at sustainable success in social welfare. He singled out the power this quiet transformation had on dealing with drug addiction in the American Society (Gore, 1999). This power to transform should be seen in light of knowledge, attitudes and practices of FBOs. The next sections focus on these three.

Knowledge: FBOs are known for their activities in the field of medicine, pastoral and spiritual care, home-based care and for programs focusing on orphans and vulnerable children. In Sub Saharan Africa, most FBOs are engaged in campaigns on HIV/AIDS awareness and by so doing they are instilling best practices (Loosli, 2004). Other studies, e.g. in Zambia, Tanzania and South Africa, on substance abuse especially on alcohol, tobacco, painkillers and other injectable drugs have engaged religious (Islam and Christian) organizations in curbing the use and abuse of both alcohol and other drugs (Nkowane *et al.*, 2004). Neiburg & Carty (2011) present a detailed account of the engagement of the people who inject themselves with drugs by the Kenyan and Tanzanian governments as a matter of policy attitude and practice. The study explores linkages of these groups with more than a thousand community based, faith based and other organizations and their efforts in trying to curb the menace. Other studies that link HIV and drug use and are key in the FBO and CBO programming include those done in Mauritius (Abdool, Sulliman and Dhannoo, 2006); Nigeria

(Adelekan and Lawal, 2006); South Africa (Parry and Pithey 2006) and Kenya (Deveau, Levine and Beckerleg, 2006). Together, these studies point to the critical role played by FBOs and therefore the need to evaluate the knowledge of personnel working in this important sector.

Attitudes: Attitudes of individuals play a significant role determining the nature of the response towards alcohol and drug abuse. For alcohol and drug use, the FBOs must project and present a supportive attitude in dealing with alcohol and drug abuse. Unless this happens, the intended recipients of message against alcohol and drug use may not elicit the expected response. Notwithstanding the critical role of FBOs, the literature on FBO attitudes towards alcohol and drug use is scant. Most of the available literature focuses on FBOs and response to HIV infection. These studies focus on the role of alcohol and drugs in HIV infection rates. Thus, alcohol and drugs are used as explanatory factors in HIV infection rather than as variables in their own right. We do know that FBOs have a strong influence on the thinking of their congregations. For example, stigmatizing attitudes of FBO leaders decreases members' care behaviors while leaders' knowledge of HIV tended to predict members' behaviors (Lindgren *et al.*, 2012). Thus, in a study focusing on alcohol and drugs one might expect a similar correlation. In this case, therefore, attitudes may shape expected behaviors of FBOs and message recipients particularly their congregations and communities in general.

Studies focusing on FBO leaders' attitudes towards alcohol and drugs abuse are few. In one such study, Gorsuch (1995) has concluded that although religiousness is associated with lower substance abuse, such a relationship occurs only for a nurturing and supportive religious environment. This finding strongly suggests that the leaders' attitudes might indeed be important factors to consider.

Practices: Practices of FBO leaders could drive communities into or away from using alcohol and drugs as demonstrated later in Figure 1.2. FBO leaders are well positioned in many communities to engage with their congregations, to initiate activities aimed at behavior change and to dialogue with communities about barriers and facilitating factors towards behavior change. The manner of interaction with the congregations, however, will be a product of their knowledge and attitudes. In previous studies, it has been argued that teachers who know more also tend to teach better (Cochran-Smith and Lytle, 1999) implying that if we view the clergy and FBO leaders as 'teachers', then a high level of knowledge among these leaders would translate to better interaction with their congregations. This, in the long run, should convert to better response by congregations on teachings focusing on alcohol and drugs within communities.

One of the activities in which FBOs can potentially engage in is in the provision of homes and centers, and counseling services for alcohol and drug recovery. This is a role that FBOs in Kenya should step forward and participate in because of their relative advantage in working directly with communities and the greater trust communities and individuals accord FBOs. In South Africa, for example, by 1999 there were numerous rehabilitation centers for alcohol and drug dependents (Schmid *et al.*, 1999). The homes, spread throughout South Africa, have played an important role in supporting and rehabilitating those who are dependent on alcohol and drugs. This is a role FBOs in Kenya should easily play.

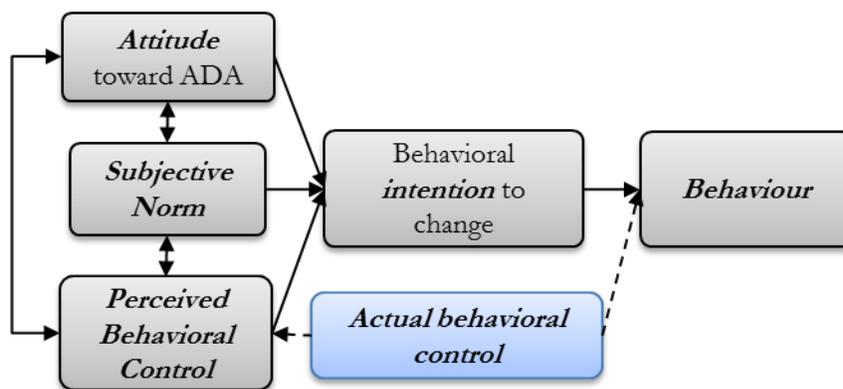
More recently, a review of the literature on the role of religious involvement in reducing deleterious health effects and negative social outcomes has shown that FBOs are effective in these practices (Johnson, Tompkins and Webb, 2003). The review findings conclude that higher levels of religious involvement provide protective factors that reduce deleterious social outcomes. The authors of this report conclude that religious involvement is associated with promoting acceptable social behaviors and enhancing positive outcomes.

In spite of the limited literature focusing on knowledge, attitudes and practices of FBOs with regard to alcohol and drugs use, there is humble evidence to point to the pole position that FBOs should adopt. FBOs are an ever present group in communities and often respond better to community needs. They are favorably placed therefore, to address community needs in respect of alcohol and drugs abuse.

1.5 Theoretical and Conceptual Framework

This research is informed by the theory of planned behavior (Ajzen 1991). In the theory of planned behavior intent is an essential component of planned behavior. Intentions are assumed to capture the motivational factors that influence a behavior; they indicate how much people are willing to try, how much of an effort they are planning to exert, in order to carry out the behavior. The stronger the intention to engage in a behavior, the more likely people will enact the behavior (Ajzen, 1991). The *theory of planned behavior* is used as a heuristic (conceptual) framework to guide the design of questions which will be asked in the survey (see Figure 1.1). In this case *intent* is seen as the FBO leader's perceived ability and power to change behavior. Thus, intent is an immediate antecedent of the behavior of interest. Behavior may be a function of how easily FBO leaders can access accurate information on alcoholic drinks and drugs, the nature of information available to them and their perceptions regarding information provided by behavior modifying agencies such as NACADA.

Figure 1.1: Theory of planned behaviour (adapted from Ajzen 1991)



For this study, focus was on the three main domains of intent to change behavior: (i) *attitude* towards use alcoholic drinks and drugs; (ii) *subjective norms* and (iii) perceptions regarding ability to be influenced by information available and interactions of FBO leaders (*perceived behavioral control*) to determine if and how these domains affect intent and are useful in predicting behavior.

The overarching domain is the level of knowledge, which I argue helps to modify attitudes and practices. Attitude towards a behavior is seen in terms of the degree to which use of alcohol is positively or negatively valued by the FBOs. A subjective norm is the perceived social pressure to engage or not to engage in a behavior, namely, to participate in activities aimed at curbing alcohol and drug use. This would include, but not limited to, social pressures from other people including the laity. Finally, perceived behavioral control refers to recipient’s perceptions of their own capacity to receive information on alcoholic drinks and drugs, which depends on the extent to which they have the skills (e.g. able to read), resources (e.g. access to internet, radio and print media) and other prerequisites needed to access the information. Ajzen (1991) refers to this as the *actual behavioral control*.

Intents of the behavioral domain which have the greatest influence on the desire for and use of information as a way of preventing abuse of alcohol and drugs in the target populations are investigated. Implied in this framework is the assumption that intent is influenced by information available to the decision maker (namely the FBO leadership). Consequently, understanding which information is most useful to recipients and how best to communicate that information is of key concern in the study.

The model below (Figure 1.2) attempts to explain the link between FBOs and other actors, namely government, NACADA, law enforcement agencies, communities and ADA suppliers. Government is the key mover, ensuring proper legislation and enforcement through the relevant organs including the police and the courts. The government works directly with communities but also through specialized agencies such as NACADA. Specifically, FBOs draw support from NACADA and may work directly to stop the alcohol and drug supply chain as well as in reducing demand at the community level.

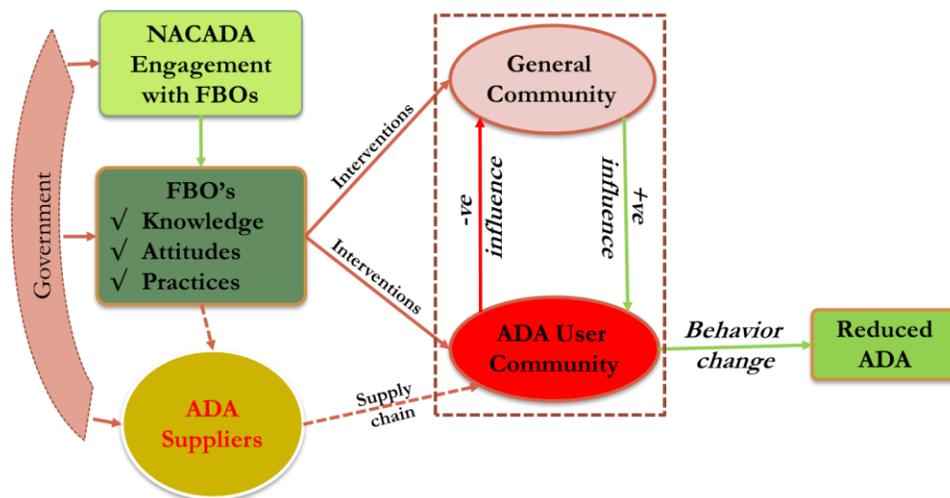


Figure 1.2: Conceptual links between FBOs and relevant actors

Reducing alcohol and drugs demand presupposes alternation of behavior among users as well as in reinforcing appropriate desired behavior in the general community and alcohol and drug user

community. The net effect of all these concerted efforts is expected to lead to reduced alcohol and drug abuse.

2.0 METHODOLOGY

2.1 Study population

This national study targeted registered FBOs and key individuals from these organizations were interviewed. The list of the registered FBOs is available from the relevant government departments. In addition, members of the community were interviewed so as to capture views of those served by FBOs. All ethical considerations such as informant confidentiality, power to terminate the interview at any time without fear or intimidation and freedom to decline to answer some or all of the questions governed data collection at all times.

2.2 Sample size and sampling strategy

Sample size: The survey targeted a sample of 400 church leaders from congregations across the country, which gives a 5% allowance for non-responses. The sample size was derived based on the sample size determination formula (Krejcie and Morgan, 1970 and Bernard, 2006) given below.

$$n = \frac{z^2 \cdot p \cdot q \cdot N}{C^2(N - 1) + z^2 \cdot p \cdot q}$$

Where:

- z = Z value (which is 1.96 for 95% confidence level)
- p = sample proportion of the population with the desired characteristics
- q = 1-p
- C = confidence interval (precision)
- n = sample population
- N = sampling frame

Accordingly, z is set at 1.96 (for a 95% confidence level); p is set at 0.50 (which is the maximum variation); q is set at 0.50; C is 0.05; and N is approximated at 25,000. The focus was on individuals since the study was on individuals' knowledge, attitudes and practices. The sample of 400 respondents was supplemented with data from IDIs with the FBO leadership. For the purpose of this study, the FBO leadership was differentiated into national, regional and local categories so as to capture involvement of FBOs at these various levels of influence.

Sampling strategy: In order to get a representative sample of the FBOs, organizations were stratified on the basis of denomination and regional representation. FBOs belonging to the following churches: the Seventh Day Adventist, Catholic, Anglican, Presbyterian, and Pentecostal among others were identified for interview. The FBOs were selected from each of the eight regions of the country and also to cover national, regional and local FBOs. Once the stratification was done, the quantitative survey relied on a stratified random sampling approach while for the in-depth interviews and focus group discussions purposive sampling was adopted.

2.3 Types of data and Data collection

Types of data: The study used two types of data to triangulate the findings. *First*, quantitative data was collected and used to generate information on the knowledge, attitudes and practices of FBOs

in relation to alcohol and drug abuse among different congregations. The questionnaire was administered face-to-face using trained research assistants. *Second*, qualitative data elicited in-depth information on knowledge, attitudes and practices of FBOs on alcohol and drug abuse. In particular, the data complemented and explained findings from the quantitative data.

Data collection & tools: *Quantitative data* was collected using a **structured questionnaire**. The questionnaire captured basic socio-demographic information which has been linked to primary variables of interest. The quantitative data included information on FBOs knowledge, attitudes and practices towards alcohol and drugs.

Qualitative data was elicited from *in-depth interviews* and *focus group discussions* using an **interview guide**. The qualitative data gathered information on knowledge, attitudes and practices relating to alcohol and drugs. *In-depth interviews* (IDIs) targeted key FBO leaders. The IDIs generated information which has been used to facilitate understanding of broader issues around knowledge, attitudes and practices relating to alcohol and drug use. Thus, the IDIs purposively targeted people in a position to provide information on the historical trends and community-wide efforts to address alcohol and drug abuse. A total of 80 IDIs (10 per region) were conducted. In addition to IDIs, 3 FGDs in each region (for a total of 24) were conducted with members of the community. This data provided community perspectives regarding FBOs and alcohol and drug use. Each FGD was composed of 6-12 participants. In addition to taking field notes during the interviews, all the IDIs and FGDs were taped after seeking permission from respondents to do so. The taped interviews were transcribed and coded for further analysis. The digital records will not be retained longer than necessary after transcription is completed and following confirmation of the transcriptions. The transcripts however will be kept for use after appropriate codes have been assigned.

2.4 Data analysis

Quantitative data has been analyzed using statistical manipulations. Data was entered in SPSS Version 20 and both descriptive and predictive statistical analysis done. The qualitative data have been analyzed using a “grounded theory” approach (Strauss and Corbin 1990), which is an iterative process by which the researcher(s) become more ‘grounded’ in the data and build richer concepts and models of the phenomena of study.

2.5 Ethical Issues

This study targets healthy individuals who attend church or faith-based related activities/programmes within their locality. As such, there were no invasive procedures like collection of body fluids or psychological tests performed. Thus, beyond normal conversational inconveniences, study participants did not experience or report adverse effects as a result of participating in this study. In order to minimize any unanticipated stress due to participation, informed consent was sought before interviewing started.

Participants were explained to on how they had been identified and their role in the study explained. In order to protect the participants’ personal space, anonymity was maintained throughout all stages of the study by use of codes and pseudonyms. Study participants were explained to that it is their right to withdraw their participation from the study at any point in time without any consequences

to them. After provision of the study-related information and before being allowed to participate, they provided their consent either through signing or verbally. Research assistants were trained on research ethics and on how to administer informed consent prior to commencement of the study.

3.0 FINDINGS

3.1 Introduction

This Chapter presents findings from the quantitative data and the qualitative findings from the focus group discussions and key informant interviews. The next Section 3.2 presents informants' characteristics including the socio-demographic information of the informants who responded to the questionnaires. It is followed by information on leaders' knowledge regarding alcohol and drugs abuse, while their attitude towards alcohol and drugs abuse is presented in Section 3.4. Section 3.5 presents information on the leaders' practices in relation to alcohol and drugs abuse. The last part of the Chapter deals with strategies to reduce misuse of alcohol and drugs in the respective communities.

3.2 Characteristics of informants

400 individuals responded to the survey questionnaire capturing information on FBO leaders' knowledge, attitudes and practices in relation to alcohol and drugs abuse. The respondents were sampled from all the regions of the country, namely: Coast, North Eastern, Eastern, Central, Nairobi, Rift Valley (divided into Upper Rift and the Lower Rift), Nyanza and Western. In total, the 400 respondents were interviewed in 20 Counties from both urban (261 i.e. 65.3%) and rural (139 i.e. 34.8%) areas. Table 3.1 summarizes the socio-demographic characteristics of the study participants, which are described below.

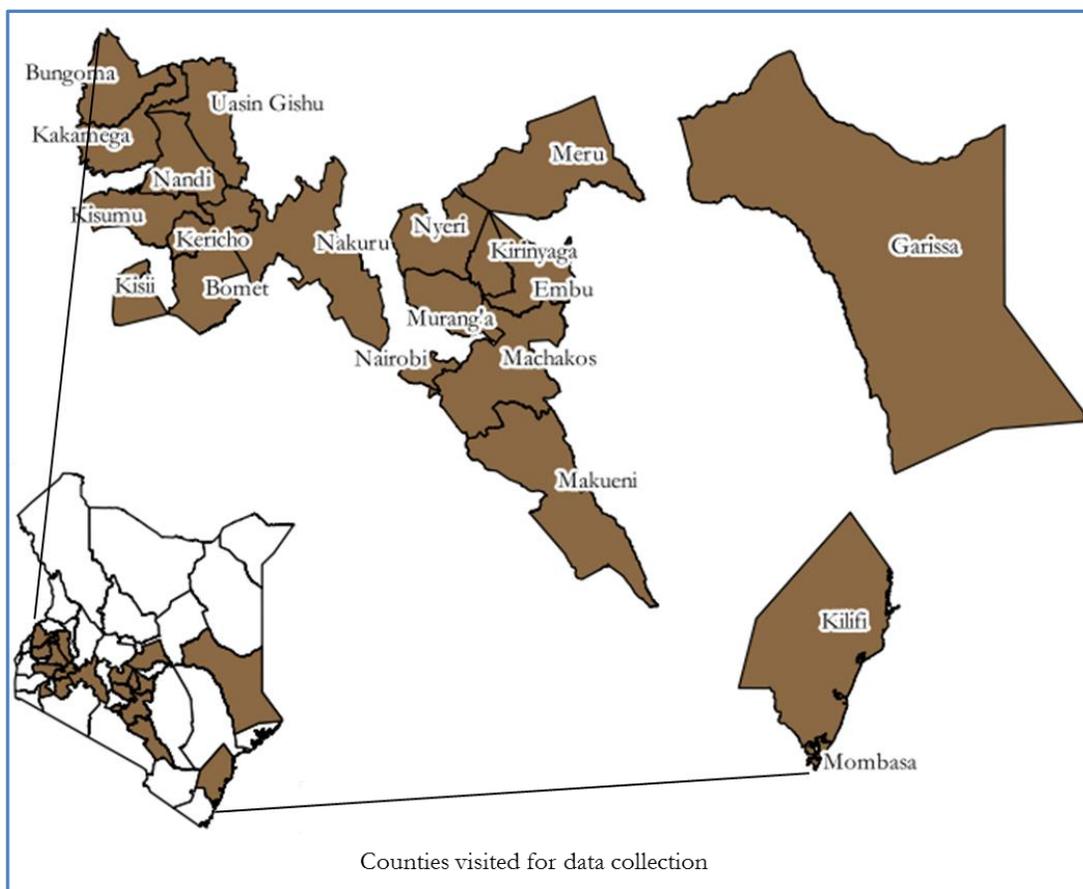


Table 3.1: Socio-demographic Characteristics of Respondents (N = 400)

Socio-demographic characteristic		Freq.	Percent
Residence	Rural	261	65.3
	Urban	139	34.8
Gender	Male	255	63.8
	Female	145	36.3
Age (years)	21-25 yrs	19	4.75
	26-30 yrs	73	18.25
	31-35 yrs	93	23.25
	36-40 yrs	74	18.50
	41-45 yrs	65	16.25
	46-50 yrs	33	8.25
	51-55 yrs	22	5.50
	56-60 yrs	12	3.0
	>60 yrs	9	2.25
Marital Status	Single (never married)	95	23.8
	Married/living with partner	287	71.8
	Divorced/Separated	2	0.5
	Widowed	16	4.0
Religion	Pentecostal	276	69.1
	Protestant	76	19.0

	Catholic	31	7.8
	Africa Christian Instituted Churches	17	4.3
Highest level of education	Lower Primary (1-4)	5	1.3
	Upper Primary (5-8)	23	5.8
	Secondary	137	34.3
	Tertiary Institution (College)	198	49.5
	University	37	9.3
Position serving in church	Church elder	156	39.0
	Pastor (80) or Bishop (2)	82	20.5
	Youth Leader	58	14.5
	Worship leader/usher	43	10.8
	Women's Leader	35	8.8
	Catechist	12	3.0
	Deacon	12	3.0
	Sabbath School Leader	2	0.5
Length of Service in the church (years)	<5yrs	232	58.0
	5-10 yrs	115	28.75
	11-15 yrs	37	9.25
	16-20 yrs	13	3.25
	>20 yrs	3	0.75

Gender: Three in every five respondents (63.8%) were male while the remaining 36.3% were female. This reflects the general male dominance in church-related leadership.

Age: Those interviewed were aged between 22 years and 67 years. The mean age of respondents was 38.03 years (s.d. 9 years). In general the male respondents were older (mean age = 39 years, s.d. = 9.54 years) compared to the female respondents (mean age = 36.17 years, s.d. = 7.6 years).

Marital status: A majority (71.8%) of the respondents were married or living with a partner while about one quarter (23.8%) identified themselves as single (never been married). Those who are widowed accounted for 4.0% of the respondents with the remaining 0.5% identifying themselves as divorced or separated from their spouses.

Religion: Close to seven in ten (69.1%) of the respondents identified themselves as Pentecostal and 19.0% as Protestant. Those who identified themselves as Catholics account for 7.8% and the African Instituted Churches respondents accounted for the remaining 4.3%.

Education: The categories of educational attainment were lower primary (1-4 years of schooling), upper primary (5-8 years of schooling), secondary, tertiary (college other than university) and university. Those with primary level of education account for 7.1% (with lower Primary representing 1.3% and upper Primary representing 5.8%). About one-third (34.3%) had Secondary level of education while almost half (49.5%) had Tertiary Institution (College) level education. Those who had University level of education account for 9.3% of those interviewed.

Position serving in church: Those interviewed serve in various positions within the church namely, Church Elder (39.0%), Pastor or Bishop (20.5%), Youth Leader (14.5%), Worship Leader (10.8%), while Catechist, Deacon and Sabbath School leader accounted for 6.5%.

Length of service in the church: A majority (58.0%) of those interviewed had served the church for less than five years. Those who had served for between 5 and 10 years account for 28.7% while the remaining had either worked for 11 to 15 years (9%) or for more than 16 years (4%). The minimum reported period served is less than one year while the maximum period served was reported as 30 years (Table 3.1).

3.3 Leaders' knowledge

3.3.1 Self-reported adequacy of knowledge

FBO leaders' assessment of knowledge focused on their own assessment of adequacy of information they possess and the knowledge of substances of abuse. They were also asked to provide information regarding substances of abuse usage, including new or emerging substances of abuse within their areas of jurisdiction. The leaders' self-reported knowledge is presented in Figure 3.1. They were asked whether, in their opinion, they have adequate knowledge on alcohol and drugs abuse to enable them communicate effectively to their congregations. Generally, the leaders reported that they have adequate knowledge to enable effective communication on issues relating alcohol and drugs. Over 50% either agreed or strongly agreed that they are adequately knowledgeable on these two issues.

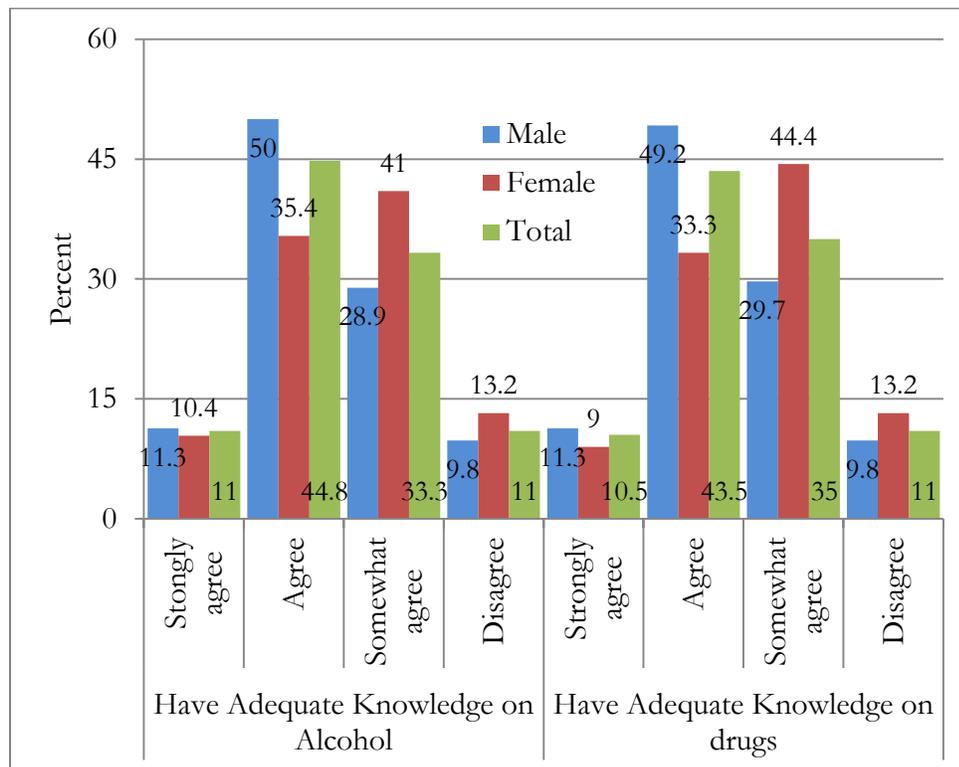


Figure 3.1: Knowledge of alcohol and drugs

Despite the leaders' agreement that they have adequate knowledge, FGD discussions as well as in-depth interviews seem to indicate to the contrary. For example, one of the FBO leaders had this to say regarding their level of knowledge of alcohol and drug abuse issues:

I think we are not well armed with knowledge on alcohol and drug use. The necessary information we need to teach the people is not adequate. Like now, I can't remember when there was a seminar from, may be NACADA, to educate the leaders. [IDI Female FBO leader, Kerugoya, Kirinyaga County]

This FBO leader's views were echoed by those participating in the FGD discussions with the community members.

I don't think the leaders are fully equipped with knowledge to deal with drugs. They are also very busy people and you don't not expect them to go to different places to deal with or talk about substance abuse. They might have the requisite knowledge but time and people to help them is what they do not have. [FGD mixed Group, Kirinyaga County]

Thus the information by the FBO leader that they did not have adequate knowledge was actually confirmed by members of the congregation who felt the same way.

A closer observation, however, does reveal differences between men and women in reported knowledge. The differences between these two groups are significant. The difference between men and women in terms of reported level of knowledge on alcohol abuse is significant (chi-square = 9.47, p-value = 0.024) while difference in knowledge on drug abuse is significant at chi-square = 12.53, p-value = 0.006.

3.3.2 Knowledge of substances of abuse

Knowledge on substances of abuse was assessed at two levels (unprompted and prompted responses). First, the respondents were asked to name the substances that they know after which the interviewer prompted them on the ones they had skipped from a pre-determined list of drugs. The responses are summarized in Table 3.2.

Table 3.2: Knowledge of substances of abuse (unprompted and prompted), N=400

Drug/Substance		Unprompted			Unprompted + Prompted		
		Male (N=256) N (%)	Female (N=144) N (%)	Total (N=400) N (%)	Male (N=256) N (%)	Female (N=144) N (%)	Total (N=400) N (%)
Tobacco products	cigarettes, cigars, pipe	254 (99.2)	142 (98.6)	396 (99.0)	255 (99.6)	144 (100)	399(99.7)
	snuff,	212 (82.8)	119 (82.6)	331 (82.8)	219 (85.5)	123 (85.4)	342 (85.5)
	chewing tobacco	213 (83.2)	111 (77.1)	324 (81.0)	218(85.2)	114(79.2)	332 (83.0)
	Kuber	134 (52.3)	60 (41.7)	194 (48.5)	141 (55.1)	65 (45.1)	206 (51.5)
Alcoholic beverages	Beer	242 (94.5)	136 (94.4)	378 (94.5)	242 (94.5)	139(96.5)	381 (95.3)
	Wine	229 (89.5)	132 (91.7)	361 (90.3)	237(92.6)	135(93.8)	372 (93.0)
	Liquor/spirits	222 (86.7)	128 (88.9)	350 (87.5)	227(88.7)	130(90.3)	357 (89.3)
	Chang'aa	210 (82.0)	111 (77.1)	321 (80.3)	216(84.4)	111 (77.1)	327 (81.8)
	Traditional liquor	190 (74.2)	102 (70.8)	292 (73.0)	194(75.8)	102 (70.8)	296 (74.0)
	2 nd generation	122 (47.8)	69 (47.9)	191 (47.9)	127(49.6)	70(48.6)	197(49.3)

Drug/Substance		Unprompted			Unprompted + Prompted		
		Male (N=256) N (%)	Female (N=144) N (%)	Total (N=400) N (%)	Male (N=256) N (%)	Female (N=144) N (%)	Total (N=400) N (%)
Marijuana	Smoked bhang	245 (95.7)	136 (94.4)	381 (95.3)	249(97.3)	137(95.1)	386 (96.5)
	Bhang cooked in food/drink	167 (65.2)	83 (57.6)	250 (62.5)	177(69.1)	85(59.0)	262 (65.5)
	Hashish /Hash oil	105 (41.0)	53 (36.8)	158 (39.5)	111(43.4)	55(38.2)	166 (41.5)
<i>Khat</i>	<i>Miraa</i>	225 (87.9)	116 (80.6)	341 (85.3)	227(88.7)	119(82.6)	345 (86.3)
	<i>Mugunka</i>	154 (60.2)	78 (54.2)	232 (58.0)	166(64.8)	82(56.9)	248 (62.0)
Heroin /Brown sugar	Snorting	126 (49.2)	65 (45.1)	191 (47.8)	145(56.6)	70(48.6)	215 (53.8)
	Injecting	99 (38.7)	62 (43.1)	161 (40.3)	119(46.5)	68(47.2)	187 (46.8)
	Smoking	87 (34.0)	55 (38.20)	142 (35.5)	106(41.4)	60(41.7)	166 (41.5)
Cocaine coke, crack	Snorting	118 (46.1)	66 (45.8)	184 (46.0)	138(53.9)	70(48.6)	208 (52.0)
	Injecting	98 (38.3)	61 (42.4)	159 (39.8)	118(46.1)	65(45.1)	183(45.8)
	Smoking	89 (34.8)	55 (38.2)	144 (36.0)	107 (41.8)	59 (41.0)	166 (41.5)
Inhalants	Shoe glue	212 (83.1)	114 (79.2)	326 (81.7)	221 (86.3)	119(82.6)	340 (85.0)
	Petroleum	169 (66.0)	83 (57.6)	252 (63.0)	178 (69.5)	90 (62.5)	268 (67.0)
	Paints/ paint thinner.	86 (33.6)	43 (29.9)	129 (32.3)	95 (37.1)	47 (32.6)	142 (35.5)
	Shoe polish	32 (12.5)	18 (12.5)	50 (12.5)	35 (13.7)	21 (14.6)	56 (14.0)
	Other	-	-	-	1 (0.4)	1 (0.7)	2 (0.5)
Prescription drugs	Amphetamine type stimulants (e.g. speed, diet pills, ecstasy)	176 (68.8)	96 (66.7)	272 (68.0)	187(73.1)	104 (72.2)	288 (72.0)
	Sedatives or Sleeping Pills (e.g. Valium, Serenax, Rohypnol)	148 (57.8)	96 (66.7)	244 (61.0)	160 (62.5)	100 (69.4)	260 (65.0)
	Hallucinogens (e.g. LSD, acid, mushrooms, PCP, Special K)	32 (12.5)	16 (11.1)	48 (12.0)	43 (16.8)	18 (12.5)	61 (15.3)
	Opioids (e.g. morphine, codeine)	10 (3.9)	10 (6.9)	20 (5.0)	21 (8.2)	14 (9.7)	35 (8.8)
	Mandrax	14 (5.5)	7 (4.9)	21 (5.3)	27 (10.5)	12 (8.3)	39 (9.8)
	Other	0 (0.0)	1 (0.7)	1 (0.3)	0 (0)	1 (0.7)	1 (0.3)

Respondents are generally aware of tobacco products, alcoholic products, marijuana and *Khat* in their various forms. Reported knowledge on these products is generally above 60%. In deed a majority of the people either in the IDIs or in the FGDs named various substances of abuse within their communities. FBO leaders readily reported the various substances of abuse such as the FBO leader from Kirinyaga County who reported that “local brews, the cheap brews” and “*miraa*” (*khat*) are common [IDI with FBO leader, Female, Kirinyaga County]. Those participating in FGDs noted that “The youth have taken into taking *khat*. It is in those kiosks that the sell *bhang*. Even when you don’t get those guys who are stationed at one place, you still find most near *khat* selling joints. Mostly in this place you get alcohol, *miraa* [*khat*] and *bhang* and to some extent you also get “*tap tap*–[*luga ya mtaani*].” The other drugs like heroin are not common.”[FGD mixed Group, Kirinyaga County]

Relatively fewer leaders knew of Heroin and cocaine although the proportion of those reporting knowledge of these rose with prompting by the interviews. Indeed, the proportion went up in all the different types of substances of abuse but that increase was very small. Less frequently mentioned were paints/paint thinners, shoe polish, hallucinogens, opioids and mandrax. All these were mentioned by less than 40% of the leaders. The least mentioned were opioids (8.8%) and mandrax (9.8%).

3.3.3 Level of drugs consumption

The leaders were asked to assess the level of drugs consumption first within their congregations and the next within the communities they operate in. The categories of groups within congregations and communities were divided into youth and adult as well as male and female. Thus, four groups were established, namely, male youth, female youth, adult male and adult female. Their responses are summarized below in Figure 3.2a and Figure 3.2b.

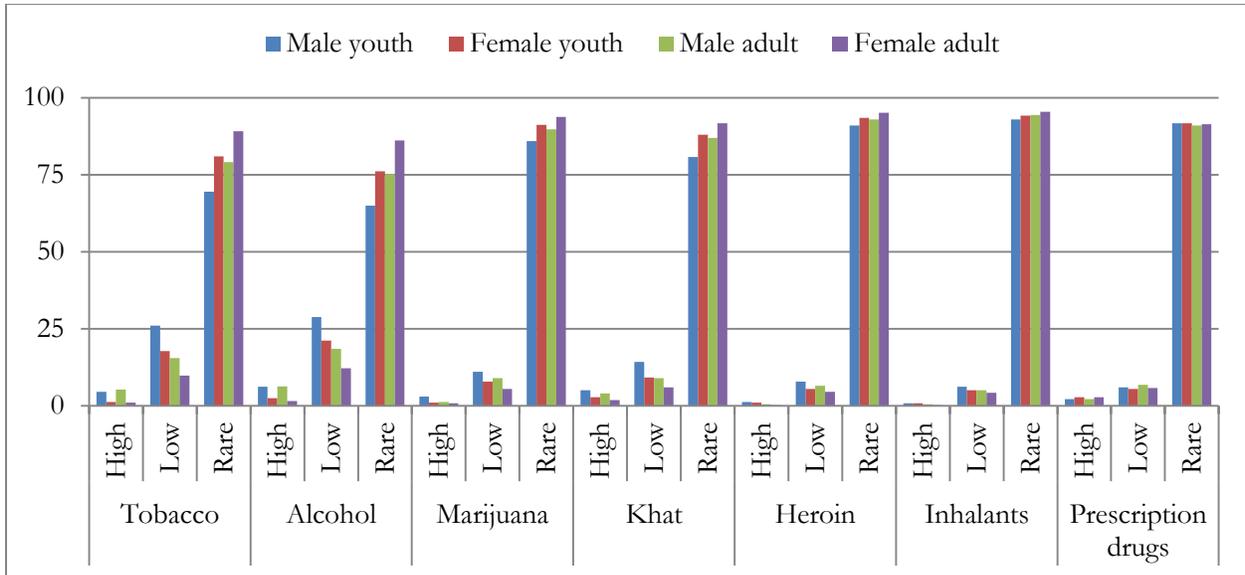


Figure 3.2a: Use of substances of abuse (alcohol and drugs) among congregations (N=400)

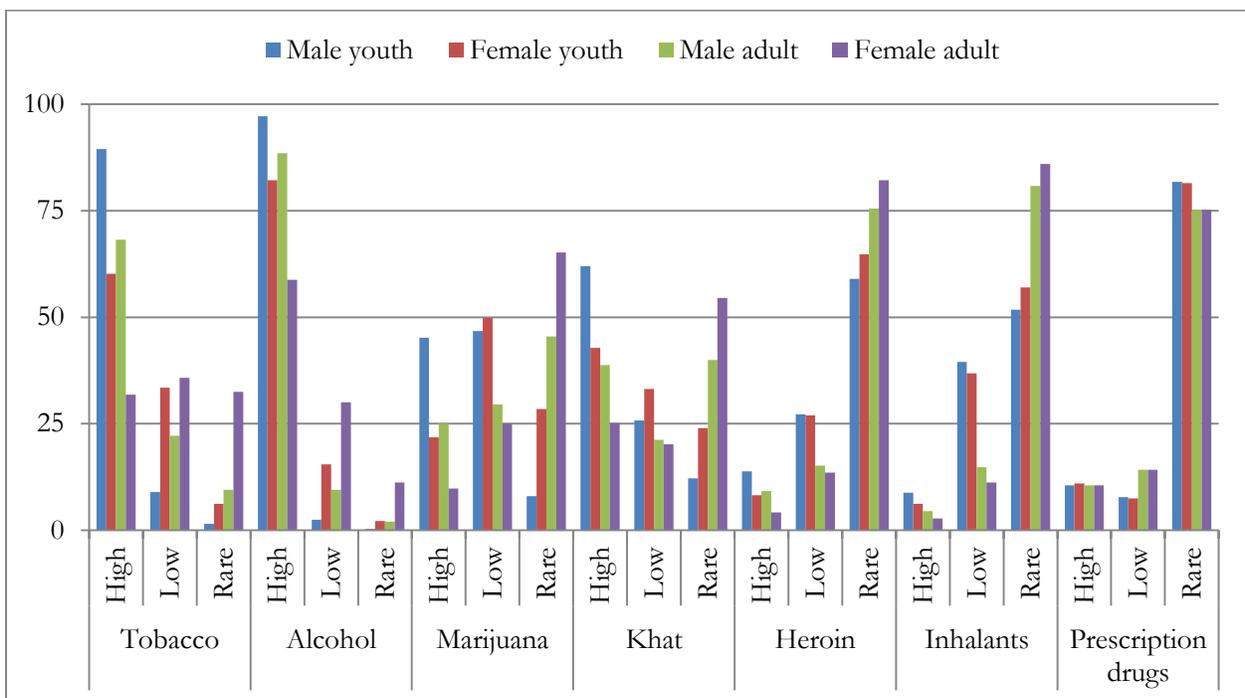


Figure 3.2b: Use of substances of abuse (alcohol and drugs) in the community

Clearly, there are differences in reported levels of substance of abuse use. Although the leaders tend to agree that use of heroin, inhalants and prescription drugs is low among congregants and the community in general, there is less agreement on tobacco use, alcohol consumption, marijuana and *khat* use among the two groups, namely the congregants and the community.

“We don’t have a high number of people with the problem of alcohol in the congregation. But, if we looked at the community, we know that there is a problem because most people with this problem don’t come to church.” [IDI Female FBO Leader, Kirinyaga County]

This information is indeed reflected in greater details when it is presented by gender (Table 3.3a and Table 3.3b).

Table 3.3a: Use of substances of abuse (alcohol and drugs) by members of the congregation (N=400)

			Male		Female		Total	
			N	%	N	%	N	%
Tobacco	Male youth	High	11	4.3	7	4.9	18	4.5
		Low	73	28.5	31	21.5	104	26.0
		Rare	172	67.2	106	73.6	278	69.5
	Female youth	High	3	1.2	2	1.4	5	1.2
		Low	48	18.8	23	16.0	71	17.8
		Rare	205	80.1	119	82.6	324	81.0
	Male adult	High	15	5.9	6	4.2	21	5.2
		Low	41	16.0	21	14.6	62	15.5
		Rare	200	78.1	117	81.2	317	79.2
	Female adult	High	3	1.2	1	0.7	4	1.0
		Low	25	9.8	14	9.7	39	9.8
		Rare	228	89.1	129	89.6	357	89.2
Alcohol	Male youth	High	16	6.2	9	6.2	25	6.2
		Low	80	31.2	35	24.3	115	28.8
		Rare	160	62.5	100	69.4	260	65.0
	Female youth	High	5	2.0	5	3.5	10	2.5
		Low	58	22.7	27	18.8	85	21.2
		Rare	193	75.4	112	77.8	305	76.2
	Male adult	High	17	6.7	8	5.6	25	6.3
		Low	49	19.2	25	17.4	74	18.5
		Rare	189	74.1	111	77.1	300	75.2
	Female adult	High	3	1.2	3	2.1	6	1.5
		Low	33	12.9	16	11.1	49	12.2
		Rare	220	85.9	125	86.8	345	86.2
Marijuana	Male youth	High	6	2.3	6	4.2	12	3.0
		Low	33	12.9	11	7.6	44	11.0
		Rare	217	84.8	127	88.2	344	86.0
	Female youth	High	2	0.8	2	1.4	4	1.0
		Low	20	7.8	11	7.6	31	7.8
		Rare	234	91.4	131	91.0	365	91.5

			Male		Female		Total		
			N	%	N	%	N	%	
	Male adult	High	3	1.2	2	1.4	5	1.2	
		Low	25	9.8	11	7.6	36	9.0	
		Rare	228	89.1	131	91.0	359	89.8	
	Female adult	High	2	0.8	1	0.7	3	0.8	
		Low	13	5.1	9	6.2	22	5.5	
		Rare	241	94.1	134	93.1	375	93.8	
<i>Khat</i>	Male youth	High	12	4.7	8	5.6	20	5.0	
		Low	42	16.4	15	10.4	57	14.2	
		Rare	202	78.9	121	84.0	323	80.8	
	Female youth	High	6	2.3	5	3.5	11	2.8	
		Low	24	9.4	13	9.0	37	9.2	
		Rare	226	88.3	126	87.5	352	88.0	
	Male adult	High	11	4.3	5	3.5	16	4.0	
		Low	21	8.2	15	10.4	36	9.0	
		Rare	223	87.5	124	86.1	347	87.0	
	Female adult	High	6	2.3	1	0.7	7	1.8	
		Low	14	5.5	12	8.3	26	6.5	
		Rare	236	92.2	131	91.0	367	91.8	
	Heroin	Male youth	High	3	1.2	2	1.4	5	1.2
			Low	21	8.2	10	6.9	31	7.8
			Rare	232	90.6	132	91.7	364	91.0
Female youth		High	2	0.8	2	1.4	4	1.0	
		Low	14	5.5	8	5.6	22	5.5	
		Rare	240	93.8	134	93.1	374	93.5	
Male adult		High	2	0.8	0	0.0	2	0.5	
		Low	18	7.0	8	5.6	26	6.5	
		Rare	236	92.2	136	94.4	372	93.0	
Female adult		High	1	0.4	0	0.0	1	0.2	
		Low	12	4.7	6	4.2	18	4.5	
		Rare	243	94.9	138	95.8	381	95.2	
Inhalants		Male youth	High	2	0.8	1	0.7	3	0.8
			Low	18	7.0	7	4.9	25	6.2
			Rare	236	92.2	136	94.4	372	93.0
	Female youth	High	2	0.8	1	0.7	3	0.8	
		Low	13	5.1	7	4.9	20	5.0	
		Rare	241	94.1	136	94.4	377	94.2	
	Male adult	High	2	0.8	0	0.0	2	0.5	
		Low	14	5.5	6	4.2	20	5.0	
		Rare	240	93.8	138	95.8	378	94.5	
	Female adult	High	1	0.4	0	0.0	1	0.2	
		Low	11	4.3	6	4.2	17	4.2	
		Rare	244	95.3	138	95.8	382	95.5	
	Prescription drugs	Male youth	High	7	2.7	2	1.4	9	2.2
			Low	12	4.7	12	8.3	24	6.0

			Male		Female		Total	
			N	%	N	%	N	%
	Female youth	Rare	237	92.6	130	90.3	367	91.8
		High	6	2.3	5	3.5	11	2.8
		Low	13	5.1	9	6.2	22	2.8
	Male adult	Rare	237	92.6	130	90.3	367	91.8
		High	7	2.7	2	1.4	9	2.2
		Low	14	5.5	13	9.0	27	6.8
	Female adult	Rare	235	91.8	129	89.6	364	91.0
		High	6	2.3	5	3.5	11	2.8
		Low	13	5.1	10	6.9	23	5.8
		Rare	237	92.6	129	89.6	366	91.5

Table 3.3b: Use of substances of abuse (alcohol and drugs) by members of the community (N=400)

			Male		Female		Total	
			N	%	N	%	N	%
Tobacco	Male youth	High	230	89.8	128	88.9	358	89.5
		Low	21	8.2	15	10.4	36	9.0
		Rare	5	2.0	1	0.7	6	1.5
	Female youth	High	150	58.6	91	63.2	241	60.2
		Low	92	35.9	42	29.2	134	33.5
		Rare	14	5.5	11	7.6	25	6.2
	Male adult	High	182	71.1	91	63.2	273	68.2
		Low	51	19.9	38	26.4	89	22.2
		Rare	23	9.0	15	10.4	38	9.5
	Female adult	High	87	34.0	40	27.8	127	31.8
		Low	91	35.5	52	36.1	143	35.8
		Rare	78	30.5	52	36.1	130	32.5
Alcohol	Male youth	High	244	95.7	144	100	388	97.2
		Low	10	3.9	0	0.0	10	2.5
		Rare	1	0.4	0	0.0	1	0.3
	Female youth	High	203	79.3	126	87.5	329	82.2
		Low	47	18.4	15	10.4	62	15.5
		Rare	6	2.3	3	2.1	9	2.2
	Male adult	High	225	88.2	128	88.9	353	88.5
		Low	25	9.8	13	9.0	38	9.5
		Rare	5	2.0	3	2.1	8	2.0
	Female adult	High	148	57.8	87	60.4	235	58.8
		Low	79	30.9	41	28.5	120	30.0
		Rare	29	11.3	16	11.1	45	11.2
Marijuana	Male youth	High	113	44.1	68	47.2	181	45.2
		Low	124	48.4	63	43.8	187	46.8
		Rare	19	7.4	13	9.0	32	8.0
	Female youth	High	49	19.1	38	26.4	87	21.8
		Low	139	54.3	60	41.7	199	49.8

			Male		Female		Total		
			N	%	N	%	N	%	
	Male adult	Rare	68	26.6	46	31.9	114	28.5	
		High	71	27.7	29	20.1	100	25.0	
		Low	70	27.3	48	33.3	118	29.5	
	Female adult	Rare	115	44.9	67	46.5	182	45.5	
		High	28	10.9	11	7.6	39	9.8	
		Low	73	28.5	27	18.8	100	25.0	
	<i>Khat</i>	Male youth	Rare	155	60.5	106	73.6	261	65.2
			High	157	61.3	91	63.2	248	62.0
			Low	64	25.0	39	27.1	103	25.8
Female youth		Rare	35	13.7	14	9.7	49	12.2	
		High	108	42.2	63	43.8	171	42.8	
		Low	83	32.4	50	34.7	133	33.2	
Male adult		Rare	65	25.4	31	21.5	96	24.0	
		High	102	39.8	53	36.8	155	38.8	
		Low	52	20.3	33	22.9	85	21.2	
Female adult	Rare	102	39.8	58	40.3	160	40.0		
	High	66	25.8	35	24.3	101	25.2		
	Low	52	20.3	29	20.1	81	20.2		
Heroin	Male youth	Rare	138	53.9	80	55.6	218	54.5	
		High	37	14.5	18	12.5	55	13.8	
		Low	69	27.0	40	27.8	109	27.2	
	Female youth	Rare	150	58.6	86	59.7	236	59.0	
		High	17	6.6	16	11.1	33	8.2	
		Low	71	27.7	37	25.7	108	27.0	
	Male adult	Rare	168	65.6	91	63.2	259	64.8	
		High	26	10.2	11	7.6	37	9.2	
		Low	40	15.6	21	14.6	61	15.2	
Female adult	Rare	190	74.2	112	77.8	302	75.5		
	High	10	3.9	7	4.9	17	4.2		
	Low	37	14.5	17	11.8	54	13.5		
Inhalants	Male youth	Rare	209	81.6	120	83.3	329	82.2	
		High	27	10.5	8	5.6	35	8.8	
		Low	94	36.7	64	44.4	158	39.5	
	Female youth	Rare	135	52.7	72	50.0	207	51.8	
		High	16	6.2	9	6.2	25	6.2	
		Low	92	35.9	55	38.2	147	36.8	
	Male adult	Rare	148	57.8	80	55.6	228	57.0	
		High	14	5.5	4	2.8	18	4.5	
		Low	39	15.2	20	13.9	59	14.8	
Female adult	Rare	203	79.3	120	83.3	323	80.8		
	High	5	2.0	6	4.2	11	2.8		
	Low	37	14.5	8	5.6	45	11.2		
Prescription	Male	Rare	214	83.6	130	90.3	344	86.0	
		High	29	11.3	13	9.0	42	10.5	
		Low							

			Male		Female		Total	
			N	%	N	%	N	%
drugs	youth	Low	22	8.6	9	6.2	31	7.8
		Rare	205	80.1	122	84.7	327	81.8
	Female youth	High	29	11.3	15	10.4	44	11.0
		Low	22	8.6	8	5.6	30	7.5
		Rare	205	80.1	121	84.0	326	81.5
	Male adult	High	30	11.7	12	8.3	42	10.5
		Low	34	13.3	23	16.0	57	14.2
		Rare	192	75.0	109	75.7	301	75.2
	Female adult	High	29	11.3	13	9.0	42	10.5
		Low	35	13.7	22	15.3	57	14.2
		Rare	192	75.0	109	75.7	301	75.2

The perception that use of alcohol and other substances of abuse among members of the community is high was reported in focus group discussions with various groups. In Kerugoya for example, one FGD discussant had the following to say: “I have stayed here for 16 years. The kind of things I see in the Estate are worrying, they sell drugs ‘live’ (on the streets)”. [FGD Mixed Group, Kerugoya, Kirinyaga County] In Movoko subcounty, Machakos County it was reported by a church leader thus:

In this region there is a lot of laxity in law enforcement. If the Mututho law says you are supposed to go up to 11.00pm, you will find at 1.00am people are still selling it [alcohol]. Number two, the opening time; If it is 5.00pm, you will find that by 3.00pm some of the pubs are open. I have seen increased number of wines and spirits shops in this town. The other factor is the high population density in the area as well as peer pressure among the *boda boda* riders. [IDI, Male FBO leader, Mavoko Sub-County, Machakos County]

According to the leaders, the main reasons why people use drugs include the following: making users have fun (98%), relax (97.5%), interact (96%) as well as making users feel important (89.8%). It is also a way of “killing” time (97%) among other reasons (see Table 3.4). Also included in the list are reasons such as to secure business deals (68.5%) and health benefits to the person using substances of abuse (55.3%).

Table 3.4: Reasons for using drugs

	Yes		No		Don't know	
	N	%	N	%	N	%
Makes people interact	384	96.0	16	4.0	0	0.0
Makes people have fun	392	98.0	8	2.0	0	0.0
Makes people feel important	359	89.8	39	9.8	2	0.5
Makes people relax	390	97.5	10	2.5	0	0.0
Has health benefits	221	55.3	174	43.5	5	1.3
Helps "kill time"	388	97.0	12	3.0	0	0.0

Helps one relate with opposite sex more freely	363	90.8	34	8.5	3	0.8
Helps one cope with stress	386	96.5	14	3.5	0	0.0
Makes one think & work smart	315	78.8	85	21.3	0	0.0
Enables people get business deals	274	68.5	120	30.0	6	1.6
Other (kills typhoid, amoeba)	4	1.0	0	0.0	0	0.0

In Mavoko Sub-County, the church leaders identified a high presence of drug dealers, residence in informal settlements and a high number of pubs in the area [IDI male FBO leader, Mavoko, Machakos County] In addition to these reasons advanced in Mavoko, in Mombasa the FBO leaders felt that peer pressure and culture were a contributing factor towards the use of alcohol in the community. "... I think culture here in the Coast, which might be the same as in other communities, it allows people to drink alcohol. So if you go to the villages you find people sitting down and drinking and there is nothing wrong with that. So it is culture." [IDI, male FBO leader, Mombasa County]

At a personal level, a majority of the FBO leaders (more than two thirds) indicated that use of drugs by the community leads to various problems including marital breakdown (96.3%), unproductive activities (e.g. when users are just lazing around, 92.5%), high school dropout rates (91%) among others. These effects are summarized in Figure 3.3.

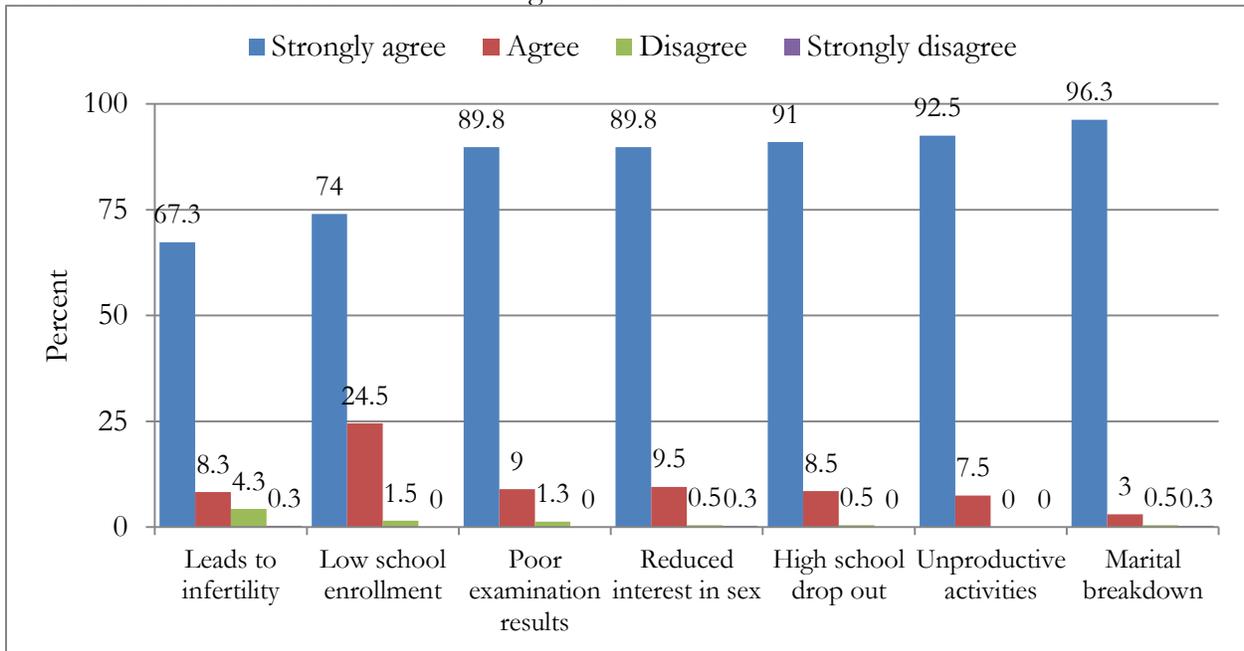


Figure 3.3: Respondents' agreement to statements about drugs use within the community

Accordingly, the FBO leaders felt that people exposed themselves to a great risk (Figure 3.4) by using substances of abuse. There is, nonetheless, less agreement among the leaders whether abuse of prescription drugs put the community at a greater risk or not. Indeed, close to a third (31%) of the leaders indicated that they didn't know the risk prescription drugs exposed the community into (Figure 3.4).

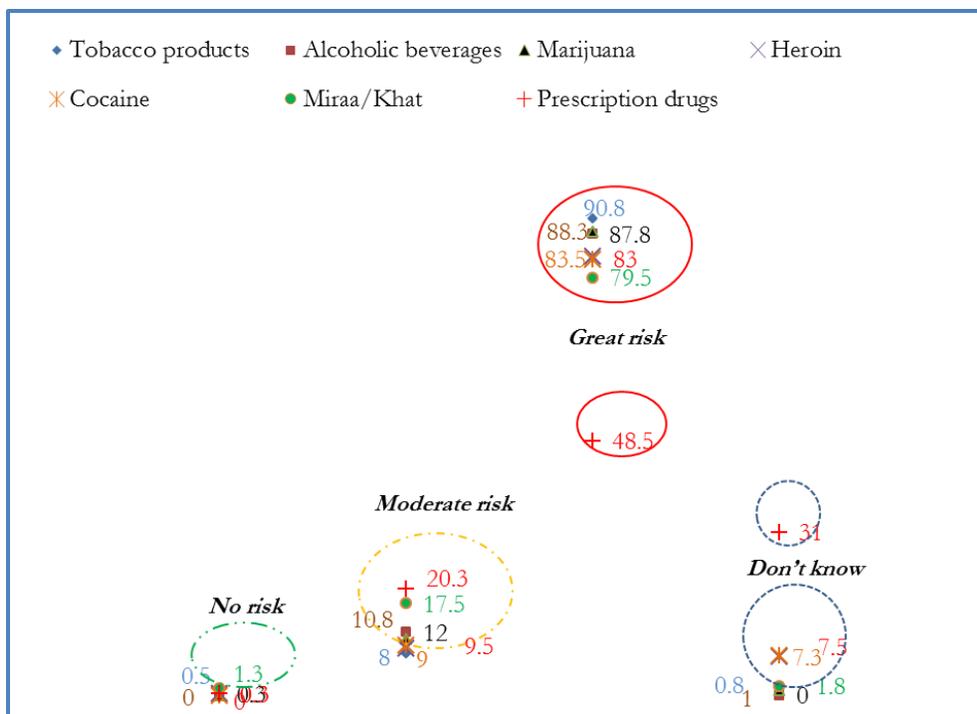


Figure 3.4: Leaders' opinion of risk exposure due to use of substances of abuse

3.3.4 New substances of abuse in the community

About one in ten (8.8%) of the church leaders indicated that there were new substances of abuse within their communities. These substances of abuse were identified variously as *Kuber* (40%), *Ndovu* (28.6%), 'Tea leaves' (14.3%), *Tambu* (8.6%), *Busaa* and Methanol (5.7% each) among others (Table 3.5).

Table 3.5: New substances of abuse in the community

Substance of abuse	Freq. (n=35)	Percent
<i>Kuber</i>	14	40.0
<i>Ndovu</i>	10	28.6
'Tea leaves'	5	14.3
<i>Tambu</i>	3	8.6
<i>Busaa</i>	2	5.7
Methanol	2	5.7
<i>Buguzi</i>	1	2.9
Diaspam tablets	1	2.9
<i>Shisha</i>	1	2.9
<i>Tap tap</i>	1	2.9
'Unga'	1	2.9
<i>Vuta pumzi</i>	1	2.9

The presence of new substances of abuse and the changing nature of drug use within communities was reported by both FBO leaders who participated in in-depth interviews as well as community members in focus group discussions. In Mavoko Sub-County Machakos County, one of the FBO leaders had this to say, "... the issue of drugs is not stagnant. A youth comes to church with a drug you have never heard off." [IDI male FBO leader, Mavoko Sub-County, Machakos County] This

was echoed by other leaders in Kirinyaga County, and Nairobi City County among other counties. Participants in the FGDs agreed with what the FBO leaders reported.

3.3.5 Rehabilitation of drug addicts

The FBO leaders were asked to state whether they agreed or disagreed with a series of statements on rehabilitation efforts. The statements focused on rehabilitation of alcohol and drug addicts, management of rehabilitation facilities, cost of treatment and rehabilitation, and role of FBOs in the campaign against alcohol and drugs abuse. Their responses are provided in Figure 3.5.

A majority (more than 50%) of the leaders agree that alcoholism is a disease like any other (91% agreed with the statement) and that FBOs are actively campaigning against alcohol and drugs abuse in the community (51.3%). On the other hand, less than a third of the leaders agreed that rehabilitation facilities in Kenya are run by professionals (33.5%), that the church has rehabilitation facilities (25.5%) and that the cost of alcohol and drug addiction treatment and rehabilitation is affordable (21.5%).

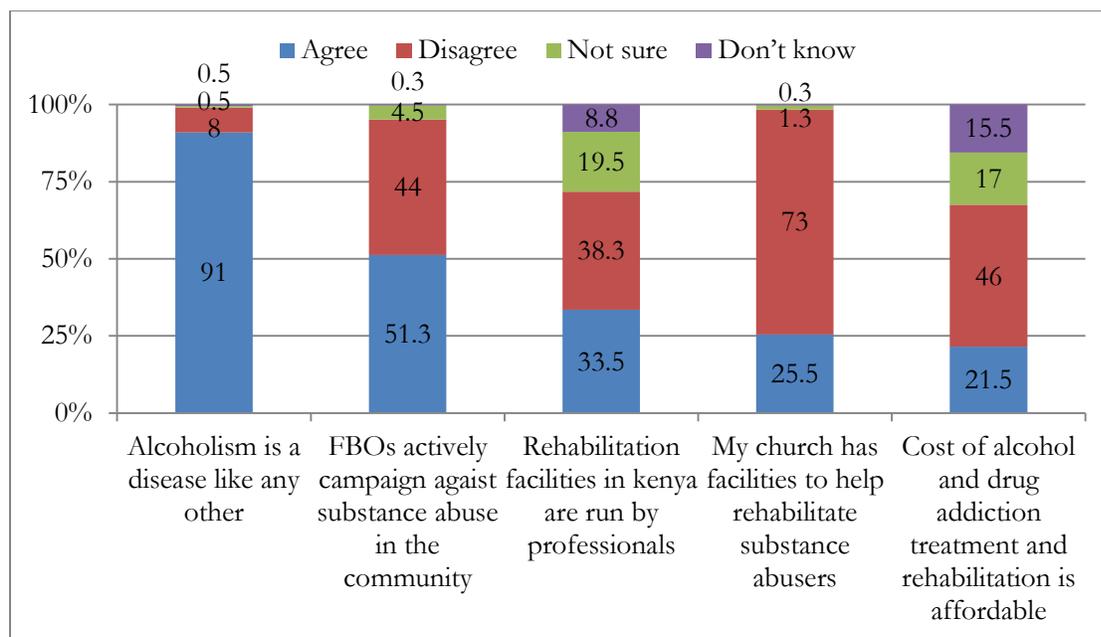


Figure 3.5: Substance abuse rehabilitation and treatment facilities

Many of the FBO leaders indicated in their response to the question on whether they were aware of alcohol and drug addiction treatment and rehabilitation centers. 63.8% percent of them responded in the affirmative. However, about one third of the FBO leaders (32.9%) reported that these centers are not capable of dealing with alcohol and drug addiction counseling, treatment and rehabilitation. The reasons why they felt that these facilities are not capable of dealing with the alcohol and drug addiction problem are summarized in Table 3.6.

Table 3.6: Reasons why the rehabilitation centers are not capable of dealing with ADA (multiple responses, N=84)

Reason	Freq	Percent
Few	50	59.52
Expensive	28	33.33
Lack of personnel (skilled staff)	14	16.67
Not known by many	14	16.67
Far/Inaccessible	6	7.14
Addicts don't reform after the visits	5	5.95
Poorly equipped/maintained	5	5.95
Demand is high	3	3.57
Privately owned (Lack govt. support)	2	2.38
Stigma associated with going for rehabilitation prevalent	1	1.19

The reasons are linked to the number of the facilities, the cost involved in accessing the services, personnel and knowledge of these facilities. Close to 60% of the FBO leaders reported that the rehabilitation and treatment centers are few, while about a third (33.3%) reported that the centers are expensive (perhaps as a result of them being few in the first place). A third problem linked to the centers is lack of personnel or skilled staff. 16.7% of those interviewed identified this as a problem. Other reasons given include lack of knowledge about the existence of rehabilitation centers (16.7%), distance to the facilities (7.1%), poor state of the facilities (6%) and high demand (3.6%). Stigma associated with the use of rehabilitation was mentioned by one respondent.

3.4 Attitudes towards Alcohol and Drug abuse

The FBO leader's attitudes towards those who are addicted to alcohol and drugs is generally positive (Figure 3.6). For example, a majority of those interviewed supported the idea that those addicted should not be dismissed from work. However, they also indicated that the family/community were not supportive enough to those addicted. In deed 70% of the FBO leaders thought that this was the case (Figure 3.7).

The public nature of the drugs problem in the country and the concern of the clergy is clearly noted in the FBO leaders' response that the clergy should be concerned. More than 95% disagreed with the statement that the clergy should not be concerned on a private matter such as alcohol and drug use.

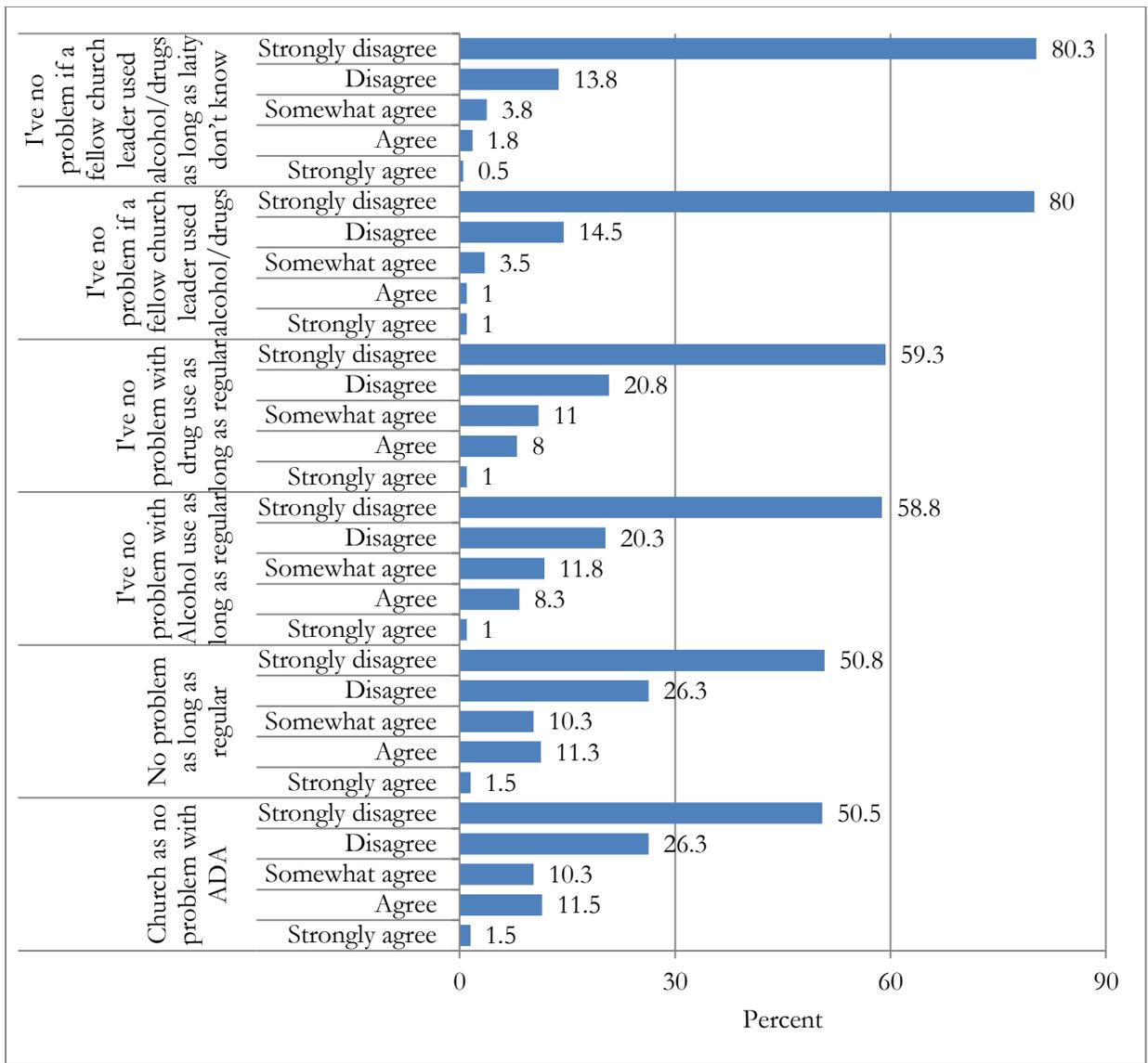


Figure 3.6: Attitudes towards alcohol and drug abuse

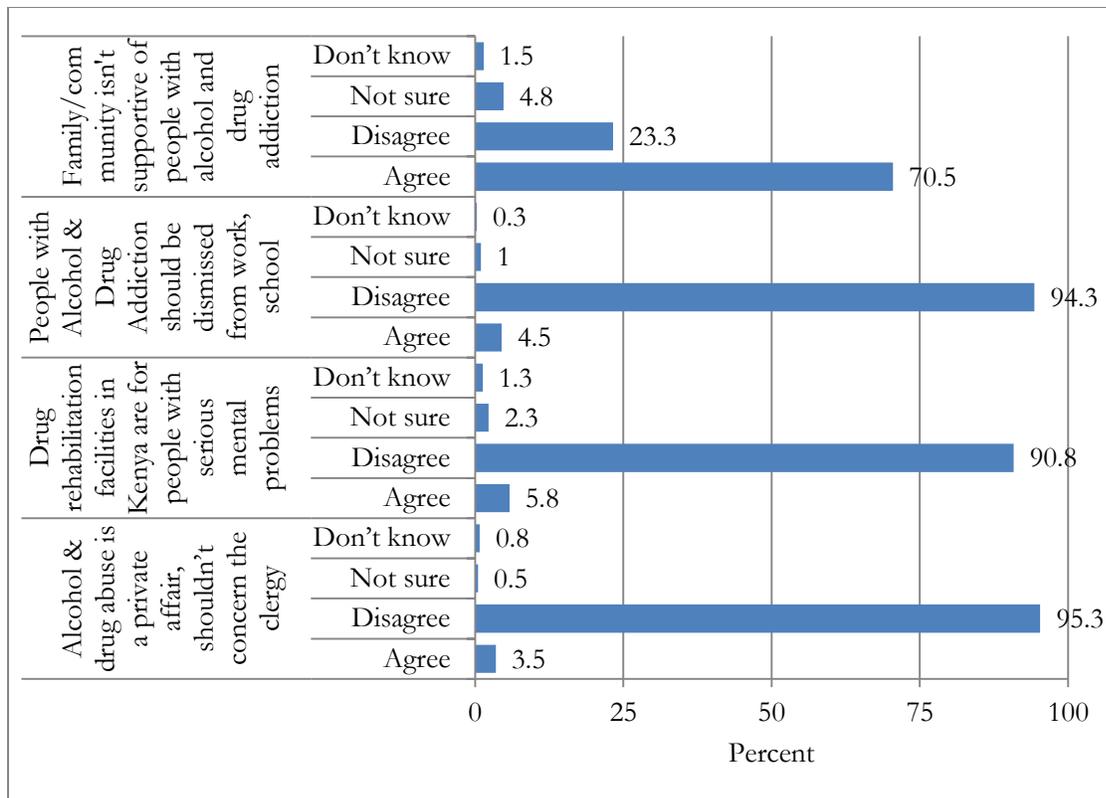


Figure 3.7: Do you agree with the following statements:...

FBO leaders noted that society has different attitudes towards alcohol and drugs use from that of the church. In the community, there are those who are bothered and concerned about use of alcohol and drugs in the community and there are those who are not bothered at all who think that it is part of life. The church is of the view that these people need help.

For us (the church) we think they need help. We don't push them out, we try to draw them in to help them. Some have been sent to the rehabilitation centers, some we walk with and they are now okay. They don't have to go to the rehabilitation centers.
[IDI, FBO Leader, Nairobi County]

3.5 Practices in Relation to Alcohol and Drug Abuse

87.8% of the FBO leaders interviewed indicated that their churches expressly prohibited church members from consumption of alcohol and drugs. Nonetheless, a large majority (87.5%) of those interviewed reported that the prohibition was not part of any vows members are made to take on formal admission into the church register. The remaining 12.5% reported that the prohibition was part of the vows taken before the members are admitted into the church register. These responses are summarized in Figure 3.8.

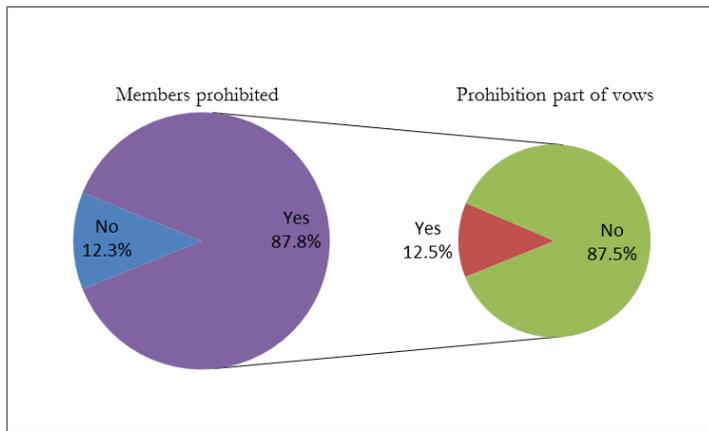


Figure 3.8: Church position on consumption of alcohol and drugs

Out of those who reported that the church has some form of prohibition against the use of alcohol or other intoxicating substances 309 did not respond to the question asking for the specific prohibition. Thirty-seven (10.5%) reported that the prohibition made it clear that the body is the temple of the Lord. As such, one should not take alcohol in reference to an often quoted verse from the Bible in the Book of Psalms. The remaining five respondents (1.4%) alluded to that fact that they swore during their baptism not to take alcohol or drugs. This, in fact, is a specific vow taken by the members of the Seventh Day Adventist Church.

The position of the church in relation to consumption of alcohol and drugs was reinforced in an in-depth interview with one of the FBO leaders. He stated that the stand of the church is that “there is no alcohol. That is what we preach, no alcohol.” [IDI FBO leader, Nairobi County] “We do this through preaching and teaching, we do not have any oaths. You see, you cannot clean the fish before catching it. You first of all catch the fish and then you clean it. We cannot tell you that you first take an oath, no. The word we teach is transformational, we expect that the word will make you change and walk in the right direction.” [IDI FBO Leader, Nairobi County]

FBO Leaders’ involvement in alcohol and drug abuse activities: One quarter of the leaders have not spoken against the use of alcohol or drugs to their congregations while just about half have spoken against alcohol and drugs use once or twice during the month preceding the interview. This reflects the level of effort from the leaders in addressing alcohol and drug addiction issues in their congregations. The remaining 25% of the leaders had addressed this problem at least twice during the preceding month (Figure 3.9). A significant finding from this survey is that one in ten of the FBO leaders (13.5%) had never talked about alcohol and drug abuse to their congregations, thereby missing opportunities to contribute to the fight against alcohol and drugs abuse. Less than 30% were consisted in delivery of this message on a weekly basis (Figure 3.10).

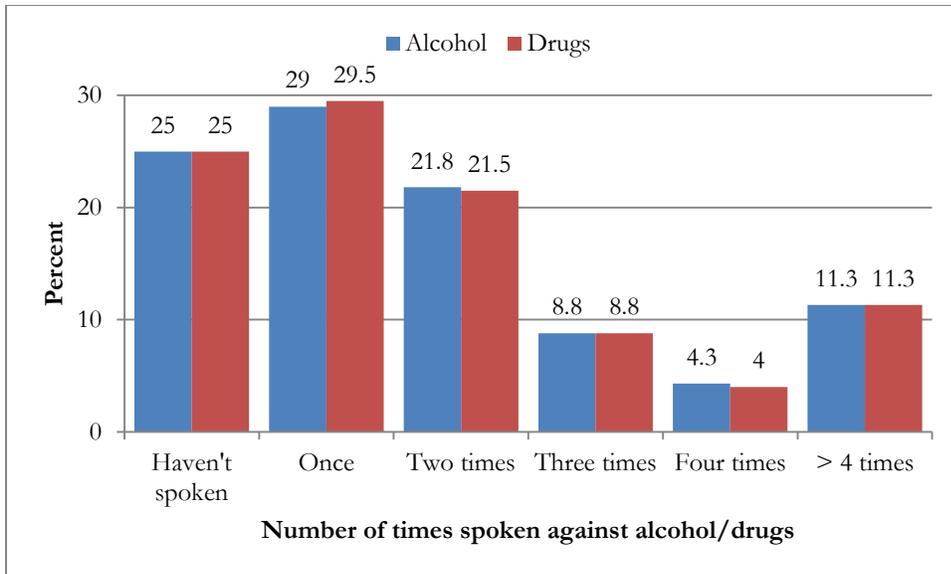


Figure 3.9: Efforts of FBO leaders against alcohol and drugs abuse within congregations

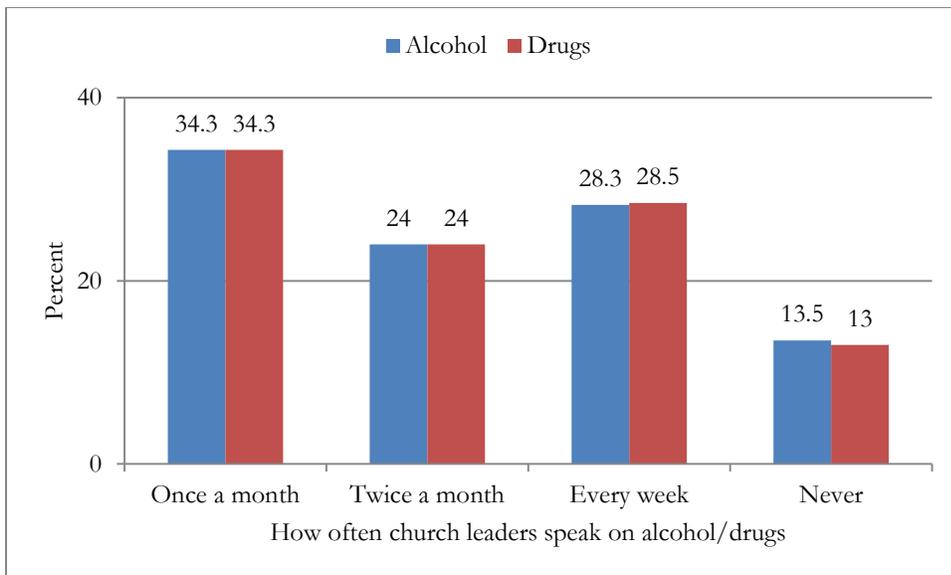


Figure 3.10: How often church leaders address alcohol and drugs issue in their congregations

The relatively infrequent involvement of the leaders in addressing alcohol and drugs abuse among their congregations is buttressed by the perceptions that they had room to improve in their delivery of messages to congregations. 54% of those interviewed reported that they still could improve speaking against alcohol and drugs abuse. Conversely put, more than 50% of the FBO leaders were satisfied in how they had addressed alcohol and drugs abuse within their congregations (Figure 3.11). These self-ranked themselves lower at 1 or 2 on a scale of 1 (lowest rank) to 5 (highest rank).

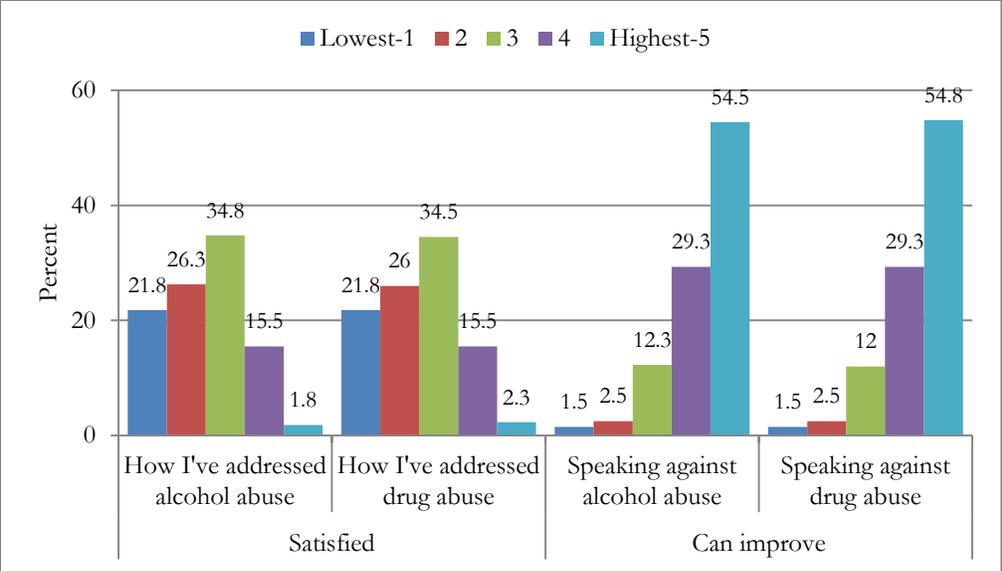


Figure 3.11: Leader's self-ranking of how they address ADA/whether they can improve

3.6 Strategies to reduce Misuse of Alcohol

The FBO leaders identified various strategies which could be put in place in order to address the misuse of alcohol and drugs in the community. Among the most mentioned strategy is awareness creation (81.75%) as shown in Table 3.7. They were of the opinion that in order to have a positive impact on reducing misuse of alcohol and drugs the dangers of using and misusing alcohol and drugs should be clearly spelt out. Providing alternative activities such as employment (34%), enforcing the “Mututho” laws (26%) and using families as role models (21%) completed the top four strategies identified by the FBO leaders. These strategies are summarized in Table 3.7.

Table 3.7: Strategies to reduce misuse of alcohol (N=326, multiple responses)

Strategy	Freq	%
Awareness creation on dangers of ADA	327	81.75
Create employment for youths	136	34.00
Enforce Mututho laws	105	26.25
Families to be role models	85	21.25
Show love to ADAs	78	19.50
Establish more rehabs	73	18.25
Use opinion leaders to speak to ADAs	71	17.75
Offer guidance and counseling	54	13.50
Arrest the drug dealers	46	11.50
Reduce corruption in licensing	38	9.50
Former users to be used as case studies	26	6.50
Use church as entry point to community	18	4.50
Reduce adverts promoting alcohol	16	4.00
Use provincial administration	16	4.00
Target youths in schools	16	4.00

NACADA need to devolve to counties	12	3.00
Set up recreational centers	9	2.25
No alcohol to children	5	1.25
Church to be an agent of change	4	1.00
Community should collectively condemn ADA	2	0.50
Increase taxation for brewers	2	0.50
Increased stakeholders collaboration	2	0.50
Get the root cause	1	0.25

One FBO leader noted that:

One thing I believe is to teach people how to respect themselves so that they don't destroy themselves. The next thing is to encourage people to start small-scale businesses such as farming so that they are not idle. We say, 'an idle mind is the workshop of the devil', so they will not be stuck in the problem. The other thing is to train the people to know that the small amount they have can slowly grow to something big if well invested. If people say they are jobless but still drink, the little money they spend [on drinking] can grow. [IDI, Female FBO Leader, Kirinyaga County]

The FBO leaders identified various ways in which NACADA could link up with FBOs. Teaching church members on issues of alcohol and drug abuse was the most identified mechanism (87.5%) of linking NACADA to FBOs. Others include conducting joint outreach programs (64%), provision of IEC materials to churches to aid their outreach activities (40%) and use of church as entry points for their activities (Table 3.8).

Table 3.8: How NACADA might link to FBOs (N=400, multiple responses)

NACADA Link to FBOs	Freq	%
Teach the members on ADA issues	350	87.5
Carry out joint outreach programs	255	63.75
NACADA to give churches IEC materials	162	40.5
Recognize church as central stakeholders	115	28.75
NACADA should use the church as entry point	110	27.5
Fund ADA activities by the church	106	26.5
NACADA should use church crusades to speak on ADA	33	8.25
Set up ADA desk in churches	24	6
Partner during schools holiday to teach about ADA	22	5.5
Second ADA professional counselors to churches	20	5
NACADA should decentralize services	17	4.25
Sermons to talk on ADA	17	4.25
Use media e.g. video, cinemas & radio	9	2.25
NACADA should train the youths	9	2.25
Set up recreational centers	8	2
Train the clergy on ADA	4	1
Offer support to church social programs	4	1

Support church outreach program on ADA	3	0.75
Deal with the drug dealers	3	0.75
Church to pray for the addicts	3	0.75
Church leaders to be NACADA ambassadors	2	0.5
Partner to create employment opportunities	2	0.5
Create interreligious forum to address the problem of ADA	2	0.5
Bar Christians from selling alcohol	1	0.25
Church and NACADA should carry out pastoral visits	1	0.25
Church calendars should include a season for ADA	1	0.25
Church should lead an exemplary life	1	0.25
Church to help in community mobilization	1	0.25
Churches should be allowed to make referrals to NACADA	1	0.25
Enforce Mututho laws	1	0.25
Follow ups is vital	1	0.25
NACADA workers should be God fearing	1	0.25
Offer alternative livelihoods to brewers	1	0.25
Rehabs - Help Churches to set up rehabilitation centers	1	0.25
Use the changed ADA's as case studies	1	0.25

The FBO leaders recognized the need to work with NACADA in joint activities such seminars, workshops, reaching out to the youth jointly, joint road shows, educative dramas, and *barazas*. As well, the use of media that is popular with the youth e.g. videos, cinemas, radio to reach out to them with messages against ADAs was identified as one other mechanism of NACADA linking up with the FBOs. In order to facilitate the church activities related to alcohol and drugs abuse, the FBO leaders reported that they would appreciate funding support for church initiated ADA activities. These activities include seminars, workshops, as well as providing financial support to counselors seconded to churches.

4.0 DISCUSSION, CONCLUSION AND RECOMMENDATIONS

4.1 Discussion

Kenya is principally a Christian country with approximately 82% of the population professing one form of Christianity or the other. These religious groups have established structures across the country to help support community outreach activities – they run schools, health care facilities, community development projects, among others and are widely felt in policy circles especially in relation to health care provision and education. The voice of the Faith Based Organizations (FBOs) in combating alcohol and drug use, however, is rarely felt in policy in circles. This study presents the knowledge, attitudes and practices of Christian FBOs in relation to alcohol and drugs abuse within their congregations and areas of jurisdiction.

4.1.1 Knowledge

The FBO leaders felt that they possess adequate knowledge regarding alcohol and substances of abuse to be in a position to effectively communicate to their congregations regarding alcohol and drug abuse issues. Indeed, they reported high knowledge with regard to tobacco products, alcoholic beverages, marijuana and *khat* in their various forms. Relatively, fewer leaders knew of heroin and cocaine although the proportion of those reporting knowledge of these rose with prompting by the interviews. Indeed, the proportion went up in all the different types of substances of abuse but that increase was very small. Despite the leaders' agreement that they have adequate knowledge, FGD discussions as well as in-depth interviews seem to indicate to the contrary.

Similarly, the leaders indicated that they were well informed regarding the level of drugs consumption within the community as well as within their own congregations. However, there are differences in reported levels of substance abuse. Although the leaders tend to agree that use of heroin, inhalants and prescription drugs is low among congregants and the community in general, there is less agreement on tobacco use, alcohol consumption, marijuana and *khat* use among the two groups, namely the congregants and the community. In the latter case, leaders felt that use of alcohol, especially, was high within the community. Elsewhere, in the USA, studies have shown a link between religiosity and alcohol and drug abuse among adolescents (Pullen *et al.* 1999). In their study, Pullen and colleagues (1999) conclude that as attendance of religious services increased, so did alcohol and drug abuse decrease. More recently in a study in a Ugandan fishing community (Tumwesigye *et al.* 2013) have discussed the link between religiosity and alcohol consumption. Their study revealed that those who reported low levels of religiosity were five times more likely to have consumed alcohol compared to those reporting low to average religiosity.

The perception of leaders is people use alcohol and drugs in order for them to have fun, relax, interact with others (peer pressure), as well as for them to feel important. Others thought that people use substances of abuse as a way of 'killing' time. The use of alcohol as part of a social process is well documented (Ziervogel *et al.* 1997, Reda *et al.* 2012, and Abikoye and Osinowo 2011). On the other hand, the FBO leaders indicated that use of substances of abuse leads to various problems including marital breakdown, unproductive activities (e.g. when users are just lazing around, and high school dropout rates. In a recent longitudinal study on Australia, Boden, Fergusson and Horwood (2013) have shown the relationship between alcohol misuse and

breakdown of relationships. Their study suggests that there is a causal association between alcohol misuse and relationship breakdown. The estimates from this longitudinal study suggest that alcohol misuse accounts for between 4.5 – 4.6% of marital/cohabiting relationship dissolution in the cohort (Boden, Fergusson and Horwood 2013).

Relatively, fewer of the FBO leaders seemed to know the risk of prescription drugs. While the FBO leaders were in agreement that tobacco products, alcoholic beverages, marijuana, heroin, cocaine and *miraa/kebat* posed a great risk to the users, fewer leaders (less than 50%) reported that prescriptions drugs posed a great risk to the users. Certainly, a one in three of the FBO leaders did not know how much a risk abuse of prescriptions drugs posed to the person abusing the substance. This may reflect the relatively low knowledge/emerging nature of prescription drugs in the Kenyan communities. Another general agreement among the leaders is that substance abuse was not completely free of risk.

4.1.2 Attitudes

It is agreed that substance abuse is of public concern owing to debilitating outcomes as witnessed in the country in recent times. Most recently, numerous deaths linked to methanol-laced drinks have been recorded in the mass media. In response, the government has put in place legislation meant to bolster efforts aimed at curbing the misuse of substances of abuse. These responses are a coordinated effort among law enforcement agencies, the judiciary and provincial administration. At the center of these efforts is NACADA.

The public nature of the drugs problem in the country and the concern of the clergy is clearly noted in the FBO leaders' response that the clergy should be concerned. More than 90% were of the opinion that they should be concerned on matters relating to alcohol and drugs abuse.

The FBO leader's attitudes towards those who are addicted to alcohol and drugs is generally positive. They regarded those who misuse drugs as individuals who needed help if only to help them reform. Thus, leaders indicated that those who abuse alcohol and drugs should be shown love rather than being shunned.

4.1.3 Practices

FBO leaders indicated that their churches expressly prohibits church members from consumption of alcohol and drugs. Nonetheless, close to nine in ten of those interviewed reported that the prohibition was not part of any vows members are made to take on formal admission into the church register. Thus, while prohibition is the order in the various Christian congregations, in practice people are not expected to take any vows towards non-use of alcohol and drugs. Some religious groups, such as the Seventh Day Adventist Church, have specific vows in their Church Manual⁵ which members have to take before they are baptized and admitted into the Fellowship of the SDA Church.

⁵Specifically, the Church Manual asks those being admitted into the church membership to avoid use substances that are harmful to the body including abstaining from all unclean foods; from the use, manufacture, or sale of alcoholic beverages; from the use, manufacture, or sale of tobacco in any of its forms for human consumption; and from the

In terms of actual pronouncements against alcohol and drugs use, a significant proportion of leaders were silent on alcohol and drugs use. One quarter of the leaders have not spoken against the use of alcohol or drugs to their congregations while just about half have spoken against alcohol and drugs use once or twice during the month preceding the interview. This reflects the level of effort from the leaders in addressing alcohol and drug addiction issues in their congregations. This is perhaps informed by the assertion by some clergy that faithfuls are like 'fish' that you "catch" first before cleaning, implying that church is for all irrespective of their status. The position also resonates with their view that those who abuse drugs should be shown love and be rehabilitated. Whether this care and support should be done within the church environment is not clear. However, a recent study has concluded that by integrating clients' spiritual beliefs and practices into treatment may speed recovery, enhance compliance with prescribed treatment, prevent relapse, and reduce treatment disparities because it provides more culturally congruent services (Hodge 2011).

As well, the relatively infrequent involvement of the leaders in addressing alcohol and drugs abuse among their congregations is buttressed by the perceptions that they had room to improve in their delivery of messages to congregations. This provides an opportunity for agencies such as NACADA to give technical support in terms of preparing focused messaging which church leaders could use to enhance their ability to effectively communicate with their congregations.

4.1.4 Working towards elimination of alcohol and drugs

Leaders identified various strategies which they proposed to apply towards elimination of alcohol and drugs misuse within congregations and in the community. The proposed strategies may be grouped into four broad categories, namely: focusing on knowledge creation among the laity through awareness campaigns; law enforcement such as strict application of the Mututho laws; eliminating corruption in licensing and punishing those who deal with substances of abuse by jailing them; establishing of support structures such as rehabilitation centers, and guidance and counseling; and, lastly use of family structures to provide support to those who are addicted or to shield children from getting into alcohol and other substances of abuse.

In the eyes of the clergy, efforts against alcohol and drugs abuse are three-pronged: knowledge creation, legal structures/systems and creating support structures. In this respect, NACADA should play the lead role in terms of providing IEC materials, training clergy and using church organized crusades to reach out to the communities. The legal structures/systems on the other hand are expected to enforce laws relating to licensing and operation of premises that sell alcoholic drinks and targeting those who distribute substances of abuse within communities. The third pillar upon which campaigns should be build relates to support structures such as rehabilitation centers, and establishment of recreational facilities to occupy would be abusers.

4.2 Conclusion

Religious groups are important segments of the Kenyan society which should play a central role to enhance anti-alcohol and drugs abuse campaigns. The knowledge, attitudes and practices assessment

misuse of or trafficking in narcotics or other drugs. (Pg. 47). Seventh Day Adventist Church Manual, 10th Edition, 2010. http://www.toc.adventist.org/site_data/1831/assets/0005/3324/ChurchManual_2010.pdf

of FBO groups contributes to the formulation of a guided discussion and approach regarding entry of FBO leaders into efforts to control alcohol and drugs abuse. The FBOs have a role to play both at the devolved level as well as at the national level.

The data presented here together with the foregoing discussion points to the following conclusions:

- i. The clergy are generally knowledgeable of issues of alcohol and drugs abuse within their congregations as well as in their various communities.
- ii. The clergy perceive their congregational members as being at low risk of alcohol and drug abuse compared to those in the community, which implies that they perceive the problem as being outside the church rather than within.
- iii. The clergy have a positive disposition towards those who abuse alcohol and drugs and are willing to accept and help them get out of addiction.
- iv. A fair proportion of the clergy do not address issues on alcohol and drugs abuse to their congregations regularly. In fact among the clergy, one in four have not broached this topic to their congregations.

4.3 Recommendations

In order for the FBO leadership to provide adequate support to their congregations, there are a number of changes which must be effected in order to have better directed support to local communities.

First, it is important to change address the knowledge of FBO leaders so that they are better equipped to handle substance abuse related problems. Although they reported that they generally are well positioned to help their congregants, they also did indicate lack of adequate knowledge to be able to competently deal with substance abuse. Thus, NACADA should consider providing support to FBO leaders in terms of IEC materials.

Second, in order for anti-alcohol and drugs abuse campaigns to be effective, the clergy should have a mind change so that they do not perceive only those in the community as being at risk. When this happens then interest on alcohol and drugs abuse among the FBO leaders will be aroused and through this their active participation will be realized.

Third, involvement of religious leaders in actively promoting non-use of alcohol and drugs is low within congregations. NACADA should work with the FBO leaders in order to sensitize them regarding the need to constantly educate their congregations regarding the dangers of alcohol and drugs abuse.

Lastly, efforts towards elimination of alcohol and drug abuse should be built on a multi-pronged system imparting appropriate knowledge to the clergy through provision of IEC materials among others, enforcing of the existing legal provisions including streamlining licensing of premises and establishing and supporting structures to facilitate rehabilitation of those who abuse alcohol and drugs.

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