

DOCUMENTING THE EFFECTS OF THE MEDIA ON ALCOHOL CONSUMPTION IN
CENTRAL KENYA

by

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B.A., Kansas State University, 2009

A REPORT

submitted in partial fulfillment of the requirements for the degree

MASTER OF SCIENCE

School of Journalism and Mass Communications
College of Arts and Sciences

KANSAS STATE UNIVERSITY
Manhattan, Kansas

2015

Approved by:

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Abstract

Kenyan society has seen problems with alcohol abuse and has seen many deaths related to illicitly brewed alcohol. A Kenyan government body, The National Authority for the Campaign Against Alcohol and Drug Abuse, (NACADA), has done research about the problem, but very few outsiders have performed research in this area. This research seeks to study the problem from outside of the standard government framework while using a cultural approach.

The purpose of this project is to document the alcohol abuse problem in Kenya, and what methods of mass communication, if any, could be used to help convey a solution to the problem. It is to provide a firsthand account of the alcohol abuse problem that plagues the East African nation in an effort to bring more awareness to the situation. To document the situation, I interviewed several key cultural figures chosen based on their affiliation with the academic, religious, medial or cultural framework of Kenyan society. Each person was asked a series of questions regarding the alcohol problem in Kenya, what could be done from their particular perspective, and how the media have and could influence the situation. The information gathered indicated that the alcohol problem is widespread in Kenya, that the people with alcohol problems tend to be men, and that the problem is multifaceted and very complex. Many factors contribute to the problem, such as idleness, poverty, unemployment, and more, and the problem affects many more people than just the people drinking the alcohol.

The information gathered is meant to help provide suggestions to helping solve this problem in Kenya. Recommendations from this research will provide guidance for those who are trying to create media campaigns to combat alcohol abuse in Kenya.

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Acknowledgements

Since I started my career in graduate school at Kansas State University, I have worked closely with many of the professors in the department. I would like to thank every professor that I have worked with, especially those on my committee - Dr. Joye Gordon, Dr. Lou Benjamin, and Dr. Nancy Muturi.

I would like to especially thank Dr. Nancy Muturi for all the time she has spent with me along the way. We visited Kenya together during the data gathering period of the project, and lived together during that time. While in Kenya she showed me to the culture and the country, and introduced me to local contacts that made this project possible. I will be forever thankful to Dr. Muturi for giving me this opportunity, and I hope that some day I am able to repay her.

I would like to thank my parents for all the love and support they have shown me during this time of my life. Without their support, I could not be where I am today. I would also like to thank my wife, Leigha, for supporting me through all the long nights and weekends. She was always the wind at my back, encouraging me when I needed it the most.

Other people that have been vital to my success include Steve Harvey, Dr. Steve Smethers, Aaron Engelman, Ryan Becker, Steven Spalsbury, and Alfonse Baki. Thank you all for believing in me and sticking with me until the end.

Chapter 1 - Introduction

The WHO (2011) estimates that 2.5 million people die each year from more than 60 alcohol related illnesses and injuries, and Kalichman, Simbayi, Kaufman, Cain & Jooste (2007) argue alcohol is the most commonly used psychoactive substance in the world, making it a global health concern. Alcohol can be a major contributing factor to poor health (Dimah, Gire, 2004) and can cause liver cirrhosis, epilepsy, poisonings, several types of cancer, hypertension, suicide and poorly controlled diabetes (Branscum, Sharma, 2010; WHO, 2011). Alcohol has also been linked to deaths from road and traffic accidents, domestic violence, HIV infection and other disorders (Obot, 2006). Unemployment has also been linked to alcohol misuse, although it is unclear which is the cause and which is the effect (Popovici & French, 2013).

Alcohol Consumption in Kenya

Alcoholism has become an epidemic in Kenya, especially among men, and specifically in the central areas of Kenya (National Authority for the Campaign Against Alcohol and Drug Abuse [NACADA], 2010). In an area where unemployment and poverty are extremely high (Central Intelligence Agency [CIA], 2013), and where cheap alcohol is readily available, alcohol abuse has been a problem (Papas et al., 2010). In 2010, the government of Kenya passed the Alcoholic Drinks Control Act of 2010 to help curb the abuse of alcohol (National Council for Law Reporting, 2010). However, the issue continues to be a problem as high unemployment rates, government corruption and lack of development plague the nation (CIA, 2013).

The high rate of alcohol abuse in Kenya could be due to the ease of availability, the social acceptability and the result of sales promotions through uncontrolled advertisements (Othienko, Kathuku, & Ndeti, 2000). Higher rates of health problems related to alcohol are linked to lower economic development and socioeconomic status (WHO, 2011). Since the Kenyan government

has liberalized the economics of the country, alcohol and tobacco companies have marketed their products aggressively (Othienko et al., 2000).

The abuse of alcohol and other substances is reported to be widespread throughout Kenya (Othienko et al., 2000). A recent study on alcohol usage in the country states that 12 percent of children between the ages of 12 and 17 use alcohol or another substance in Kenya (NACADA, 2010). The high prevalence of “second-generation alcohol” or “unrecorded alcohol,” homemade or illicitly made alcohols made outside of government control (Muturi, 2014; WHO, 2014) with high potency and made under unhygienic circumstances (NACADA 2010), contributes to the alcoholism problem. These are common at many social and cultural ceremonies (Papas et al., 2010) and have been shown to have a higher alcohol content than normal drinks (Papas et al., 2009; Willis, 2003).

These types of alcohol are more dangerous because lack of official governmental regulation allows for any number of things to be used during the brewing process (NACADA, 2010). Njue, Voeten, & Remes (2011) found that these illegal brews were found to be available in local bars and drinking dens, especially in the lower socio-economic neighborhoods (Njue, Voeten, & Remes, 2011). The second-generation alcohols, or cheap alcohol with a high alcohol content (Muturi, 2014), were reported to have increased in central Kenya (NACADA, 2010). The affordability and accessibility of second-generation alcohol contribute to its prevalence in the area (NACADA, 2010).

Alcohol is a worldwide leading factor for death for men ages 15 to 59 and globally, 6.2 percent of male deaths can be attributed to alcohol, in comparison to 1.1 percent for women (WHO, 2011). Researchers estimate that about 17 percent of men and about 8 percent of women will become alcohol dependent during their lifetimes (Hasin, Stinson, Ogburn, & Grant, 2007).

Men have higher rates of alcohol related deaths than women, and are almost twice as likely to be involved in an alcohol-related car accident than women (Chen & Ti, 2010, National Highway Traffic Safety Administration, 2006). The low rates of alcohol abuse for women in Kenya could be linked to the greater socio-cultural aspect of most African communities, where women are shunned if they smoke or drink (Othienko et al., 2000).

The National Authority for the Campaign Against Alcohol and Drug Abuse (NACADA), the Kenyan organization run by the government to address the alcohol and drug problem in the country, currently has a program that is supposed to combat alcoholism (NACADA, 2012). However, regardless of the current prevention interventions, there has been limited or no change in the abuse rates of alcohol in central Kenya (NACADA, 2010). It is important to understand that, for whatever reason, these current campaigns against alcoholism in Kenya are not working. The goal of this project was to document the perceptions of the people most affected by the problem and begin to identify what mass communications strategies could be used to help combat the problem.

Problem Statement

With the recognition that excessive alcohol use is a problem in Africa, and more specifically Kenya, several factors must be explored to determine how to combat alcohol abuse. The top-down approach that has been implemented by NACADA has not been effective, nor have the laws implemented by the government to limit the supply and consumption of alcohol. The alcoholism problem must be viewed from the perspective of those communities that are effected by the problem. A new approach is needed, an approach that must come from a cultural perspective of the problem in which the perception and severity of the problem, and susceptibility and self-efficacy of the people and the problem must be investigated.

Alcohol consumption is nothing new. However, the level of alcohol abuse is increasing in Kenya, along with the negative health effects that coincide with prolonged alcohol abuse (NACADA, 2010). Since the main problem lies with young males, the available work force is dwindling and increasing strain is put on other members of the family, as men are no longer participating in day-to-day activities (NACADA, 2010). The future of Kenyan society relies on a solution to this problem. Economic issues such as idleness, unemployment and poverty are largely responsible for why alcoholism has become such an epidemic in Kenya (Muturi, 2014a; NACADA, 2010).

In order to understand what can be done to help curb the problem, the cultural approach to risk perception is best implemented to perceive the underlying causes of alcoholism in Central Kenya. This approach puts emphasis on examining the relationship between cultural structures and cultural practices, and takes into account the role of the media in these contexts (Dutta & de Souza, 2008). The culture-centered approach also allows for interaction and engagement from the affected community during the development of the health communication campaign (Muturi, 2014; Dutta & de Souza, 2008), ultimately making the campaign more effective. This approach is relevant in Kenya, where the top-down approach of disseminating information about alcohol abuse has proven unsuccessful.

Justification

Kenya is a part of the East African Community, which consists of Tanzania, Uganda, Rwanda and Burundi (CIA, 2011). Kenya is considered to be the financial heart of the Eastern African Community, as well as the more general eastern section of Africa (CIA, 2011). If alcoholism is allowed to run rampant, Kenya may lose its standing as the financial stronghold of eastern Africa. With a solution, or a step in the right direction, to the problem of alcoholism in

Kenya comes a more stable society. The aim of this project is to describe the problem from a cultural perspective, and to give a voice to those directly affected by the problem. This information could be used to create a health communication campaign aimed at stopping the alcohol abuse problem in central Kenya.

Observations of the problem for this project were obtained through interviews with experts in Kenya about alcoholism and alcohol abuse. These interviews were combined with footage of Kenya while researching in-country. Several members of the community helped understand the problem from within the culture. These community members consisted of a Professor of Journalism, a Professor of Sociology, a spiritual leader, a layman, and a medical professional. Efforts were made to speak on-the-record with a member of the government body in charge of the problem (NACADA) and a government leader in the community (a police chief), however, neither was willing to speak on-the-record about the problem.

The purpose of this video documentary is to show the problem from the perspective of the people that deal with it every day. This perspective best shows how engrained the alcohol has become in the culture, and how people in the community have become aware and want change to happen. A poor economy, government slowed by corruption, and lack of international interest, among other factors, has caused the problem to fester. This documentary is the starting point to gain international attention for this issue.

Chapter 2 - Literature Review

This study is an examination of alcohol abuse in central Kenya with the intention of developing a health communication campaign to lower the rate of alcohol abuse in this specific region. This chapter defines alcohol abuse in detail, discussing the causes and effects of prolonged alcohol abuse and explains how alcohol abuse affects individuals at the personal, familial, and societal levels. It explains how alcohol abuse has become an epidemic in central Kenya and what steps are currently in place to help eliminate the problem.

This chapter introduces the reader to the media effects of alcoholism and how previous health communication campaigns have attempted to stop or prevent alcohol abuse. It details the growth of the problem in Kenya, citing direct causes and indirect causes that have perpetuated the problem. These issues are presented within the theoretical context of the study, which is also presented in this chapter. Research questions based on the theoretical framework and background information are also provided in this chapter.

Alcohol Consumption and Health Risks

Alcohol is one of the most abused substances globally, resulting in the deaths of millions each year (WHO, 2011). Alcohol is a central nervous system depressant, and has been shown to cause impairments in judgment, sometimes resulting in poor decision making (Mbulaiteye et al., 2000) and is the third largest risk factor for disease and disability (WHO, 2011). Drinking has been linked to liver cirrhosis, epilepsy, poisonings, several types of cancer, hypertension, suicide and poorly controlled diabetes (Branscum, Sharma, 2010; Dimah, Gire, 2004; WHO, 2011), has been shown to cause or increase the risk of infectious disease, cancer, diabetes, neuropsychiatric disease, cardiovascular disease, liver and pancreas disease, and unintentional and intentional injury (Rehm, 2011).

Evidence has shown that alcohol consumption can have a negative impact on those fighting diseases such as tuberculosis, human immunodeficiency virus (HIV), and pneumonia, and this is especially true in sub-Saharan Africa (Rehm, 2011). Alcohol has been shown to be a factor in the spread of STDs and instances of unsafe and unprotected sex, and can cause lowered male sex drive and lead to low levels of testosterone (Muturi, 2014). Alcoholism is controlled not only by pharmacological factors but also by cognitive factors (Brown, Goldman, Inn, Anderson, 1980) and has been associated with mental health problems (Dimah & Gire, 2004).

Sustained alcohol abuse, such as alcoholism, has been linked to other issues such as car crashes, domestic violence, fetal alcohol syndrome, neuropsychological impairment, poor medication adherence, economic cost and lost productivity, and psychiatric comorbidity (Hasin et al., 2007; Rehm, 2011). The negative effects of alcohol extend beyond the drinker and impact coworkers, household members, relatives and friends, strangers and the community as a whole (Dimah & Gire, 2004; Rehm, 2011), and can negatively affect the socio-economics of close family members (Othienko et al., 2000; Dimah & Gire, 2004).

Alcohol Use in Africa

Alcohol has a long history in sub-Saharan Africa (Clausen, Rossow, Naidoo, Kowal, 2009; Obot, 2006). The traditional pattern of drinking was based around ceremonies and events (Clausen et al, 2009; Willis, 2006). Countries in sub-Saharan Africa consume some of the highest rates of alcohol in the world (Woolf-King & Maisto, 2011), and alcohol plays an important role in social gatherings, rites of passage, and local economies (Tusekwa, Mosha, Laswai & Towo, 2000; Woolf-King & Maisto, 2011). Alcohol in Africa has traditionally not been a commodity for sale, but a beverage brewed locally by women for men (Clausen et al., 2009). Much of the alcohol consumed in rural areas is locally and sometimes illicitly made

(Obot, 2006). During the 20th century, when wage employment began to increase across Africa, alcohol became a commodity for sale (Willis, 2006). This increased commercial availability of alcohol brought about new restrictions to control drinking habits, including where alcohol could be sold and drunk, hours during which alcohol could be served, and liquor licenses (Willis, 2006). Race was central to these regulations and in many cases, especially in British controlled territories, Africans were not allowed "European" liquors, including bottled beer, leaving traditional and local brews as native African's only option (Willis, 2006).

More recently, large quantities are brewed by locals or commercial enterprises to satisfy a growing number of consumers (Clausen et al., 2009; Obot, 2006). In post-colonial Africa (circa 1950s and later), the attitudes towards alcohol changed drastically and, as new African politics and economics took over, Africans were encouraged to drink bottled beer or bottled spirits, rather than more traditional brews (Willis, 2006). As the commercial alcohol market continues to grow in sub-Saharan Africa, many countries face transitions in the way alcohol is made, consumed and marketed (Clausen et al., 2009). While bottled and imported spirits are a popular sign of wealth and status, locally made "traditional" brews are still very popular amongst a very large unemployed sector, as they are more affordable and readily available for purchase (Willis, 2006).

Men and Alcohol in Africa

During pre-colonial Africa, alcohol was used for pleasure at the end of the workday and was reserved for adult males (Odejide, 2006). Throughout this time period, the maintenance of societal well-being and the drinking of alcohol were mainly left to the elder men of the community (Willis, 2006). As Africa shifted more towards wage employment during the 20th century, younger men were able to earn money and purchase the alcohol that women had begun

to sell, instead of only supplying older men as a sign of their dominance of the household (Willis, 2006). During this transition period, alcohol use moved from the household to a specialized drinking spot, such as a licensed beershop or an illegal drinking den (Willis, 2006).

In recent years in sub-Saharan Africa, adult males are still the most common alcohol consumers and are also more likely to drink heavily (Clausen et al., 2009; Woolf-King & Maisto, 2011; Kalichman et al., 2007). A recent meta-analysis of research has shown that, in several Eastern African countries, including Kenya, Uganda and Tanzania, men drink more liters of alcohol per year than women (Woolf-King, Steinmaus, Reingold, & Hahn, 2013). However, for many women in traditional African culture, alcohol and tobacco use results in shunning, which might explain lower use rates among females (Othienko et al., 2000). Similarly to earlier in the 20th century, the women continue to help make and sell local brews, while men are the main consumers (Clausen et al., 2009).

Kenyan Context

Kenya is a presidential republic located in East Africa that gained its independence from Great Britain in 1963 (CIA, 2011; Ndetei, Mathai, Khasakhala, Mutiso & Mbwayo, 2010; Njue, Rombo, & Ngige, 2008). Most of the population of the developing country lives in rural areas, and farming is the mainstay of the economy (Njue et al., 2008). The country has 42 distinct ethnic groups with different languages and culture (Njue et al., 2008). The Kikuyu ethnic group in central Kenya is the largest in the country (KNSB & ICF Macro, 2010; Muturi & Mwangi, 2010).

Kenyan Culture

Kenyan society is comprised of ethnic Kenyan traditions (social and cultural practices apparent before the colonization of the British) and Western ideas that were imported during the

colonial era (Muturi, 2002; Njue et al., 2008). There are three main classes of people in urban Kenya - the wealthy elite, middle class, and the unemployed or underemployed (Muturi, 2002). During the colonization period, the British created a stratified educational system in which Europeans received the highest level of education, Asians received a mid-level education, and native Africans received the lowest level of education, and were pushed towards Christianity (Muturi, 2002).

Othienko et al. point to social acceptability as one reason alcohol and tobacco use rates are so high in Kenya (2000). Alcohol use rates tend to be lower among less-urbanized peoples of Kenya, and similar studies found that people with a more westernized cultural orientation were more likely to use illicit substance such as cannabis and inhalants (Othienko et al., 2000; Eide & Acuda, 1997).

Family Life

Kenyan society places high importance on childbearing, high enough that adults will risk infecting their partners with a sexually transmitted infection (STI) in order to procreate (Lasser, Fite, & Wadende, 2011). In Kenyan families, the father stands atop the food chain as the provider and protector of the family, as well as "the symbol and custodian of the ultimate power and responsibility in the family and community at large," (Lasser et al., 2011, p. 50). Fathers in Kenya have traditionally trained their sons in a trade or craft and encouraged their sons to learn from other male elders in the community, giving the father more influence over his son than his daughter (Lasser et al., 2011). Men are also in charge of decision-making concerning the economic and political well-being of the family (Njue et al., 2008).

Kenyan families face a myriad of challenges, including poverty, malnutrition, illiteracy, unemployment, gender inequality, childhood mortality, and HIV/AIDS infections, among others

(Njue et al., 2008). While the population is almost evenly split between males and females (50.5 percent females), men account for around 70 percent of the workforce and tend to be more educated than women (Njue et al., 2008).

Alcohol Consumption in Kenya

Researchers have spent many hours determining reasons for drinking, with varying results. As Leigh (1990) points out, some researchers have found that, when people explain their motivations for drinking, the responses may “represent after-the-fact interpretations of the effects experienced when drinking, or the choice of a socially acceptable explanation” (p. 91). Such explanations might be the case for problem drinkers in Kenya, especially in the central province.

Alcohol has had a long history in Kenya, a history that is a product of western culture, equivocal laws, capitalism and government corruption. In the 1960s, Kenya Breweries Limited (KBL) was Kenya's largest commercial brewery and, by the end of the decade, had swallowed up all of the smaller competitors (Willis, 2003). However, research done during the 1970s indicated that a large part of the alcohol market was composed of small-scale producers of fermented brews (*busaa*) and liquors (*chang'aa*), not of the major commercial enterprises (Willis, 2003). This traditional alcohol was once used in ceremonies and during special occasions by older men, but now has become a commercial enterprise on its own (Papas et al., 2009; Willis, 2003).

Types of Alcohol in Kenya

Alcohol use is very prevalent in the central areas of Kenya (Muturi, 2014a) and alcohol has touched the majority of households in the country (NACADA, 2010; Walt, Kinoti, & Jason, 2013). There is a high prevalence of “second-generation alcohol” and traditional liquors (Muturi, 2014a), which have no governmental regulation and are made with some sense of secrecy (NACADA, 2010; Willis, 2003), contributing to the alcoholism problem. The alcohol content of

these illicit brews can vary widely, as does serving size, and drinkers continually refill their cups while drinking (Lo, Oeltmann, Odhiambo, Beynon, Pevzner, Cain, & Phillips-Howard, 2013). These types of alcohol are highly potent and are commonly adulterated with dangerous and unhygienic substances (Muturi, 2014, 2014a; NACADA, 2010). A study done by NACADA (2010) argues that the increase in second-generation alcohol production and sales is due to its availability, affordability and accessibility.

A popular form of these traditional alcohols goes by the name of "*chang'aa*" and is made from millet or corn (Lo et al., 2013). Illicit alcohol is cheaper than commercial brews, only costing about 20 Kenyan shillings (\$.25) per glass (Lo et al., 2013). A study by NACADA in 2010 found that, of the current alcohol users studied, only 48.4 percent used first-generation alcohol, while the majority of respondents drank second-generation alcohol (NACADA, 2010). *Chang'aa*, along with other illicitly made alcohols, has been shown to cause death, blindness, methanol poisoning and other health issues (Lo et al., 2013).

Popular drinking times are an important indicator of the alcohol problem, since usage during daytime or working hours would generally occur at the expense of engaging in socially or economically productive activities (NACADA, 2010). A NACADA (2010) study found that nearly 60 percent of respondents reported alcohol consumption before noon, although the time period with the highest amount of drinking was between 6 and 11 pm. This is in conflict to the laws, which dictate that drinking in local bars or pubs is prohibited before 5 pm and after 11 pm (National Council for Law Reporting, 2010).

Potential Causes for Alcohol Consumption in Kenya

Alcohol use in Kenya has been shown to directly correlate with socio-economic status. The lower the socio-economic status, the higher rates of self-reported alcohol consumption and

drinking to get drunk (Lo et al., 2013). Idleness is the highest rated factor for alcohol abuse in Kenya, with peer pressure, unemployment and work-related stress also topping the list (NACADA, 2010). Alcohol makes people feel good, have fun, relax, escape stress, interact with others and kill time (NACADA, 2010).

Economic Context

The Kenyan economy, mainly agricultural and industrial, has been in decline for several decades (KNSB, 2010). The weakening economy has been attributed to external shocks and internal structural problems, low commodity prices, world recession, bad weather and has contributed to the worsening welfare of the Kenyan people (KNSB, 2010). Economic policy in Kenya favors privatization and deregulation (Economist Intelligence Unit, 2012).

Muturi (2005) found that one contributing factor to the increase in reproductive health problems in Kenya is the deterioration of the country's economy. NACADA has also associated economic factors to high alcohol consumption (NACADA, 2010).

Through the Kenyan "economic liberalization process," sellers of alcohol and tobacco have aggressively marketed their products through the mass media (Othienko et al., 2000). Alcohol and tobacco are not the only illicit substances in Kenya, but they are the most prevalent due to availability and cost (Othienko et al., 2000). While there were reports of youth under the age of 18 using alcohol (approximately 25.6 percent for males and 5.8 percent for females), the majority of the problem lies with males between the ages of 19 and 55, and some men above 55 (NACADA, 2010).

Interventions and Strategies Used to Combat Alcoholism

Alcoholism is prevalent around the world, and is not a problem unique to Kenya. Other countries have created strategies to combat alcoholism, and to stop the use of illicit alcohol. In

1985, Mikhail Gorbachev became the leader of the Soviet Union and started a campaign against drinking (Dorman & Towle, 1991; Nemtsov, 1998). The campaign had two main objectives: to reduce the amount of legally made and sold alcohol, and to suppress illegally homemade alcohols (Nemtsov, 1998). While the prices of legal alcohol increased and the amount sold decreased (Nemtsov, 1998), some media were also used, including health education programs and anti-alcohol propaganda (Dorman & Towle, 1991). Successes from the campaign include a decrease in alcohol-related deaths and injuries, a decrease in occupational and domestic violence and a decrease in public drunkenness (Dorman & Towle, 1991). Some negative results included higher rates of illegally made alcohol and deaths from the use of methyl alcohol and anti-freeze as substitutes for alcohol (Dorman & Towle, 1991).

The Role of NACADA

The National Authority for the Campaign Against Alcohol and Drug Abuse (NACADA) is a Kenyan organization established by an Act of Parliament on 24 July 2012, although it had been functioning since 1996 under the Inter-Ministerial Drugs Coordinating Committee (NACADA, 2012). The organization's main focus is to reduce the demand for alcohol and drugs (NACADA, 2012) and their mission, as published on their website, is: "To provide leadership on policy development, education, regulation, management, programme implementation and research coordination on matters pertaining to drug and substance abuse in Kenya," (NACADA, 2012).

NACADA has produced research in areas relating to alcohol and drug abuse in Kenya. In 2010, a baseline survey was performed in Kenya's Central Province to study the magnitude, causes and effects of alcohol from a community perspective (NACADA, 2010). This research included background information, gauging the magnitude of alcohol use, explanatory factors for

alcohol use, effects of alcohol use, protective factors against alcohol use, lifetime prevalence of alcohol use, current usage amongst the general population and alcohol use interventions (NACADA, 2010).

While NACADA is the government body in charge of stopping alcohol abuse in Kenya, the organization is not doing all that it could. They have produced several telling reports, all of which are published on the organization's website. However, these reports tend to be buried and are not easily accessible to the public, other than that they are online. Also, the organization has not implemented any strategies to incur change; its approach is a passive one of gathering information and reporting. While NACADA has the opportunity to instigate change from a cultural perspective, the organization has instead only produced reports that are too esoteric for the general populace, and serve only to measure the abuse, not stop it.

Other Communication Methods for Communicating the Health Issue

Alcohol use typically begins during adolescence, making schools an opportunity for early intervention (Stigler, Neusel, & Perry, 2011). Only 67.5 percent of people on average cited only negative health effects as a reason not to drink in Kenya (NACADA, 2010). Krieger, Parrott and Afifi (2006) suggest that optimistic bias is greater in situations in which people perceive a sense of control over events and outcomes, so perhaps Kenyans have not felt empowered to take control of the situation. The researchers also point out that many campaigns against alcohol use are centered on a reward-versus-cost model (Krieger et al., 2006). "Messages with utilitarian underpinnings are often successful at increasing knowledge about the potential short-term consequences of alcohol use but generally do not change actual drinking behavior," (Krieger et al., 2006, p. 241).

The Role of Health Communication in Alcohol Prevention

Personal and public health are guided by health information and communication, is the main method for gathering relevant health information (Kreps, O'Hair, & Hart, 1995). Health communication research must take multiple aspects into account, such as situational, psychological and societal factors to understand the full dynamics of health care (Kreps, 2008). Qualitative methods can help answer some of these questions from a cultural perspective, and can help the respondents feel more comfortable when answering questions about their personal health because they are able to explain their problems in a more in-depth manner, providing more context to their responses (Kreps, 2008).

The WHO defines health as "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity," (World Health Organization, 1946, p.1). The end goal of health communication is to facilitate improvements in the delivery of health care and to ultimately improve health outcomes (Kreps, 2012). Health communication tends to be an applied area of research and is typically focused on investigating and addressing health care and health-promoting issues (Kreps, 2012). Health communication can be used to inform public health policies, promote equity in health care, and to improve the media coverage of health issues (Kreps, 2012).

Health Communication Campaigns

Over the last fifty years, modernization and globalization have widened the gap between the health-rich and the health-poor (Dutta & de Souza, 2008), creating an even greater need for health communication campaigns. Health communication campaigns were originally started in the United States to bring about health improvements in the southern states (Dutta & de Souza, 2008). Health communication relies on the contrast between developed and undeveloped areas

and the idea that a technologically more advanced society would "modernize" a less advanced society (Dutta & de Souza, 2008). These campaigns were based on the belief that powerful governments could improve the lives of people from less developed areas, and are often funded by agencies like the United States Agency for International Development (Dutta & de Souza, 2008). The dichotomy between developed and undeveloped societies gave birth to the sender-receiver mode of communication inherent in most health communication campaigns, and thus is called the "dominant framework" (Dutta & de Souza, 2008). Since the beginning of health communication and the dominant framework of the sender-receiver method, communicators have undermined the values of local cultures and promoted foreign solutions for local cultures (Dutta & de Souza, 2008).

DeJong and Winsten (1990) argue for a diffusion of innovations perspective on health communication. This model defines certain objectives, such as establishing the health problem as a priority, increasing knowledge and working to decrease beliefs that impede the new behavior to show personal benefits, teach new skills, show how to overcome barriers, teach self-management of new activities, and provide social support for the changes (DeJong & Winsten, 1990). DeJong and Winsten (1990) argue that six factors contribute to successful campaigns: "...specification of a well-defined target audience; formative research to understand the target audience and pretest campaign materials; messages that build from the audience's current knowledge and satisfy its preexisting needs and motives; a media plan to guarantee exposure to the campaign; procedures for evaluating progress; and a long-term commitment," (p. 32).

Mass Media as an Effective Means to Provide Health Information

Media can be used in health campaigns to fill information gaps, expose people to new ways of living, and help establish modernization in developing countries (Dutta & de Souza,

2008). Mass media health and development campaigns are intended to reach a vast audience, with success of the campaigns generally tied to the ratings of the programs (Dutta & de Souza, 2008). However, several challenges stand in the way of successful media health campaigns. Changing behavior proved more difficult than health advocates expected, and most people who would respond to health campaigns were those already looking to make healthy decisions, leaving the target group unchanged (DeJong, Winsten, 1990). However, DeJong and Winsten (1990) suggest three arguments in favor of mass media health campaigns: behavior change tends to be slow, so short-term media campaigns will be less effective; health advocates must gauge success based on cost-effectiveness, not proportional success rates; and many studies have shown mass media health campaigns to be successful. Mass communication campaigns against alcohol tend to be the most successful when their messages are reinforced by other efforts, such as increased law enforcement, grassroots activities, and other media messages related to the content (Elder, Shults, Sleet, Nichols, Thompson, Rajab, 2004).

Theoretical Framework

Social Cognitive Theory

This project is based, in part, on Social Cognitive Theory as designed by Albert Bandura. As part of his Social Cognitive Theory, Bandura posits that human behavior has been viewed as either an outside-in, or inside-out interaction (Bandura, 2001). In other words, the individual was either given credit for his actions or was at the mercy of the environment around him or her. Bandura (2001) shows this relationship as a three-way schematic where personal determinants, behavioral determinants and environmental determinants interact.

Bandura spends quite a bit of time considering the effect of the mass media on individuals' constructions of reality (Bandura, 2001). He argues that over-exposure to these

alternated realities or perceptions of realities might eventually lead the viewer to believe that what the media portrays is the actual state of human affairs (Bandura, 2001). According to Bandura (2001), there are “dual paths of influence” when it comes to individuals being affected by the media; media influences behavior directly and through a connection to a social system (Bandura, 2001). Humans are situated in interpersonal networks, Bandura (2001) argues, and the people within these networks discuss what happens in the media. In this way, humans interact socially to determine their reality.

Health Belief Model

This research is based, in part, on the theoretical framework of the Health Belief Model. The Health Belief Model is founded on six components: severity, susceptibility, benefits, barriers, cues to action and self-efficacy (Dutta-Bergman, 2005). According to Dutta-Bergman (2005), perceived severity “refers to the individual’s assessment of the outcomes associated with the preventive behavior,” (p. 106) whereas perceived susceptibility “focuses on the individual’s assessment of the extent to which he or she is likely to succumb to the negative outcomes,” (p.106). Dutta-Bergman (2005) continues to say that both susceptibility and severity need to be high for people to change their behavior.

The health belief model also considers the perceived benefits and barriers of health communication (Mattson, 1999). As Carpenter (2010) argues, the “target behavior must be likely to prevent the negative health outcome,” (p. 662) for an individual to adopt it. Barriers, on the other hand, “decrease the individual’s ability to engage in the preventive behavior and are described as the evaluation of potential negative consequences” that might result from the proposed behavior (Dutta-Bergman, 2005, p.105).

The model includes cues to actions where the individual is asked to perform some action to change their behavior (Carpenter, 2010). Cues to action may consist of external cues, such as mass media (Carpenter, 2010), and “are the specific stimuli necessary to trigger appropriate health behavior[s],” (Mattson, 1999, p. 243). Some internal cues are “intrapersonal in nature and constitute perceptions or social cognition and physical cues about personal health and illness,” (Mattson, 1999, p. 243). Carpenter (2010) argues that the cues to action section is the “most underdeveloped and rarely measured or researched element of the model,” (p. 662). Mattson (1999) contends that if individuals have high self-efficacy, they are more likely to fulfill the specific action.

Risk Perception

It has been postulated that continued involvement in risky behavior, such as alcohol use, provides some potential positive and beneficial outcomes (Fromme, Katz, & Rivet, 1997). Another problem is that people who engage in risky behaviors perceive greater benefits from said behaviors, and greater control over the consequences associated with those risks (Fromme et al., 1997). Some people choose what to fear and how much to fear it based on how that risk affects their life (Wildavsky & Dake, 1990). According to this theory of “cultural risk perception,” selective attention to risks and preferences for certain kinds of risks are related to the cultural biases of a particular society (Wildavsky & Dake, 1990). This cultural approach to risk perception theory will be essential in this investigation in order to discover what current perceptions the culture in Kenya’s Central Province has with regards to heavy drinking.

Research Questions

The goal of this project was to document the alcohol abuse problem in Kenya from the people most effected by the problem and begin to identify what mass communications strategies

could be used to help combat the issue. Several questions were developed around the goal of the study and the theoretical framework.

Q1: What social and cultural aspects of Kenya have led to the increase in alcohol abuse?

Q2: What cues to action will be effective in combating alcohol abuse in Kenya?

Q3: What are Kenyans perceptions of the risks of alcohol abuse?

Chapter 3 - Methodology

The goal of this project was to investigate the causes and factors contributing to alcoholism in Kenya and determine the best methods to curb the problem using a communications framework. This chapter explains the methodology used in gathering information and the techniques for selecting interview participants. Interviews were recorded in order to make a video documentary, which was developed to detail the perspectives of the people in impacted communities.

Documentation Method

To fully explain the problem of alcohol abuse in central Kenya from a cultural perspective, interviews were conducted with key informants selected through a snowball method. The interviews were both audio and video recorded following signing of a consent form, as well as a video release document. This documentation method allowed the interviewees to be heard in their own voices and to explain the problem from their firsthand experiences. These interviews were then compiled into a documentary format to tell the story of alcoholism in Kenya directly from the people experiencing the problem.

Recruitment of Participants

Participants were recruited with the help of local contacts made while conducting research in-country. Several candidates with academics and cultural participants were referred through a local contact. These candidates were then contacted separately and interviewed individually. The interviewees were made aware of the purpose of the study before the interview; interviewees were volunteers and were not paid for their service. A neutral location was chosen in which to perform the interviews and, as the interviews were recorded on video, special care

had to be taken that any area used was open to the public or both the interviewer and the interviewee were permitted to record video on the premises. The interviewer was able to conduct the interviews in a private environment in order to make the respondents feel more at ease. In some situations, the respondents suggested the location for the interview due to better knowledge of the area.

The individual nature of the interviews served three main purposes. First, that each respondent had ample time to answer each question in-depth and allow the researcher the opportunity for follow-up questions. Secondly, that each respondent was able to answer each question solely from their experience and professional mindset, since each respondent represented a specific field or area. Lastly, that each respondent was able to be recorded on video without the distraction of other people in the room.

The participants were selected based on their knowledge and expertise on the topic and included: a health professional (nurse), a professor of journalism, a professor of sociology, a local spiritual leader, and a layman. Other respondents were sought after but declined to comment on video about the problem, including a local police chief and a leader of the NACADA organization.

Observation

The researcher was also able to personally observe the alcohol consumption behaviors of Kenyans by entering several drinking dens and pubs and observed people drinking during the middle of the day, in the evening and later at night. Illicit alcohol was available at every drinking establishment that the researcher entered. People were seen all about Kenya, sleeping face-down in the parks in the middle of the day. Men walked around highly intoxicated during the middle of the afternoon.

The researcher also traveled throughout the central region, recording video and audio of the Kenyan culture. These recordings included traveling to Nairobi, Thika Town and rural central Kenya. With the company of local residents, the author was able to participate in and observe cultural events such as traditional weddings, the daily life of Kenyan farmers, and meals with several Kenyan families. Footage was also gathered of the drinking culture in and around local restaurants and bars, at the cultural events, and even in local drinking dens. In one instance, the researcher was able to sit with a group of individuals who had brewed their own alcohol from honey in the shed behind their house.

Interview Guide

An interview guideline drawn from the theories and the literature review was developed. The purpose of the guideline was to help the interviewer stay on track, but also to prompt where clarification was necessary. The guideline was based on two questions: “What are the major contributing factors to alcoholism in Kenya?” and “What can be done about it from a mass communications perspective?” The initial questions were the same for all respondents, so that the researcher was able to get multiple perspectives of the same question from multiple fields of expertise. Interviews were conducted and recorded in English, as it is the official language in Kenya and did not require the use of a translator for the researcher (CIA, 2013). The interview guide included questions about the causes and effects of alcoholism, as well as possible interventions from a communications perspective. For the full interview guide, see Appendix A.

Video Recording Procedure

All of the interviews were recorded on video with audio by the researcher using audio and visual equipment rented from the Division of Communication and Marketing of Kansas State University. Respondents were asked to sit while answering questions in order to frame

them in the shot correctly and were asked to wear a lavalier (or lapel) microphone on their person, as is common with video interviews. All respondents were asked to sign a consent form allowing the researcher to use the interviews for research and publication purposes. All of the respondents signed the forms and were fully aware of being recorded.

Chapter 4 - Findings

The video revealed several different common threads about the problem of alcohol abuse in Kenya. As such, the documentary has been broken into scenes to explore each common thread in its own regard. The first scene introduces Kenya from a cultural and economic standpoint. The second scene includes a brief history of alcohol in Kenya and some of the factors that caused the alcoholism problem. The third scene talks about the different kinds of alcohol available in Kenya, including illicitly made alcohols. The fourth scene discusses how the economy plays a role in the problem, with high levels of poverty and unemployment causing many people to turn to alcohol. Scene five examines the negative health effects that alcohol, especially illegally brewed alcohol, can have on the human body. The sixth scene discusses what impacts alcohol abuse can have on the family and societal structures in Kenya. The seventh, and final, scene demonstrates how advertising and mass communication have played a role in the perceptions of alcohol use in Kenya.

Link to documentary: <https://www.youtube.com/watch?v=RMBTSlcJSmI>

Scene 1 – Culture and Economy of Kenya

The Western perception of Kenya is that of a rich culture filled with vast and abundant wildlife. While this is certainly true, issues such as poverty and unemployment also define the region. Kenya sits in the East African Community, and represents one of the strongest economies in the region. However, the social concerns in the country are reaching a boiling point. Poverty hovers around 40 percent and government corruption plagues the nation. Alcohol represents one of the biggest problems in Kenya, with many unemployed and idle people turning to drinking for an escape

Scene 2 – Rise of Drinking in Kenya

This chapter discusses the rise of drinking in Kenya. The interviewees talk about how alcohol was historically only consumed during "rituals or ceremonies," and only relatively recently has been commercialized. The interviewees also discuss the social pressures to drink, and how partaking in drinking alcohol has become the norm. People cannot find jobs, or only want a certain type of job, and therefore have extra time with nothing to do. This extra time is commonly filled with drinking. Factors leading to the alcoholism problem include peer pressure, family influence, availability, accessibility, and affordability, among others. Historical factors include psychological scars from the fight for independence from the British during the 1950s. The Kenyan people felt trapped by the poor economy, the government and lack of employment and thus turned to alcohol as an escape. The new culture of drinking in Kenya was then passed through the generations.

Scene 3 – Types of Alcohol

This chapter discusses the different types of alcohol available in Kenya. There are major brands of alcohol and beer available in Kenya, however most of the people cannot afford them. There is another, cheaper type of alcohol available for sale that is high in alcohol content (up to 40 percent) and generally made outside government standards. This type of alcohol includes local brews called *Chang'aa* or "fortified wines." This type of alcohol is commonly brewed in unhygienic conditions and, in order to make the drink stronger, brewers add formalin, industrial chemicals, battery acid, used women's underwear, used women's feminine products, and other substances. This alcohol is illegally brewed and is not passed by the Kenyan Bureau of Standards (KBS), although sometimes the bottles are illegally marked as if they have been passed by the

KBS. This alcohol has been known to cause blindness and death. Most of the people selling the alcohol are women, and most of those who use it are men.

Scene 4 – Economic Issues

Without many leisure activities in Kenya, the people become idle in their free time. This, and high levels of poverty, can lead to "escapism," which can include turning to alcohol in order to escape problems. In Kenya, an activity like going to the movies can be too expensive for many Kenyans, leaving drinking alcohol as a cheap and accessible alternative. Instead of drinking one bottle of beer from a large manufacturer, people drink the cheaper, illegally made alcohol to get drunk for less money. While large breweries exist in Kenya and produce standardized alcohol that is safe, many people cannot afford it. The people who brew this illegal alcohol are in it to make money, and they feel no "moral obligation" to the consumers.

Scene 5 – Health Effects

These "traditional brews" are made with very little hygiene, and have led to several instances of death or blindness from consumption of the brews. Alcohol has effects on the whole body; it has heavy effects on the brain, heart, nervous system, and liver. As alcohol impairs judgment, it can lead to unprotected and illicit sex. Conversely, as men become overly drunk, they are not physically able to have sex, leaving some women to complain that their husbands cannot fulfill their marital obligations. Women then look for sex in other areas, and can in turn spread diseases like HIV. Therefore, HIV is spread, not by the heavy users of alcohol, but as a secondary consequence.

Scene 6 – Family and Social Issues

Alcohol abuse can cause severe family and marital problems. In Kenya, it is common to see families going to pubs as outings, teaching children about the social aspects of alcohol

consumption very early in life. The need to drink can also cause people to turn to theft or robbery to get the money needed for alcohol. There is a declining birth rate in the provinces hit the hardest by alcohol abuse, as many of the men abusing alcohol have become impotent. Alcohol consumption can start as early as 6 am, a time normally reserved for working and being a productive member of society. Since many men are drinking during this time, they are unable to find work and cannot provide for their family. This can cause such an issue with family finances that some families cannot afford to send their children to school. These issues can combine to cause strained family relationships.

Scene 7 – Advertising and Mass Communications

Kenyan Breweries Ltd, a large beer manufacturer in Kenya, started an advertising campaign with the slogan, "Two beers after work, just to socialize," (translation from Kiswahili). However, Kenyan Breweries no longer uses this slogan, which could help people understand drinking in moderation. One respondent argues that electronic media, such as television, are glorifying the use of alcohol, and thus creating a reward system for people to encourage drinking. He believes there is room for the electronic media (such as television) to behave more responsibly and report on the negative effects of alcohol, instead of just glorifying it. Using television as a way to reach people of Kenya about the alcohol problem could help to reach a younger audience, as lots of youth watch TV. Starting education in schools from a young age might also help curb the use of alcoholism. Also, while there are laws surrounding alcohol use, there is very poor enforcement of the laws. If the government began enforcing those laws, alcohol use might decrease.

Chapter 5 - Conclusions and Recommendations

The goal of this project was to document the alcohol abuse problem in Kenya from the eyes of the people most effected by the problem, and to begin to identify what mass communications strategies could be used to help combat the problem.

Based on responses from the video interviews, there are several conclusions we can make about this issue. Alcohol is not new to Kenya, however, and only recently has alcohol abuse become a serious issue. There are several possible reasons for the rise of drinking and alcohol abuse in Kenya. Of these reasons, a theme emerged above all others during the interview process: after the introduction of influence from the western world, the style of drinking alcohol in Kenya changed drastically. While a poor economy, idleness and other factors contribute to the current drinking problem, before western influence, alcohol was used only for traditional ceremonies, and only amongst the elders.

The study also found that the illegally made alcohol or traditional brews (also referred to as "second-generation alcohol") are a major part of the problem. While many of the large, branded alcohol companies are present in Kenya, these alcohols are too expensive for the average Kenyan. Many people turn instead to the illegally made alcohols that are made outside of government regulation. The high consumption of alcohol leads to serious health issues, including blindness and death. In fact, it is common to see many deaths at an event where this alcohol is consumed and many multiple-death cases have been documented. These alcohols were found to be as common, or more common, than alcohol made by major brewing companies. Illicit alcohol came in many forms - in homemade batches brewed in five gallon buckets or in bottled versions that resembled legally made alcohol. They are very available and can be bought in local pubs and stores with ease.

Poverty and unemployment are major factors that contribute to alcohol abuse in Kenya. Being unemployed causes people to become idle, and therefore to look for other ways to spend their time. Idleness is extremely common in Kenya, with men sitting on every street corner during the working hours of the day. Many of these men are dressed in work clothes even though they aren't going to work. In Kenya, as there are not many cheap leisure activities, and because illicit alcohol is so cheap to buy, many of these unemployed and idle people turn to alcohol as a way to escape their situation. Pubs have people in them at all hours of the day, including during the hours normally reserved for working.

Lack of attention to social consequences can also be said to be a contributing factor. While many people are aware of people dying or going blind from these illicit alcohols, the secondary consequences, such as destruction of family life and marriages, might be less noticeable to the people with an alcohol abuse problem. As people respond to their perception of the risk and not the actual risk itself (Sjoberg, 1998), there will likely be no response when there is little perceived risk. Families of those addicted to alcohol have to bear all the responsibility of the household, including, in some cases, earning the main income for the family. It is also common for alcohol abusers to drink in front of their families, including their children. This only works to reinforce alcohol abuse in younger generations and is something that should be addressed.

Serious health issues were observed during the study. Many people lay on the ground or sit on the sidewalks in the middle of the day, seemingly unable to do anything else. Men were so drunk they could hardly stand, and when they could, they would only ask for money to buy more alcohol. These health consequences are nothing short of dire for those that become addicted to alcohol.

While the problem continues in Kenya, the mass communications and media, including radio and TV, do little to address the problem. As Carpenter (2010) argues, mass media can be an effective external cue to instigate a change in behavior. However, there are no major public service announcements or other serious campaigns directed at stopping the problem. In fact, the media only works to promote drinking through TV shows and advertisements that glorify its use. Alcohol is associated with success and happiness in the media, an image that works to create a positive perception of alcohol instead of representing the negative health and social effects that are rampant in Kenya.

Lack of effective interventions by the government, and government agencies in charge of studying and addressing issues such as alcoholism, is also a contributing factor. This lack of action from the government and its bodies starts at the higher levels and works its way down to local officials and police officers. While in Kenya, no government official would speak on camera about the problem. This signifies the greater problem of the government not taking responsibility, which has caused the alcohol abuse to spread. Not until this issue is addressed will alcoholism in Kenya have a chance at being stopped. As Elder et al. (2004) point out, mass communication campaigns tend to be the most successful when their methods are reinforced by other efforts, such as increased law enforcement. When the government does not participate, the problem becomes that much more difficult to solve.

Suggestions for Future Alcohol Prevention Campaigns

Based on the research of this study, which includes in-depth interviews with thought leaders in Kenyan culture in regards to alcohol abuse, the following recommendations are provided to guide future campaigns against alcohol abuse in Kenya.

Recommendation Number One

The drinking culture in Kenya has changed drastically since the introduction of Western influence. The first recommendation is to reestablish a drinking culture in Kenya that empowers healthy and moderate use of alcohol, and actively promotes against heavy use and abuse of alcohol. This would include creating messaging around a drinking culture that dictates appropriate levels of drinking, while still maintaining a strong stance against drinking in excess.

Recommendation Number Two

Based on the findings of this study, the illicitly made alcohols are the ones most directly and frequently contributing to the alcohol abuse problem in Kenya. The government has passed laws outlawing these alcohols, but has not been very efficient in enforcing them. A communication campaign should target this lack of government effort, and call for the people of Kenya to demand that their local police departments and higher level government officials enforce these laws vigorously. The goal of this tactic is to put pressure on government officials to enforce the laws that are already in place, and to bring attention to the lack of government success in this area.

If the traditional and low quality alcohols are illegal, then there is only one body, the government, that can help enforce these laws and eliminate the problem.

Recommendation Number Three

Educating the public about the adverse physical and sociological effects of alcohol will be an important part of any campaign aimed at curbing alcohol abuse. Based on the findings from this study, integrating educational programs into the primary or secondary schools of Kenya is recommended. Many children see alcohol abuse first-hand from family members

starting at a young age. Educating the young population will be important to help stop future generations of Kenyans from following this same path.

Recommendation Number Four

This study highlighted several secondary effects of alcohol abuse in Kenya; the most troubling of these were the effects it has on the families of the abusers, especially the women. Communicating the perspective of the woman as they are affected by alcohol abuse, engaging the women in the conversation, is recommended based on the findings of this study. Allowing the women to have a role in the alcohol abuse paradigm is new, as there has been no evidence of community participation in current alcohol abuse health campaigns in Kenya (Muturi, 2014). Many women's husbands are too drunk to work, have sex, or perform other husbandly duties. The women of the households are left with all the responsibility of the family, and also must take care of the husband when he is unable to do so. These women's voices need to be heard, and any communication campaign directed at curbing alcohol abuse in Kenya should include this perspective.

Study Limitations

Several limitations presented themselves during the research process. Kenya is a foreign country for the researcher, and thusly provided several cultural limitations. The researcher is not Kenyan, and this provided a cultural divide between the researcher and the participants, and caused several safety issues, as well. Caucasian people are viewed in Kenya as being wealthy, and therefore become targets for robbery and theft. This caused the researcher to be limited in the areas where he could travel and take video equipment. Race could have caused trust issues with the participants, although this was never mentioned by any of the participants and all participated of their own will.

Another potential issue was the limited sample size of interview subjects. The researcher was only able to attain five interview subjects, although each were from a different professional background. Not every respondent was equally familiar with the alcohol problem, although all respondents had first or second hand experience with the issue of alcohol abuse. More research should be done with a broader range of respondents to gain a broader perspective of the problem. Four out of five respondents were male, and although most of the people abusing alcohol are male, it does not fairly represent the woman's perspective of the problem.

The researcher was in the country for a fairly short amount of time (around six weeks), and therefore had to rely on a colleague, Dr. Nancy Muturi, to help create and foster relationships and recruit participants in the research. The short amount of time in-country also limited the geographic region of the study to the Central Province.

The researcher also ran into difficulties trying to ask government officials about the alcohol problem. The researcher and Dr. Muturi attempted but were unable to speak with a local police chief. NACADA was also approached for comment and the researcher was granted an audience with a high ranking member of the NACADA team. However, this person was unwilling to go on record with any of his statements, despite being a leader and public figure. Therefore, further exploration of the government voice on this issue is recommended.

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Appendix A - Interview Guide

The interview guide consisted of questions such as listed below. Questions differed slightly based on the expertise of the interviewee, and follow up questions were also included to probe deeper into responses.

- Why do Kenyans drink so much?
- How has alcoholism become such an epidemic in Kenya?
- What about Kenyan society allows this to continue to happen?
- What social impacts does the alcohol problem have on Kenyans?
- Have religious leaders seen this problem? What have they, or can they, do to help the problem?
- What are the health effects of alcohol?
- Are the homemade alcohols worse? How are they worse?
- From a health or community perspective, what are some of the effects of alcohol abuse?
- What needs to be done about alcoholism and by whom?
- How can media be used to help address the problem?
- What is the relationship between alcoholism and HIV/AIDS?

Appendix B - Photograph & Video Release Form

I hereby grant permission to the rights of my image, likeness and sound of my voice as recorded on audio or video tape without payment or any other consideration. I understand that my image may be edited, copied, exhibited, published or distributed and waive the right to inspect or approve the finished product wherein my likeness appears. Additionally, I waive any right to royalties or other compensation arising or related to the use of my image or recording. I also understand that this material may be used in diverse educational settings within an unrestricted geographic area.

Photographic, audio or video recordings may be used for the following purposes:

- conference presentations
- educational presentations or courses
- informational presentations
- on-line educational courses
- educational videos

By signing this release I understand this permission signifies that photographic or video recordings of me may be electronically displayed via the Internet or in the public educational setting.

I will be consulted about the use of the photographs or video recording for any purpose other than those listed above.

There is no time limit on the validity of this release nor is there any geographic limitation on where these materials may be distributed.

This release applies to photographic, audio or video recordings collected as part of the sessions listed on this document only.

By signing this form I acknowledge that I have completely read and fully understand the above release and agree to be bound thereby. I hereby release any and all claims against any person or organization utilizing this material for educational purposes.

Full Name _____

Street Address/P.O. Box _____

City _____

Prov/Postal Code/Zip Code _____

Phone _____ Fax _____

Email Address _____

Signature _____ Date _____

If this release is obtained from a presenter under the age of 19, then the signature of that presenter's parent or legal guardian is also required.


Parent's Signature _____ Date _____

IRB Approval Letter



University Research Compliance Office

TO: Nancy Muturi Protocol Number: 6053.0
School of Journalism and Mass Communications
Kedzie Hall

FROM: Rick Scheidt, Chair 
Committee on Research Involving Human Subjects

DATE: October 22, 2014

RE: Approval of Your Proposal Entitled, "Excessive Alcohol Consumption and Risk of HIV Infection among Young Adults."

Federal regulations stipulate that human subjects protocols can be approved by IRB's for only one year, and require "continuing review" and approval to continue past the expiration date.

On the basis of the IRB "continuing review," your project is classified as follows:

Active. The activity is pending or in progress, and there have been no changes that have occurred or are contemplated that would affect the status of human subjects.

EXPIRATION DATE: 12/8/2015

If the activity persists, it will be eligible for continuing review several months prior to the new expiration date.

IRB Approval Letter



University Research Compliance Office

TO: Nancy Muturi
Journalism and Mass Comm.
105 Kedzie

Proposal Number: 6053

FROM: Rick Scheidt, Chair
Committee on Research Involving Human Subjects

DATE: December 1, 2011

RE: Approval of Proposal Entitled, "Excessive Alcohol Consumption and Risk of HIV Infection among Young Adults."

The Committee on Research Involving Human Subjects has reviewed your proposal and has granted full approval. This proposal is **approved for one year from the date of this correspondence, pending "continuing review."**

APPROVAL DATE: December 8, 2011

EXPIRATION DATE: December 8, 2012

Several months prior to the expiration date listed, the IRB will solicit information from you for federally mandated "**continuing review**" of the research. Based on the review, the IRB may approve the activity for another year. **If continuing IRB approval is not granted, or the IRB fails to perform the continuing review before the expiration date noted above, the project will expire and the activity involving human subjects must be terminated on that date. Consequently, it is critical that you are responsive to the IRB request for information for continuing review if you want your project to continue.**

In giving its approval, the Committee has determined that:

- There is no more than minimal risk to the subjects.
 There is greater than minimal risk to the subjects.

This approval applies only to the proposal currently on file as written. Any change or modification affecting human subjects must be approved by the IRB prior to implementation. All approved proposals are subject to continuing review at least annually, which may include the examination of records connected with the project. Announced post-approval monitoring may be performed during the course of this approval period by URCO staff. Injuries, unanticipated problems or adverse events involving risk to subjects or to others must be reported immediately to the Chair of the IRB and / or the URCO.