Peer To Peer User Guide

Drug and Alcohol Peer To Peer Prevention Program

UYDEL

Partners in Prevention

Mentor
Prevention • Opportunity • Protection
www.mentorfoundation.org

2011

TABLE OF CONTENTS

Preface

This guide is developed to facilitate the work of Peer Counsellors in training Peer Educators in substance abuse prevention. It is based on the experience from the peer to peer drug prevention programs conducted by UYDEL. This peer to peer guide provides a framework for all peers to help prevent drug abuse in areas/communities where they come from. This guide presents the key areas/topics that are deemed essential in preventing and/or lowering drug and alcohol use in the East African Region. This PPPP guide is intended to make certain that the necessary information, skills, methods and responses are available and known to a wide spectrum of both youths and other individuals responsible for change the community.

In addition, this guide stresses the importance of alcohol and drug abuse prevention among young people by stressing the risk and protective factors that may or may not expose a young person to drug abuse and ways of avoiding them. The concept of peer education provides a rationale and effective vehicle for using drug peer counselors as a major strategy in community based drug abuse prevention programs. Drug peer counselors are responsible for providing confidential addictions counseling, education and support to individuals, families and the communities experiencing addictionsand for promotinghealth lifestyles and healthy choices.This may include confidential individual, family or group counselingabout the causes and effects of addictions support for families dealing with addictions and/orreferrals to treatment for individuals requesting this opportunity.As a social change agent, the peer counselor needs to be familiar with other services and resources in the community and work closelyto provide information and support when required. That's why this guide goes an extra step to give contacts of institutions where young people may seek alcohol and drug abuse counseling and rehabilitation services.

This guide is organized in 3 sections namely; Section 1 focuses on background information on drug abuse and skills for peer to peer counseling; Section 2 emphasizes background information on peer to peer counseling and section 3 focuses on resources for peer to peer counseling. We wish you a successful application of this guide.

Acknowledgement

UYDEL wishes to acknowledge the technical support from Jeff Lee M.Ed, the Executive Director of Mentor Foundation; Prof. Ken Winters and Richard MacKenzie MD who committed time to review the content of this guide. UYDEL appreciates the financial support from Fonds De Lutte through Mentor Foundation International that enabled the extensive review of this peer guide. The administration is highly indebted to Mr. Kasirye Rogers, Executive Director UYDEL and Dr. David Basangwa, Consultant Psychiatrist Butabika Hospital for their technical input into this guide. This guide was also made possible through the timely efforts and commitment from UYDEL staff namely; Mutaawe Rogers, Nabulya Anna, Kacwamu Regina and Nassaka Jackie. Without their hard work this important practical guide would not have become a reality.

UYDEL appreciates the drug peer educators and staff from partner NGOs that participated in the review meetings of Peer to Peer Drug Abuse Prevention Programme and Training of Trainers workshop. As a result UYDEL has been able to reach over 8,000 young people with drug abuse prevention messages through peer education trainings and approaches. We are grateful for their wise contributions without which this guide would not have seen the light of day. UYDEL also extends its sincere thanks to all those not mentioned but duly contributed to the timely completion of this guide. May God reward them handsomely.

Acronyms

AIDS	:	Acquired Immuno Deficiency Syndrome
AMREF	:	African Medical and Research Foundation
ARVs	:	Anti Retrovirals
CSAP	:	Center for Substance Abuse Prevention
CSOs	:	Civil Society Organizations
EAAPA	:	East Africa Alcohol Policy Alliance
EMCDDA	:	European Monitoring Centre for Drugs and Drug Addiction
FMG	:	Female Genital Mutilation
FP	:	Family Planning
HIV	:	Human Immunodeficiency Virus
IDP	:	Internally Displaced People
IDU	:	Injecting Drug Users
IEC	:	Information, Education and Communication
IOGT-NTO	:	International Organisation of Good Templers
IUCD	:	Intra-Uterine Contraceptive Device
LSD	:	Lysergic acid diethylamide
MDD	:	Music Dance and Drama
NACADA	:	The National Campaign Against Drug Abuse Authority
NGOs	:	Non Governmental Organizations
PIDC	:	Pediatric Infectious Diseases Clinic
PPPP	:	Peer to Peer Prevention Program
RH	:	Reproductive Health
STDs	:	Sexually Transmitted Diseases
STIs	:	Sexually Transmitted Infections
UNODC	:	United Nations Office on Drugs and Crime
UYDEL	:	Uganda Youth Development Link
WHO	:	World Health Organization

First produced 2009

Reproduced 2011

A UYDEL Publication-2011

A Situational Analysis of Drug Abuse

Prevalence of Drug Abuse Globally:

Psychoactive substance use poses a significant threat to the health, social and economic fabric of families, communities and nations. The extent of worldwide psychoactive substance use is estimated at 2 billion alcohol users, 1.3 billion smokers and 185 million drug users.

The harmful use of alcohol is a global problem which compromises both individual and social development. It also causes harm far beyond the physical and psychological health of the drinker. It harms the well-being and health of people around the drinker. An intoxicated person can harm others or put them at risk of traffic accidents or violent behaviour, or negatively affect co-workers, relatives, friends or strangers. Thus, the impact of the harmful use of alcohol reaches deep into society.

WHO (2011) notes that:-

- The harmful use of alcohol results in 2.5 million deaths each year.
- 320,000 young people between the age of 15 and 29 die from alcohol-related causes, resulting in 9% of all deaths in that age group.
- At least 15.3 million persons have drug use disorders.
- Injecting drug use reported in 148 countries, of which 120 report HIV infection among this population

Prevalence of Drug Abuse in East Africa:

Uganda:

In Uganda, drug abuse has been described as a problem especially among marginal groups, who are unemployed. Cannabis is mainly abused by street and school youth, as well as by soldiers; heroin tends to be consumed by urban and street youth; cocaine abuse is prevalent among high income groups; Somali refugees and town youth abuse khat. An increase is reported in the abuse of opiates and cocaine, as well as the abuse of cannabis and volatile solvents. There has also been a reported increase in the abuse of benzodiazepines,

A marijuana garden in Kakiri, Wakiso District

a decrease in the abuse of barbiturates, and an even larger decrease in the abuse of amphetamines. According to the 2009, Uganda annual Police crime report, there were 2,034 reported and investigated narcotics cases, which led to 2,274 arrests compared to 2,542 in 2008. The trend has been attributed to inadequate laws and weak border controls. The increase in the abuse of cannabis, hard drugs and volatile solvents is attributed to unemployment, social upheavals, family disruptions as well as high rates of drop-outs from school. Increased production and trafficking of cannabis has led to increased availability of the drug. As opiates and sedatives are usually injected, their use represents a stronger commitment both to their drug of choice and the associated lifestyle. But there are still those who moderate their use through ingesting sedatives or smoking opiates. It is important to know that these methods of using drugs does not decrease the chance of addiction or the lifestyle problems associated with their use or in getting a ongoing supply.

Hallucinogens and amphetamines are usually taken by mouth and have episodic patterns of use depending on their availability. Multiple drug abuse like volatile solvents mixed with alcohol, and combinations of cannabis and volatile solvents with alcohol have been reported by NGOs This is often referred to as polypharmacy. Cannabis is usually smoked but may be cooked with food especially food containing chocolate The caffeine in the chocolate increases the intensity of the desired reaction. Khat is sold openly and chewed by youth in urban centres. Petrol is sniffed either from small bottles or from soaked cloth, mostly by urban youth and street children.

Alcohol and drug abuse is on the rise across all age groups particularly among school going children and out of school young people, women and people living in Internally Displaced People's camps - a common problem in Uganda. The school going children are increasingly getting involved due to a range of reasons that include wanting to be accepted by peers, to cope with academic pressures and for some the desire to ease the realities of everyday living. Therefore drug and substance abuse cuts across gender, although males are more inclined to the problem.

Drug abuse culture is also highly promoted in film, video halls and disco places. Prostitution and sexual exploitation of children is highly linked and further fuels the use of drugs. The risks associated with the use of drugs is compounded by the present epidemic of HIV/AIDS. There is a belief among some groups that the use of such drugs as cannabis provides a self-cure and lowers the risks of spread of HIV/AIDS in the body. Low levels of awareness among the youth, parents and guardians of the severe consequences of drug abuse allows the problem to silently increase to epidemic proportions Social stature and being will off does not protect. High-class social groups are reported to be using expensive drugs.

Consequences of drug abuse include; poverty, mental illnesses, crime, school dropouts, exposure to STD's and HIV and other forms of social misconduct such as increased child abuse, sexual abuse and domestic violence. Knowing right from wrong is often blurred under the influence of drugs.

Several strategies exist for drug abuse, prevention, treatment and rehabilitation. However a clearer understanding of the factors that lead to drug abuse and the related behaviour and consequences is critical to inform decisions on the strategies we need to use in prevention. This manual provides information on topics that are deemed vital for an appreciation of the drug and substance abuse challenge posed to youth in Uganda. The basic facts on reasons for, prevention and treatment of drug abuse are clustered for easy reference.

Responses to drug abuse:

Uganda does not have an effective law, though one has been on the shelves since 2005. The National Drug Authority Act 2000 is weak and not comprehensive. Similarly, Uganda has developed a master Plan and Policy on drug abuse. Many documents remain as drafts and thus cannot provide the authority to address the issues associated with drug abuse. The Uganda Police operates a narcotic police unit that is very vigilant at airports and discouraging and even destroying cannabis. The unit is underfunded, has a diminishing workforce and limited infrastructure to effectively divert importation and distribution. Enforcement is primarily done by the Police and the Ministry of Health (mental health division and psychiatry hospital). There is a dire need to increase capacity not only in treatment and management but in training people in prevention and law enforcement. NGOs despite their limited capacity operates mainly in major urban centers. They reach out with their messages on posters and on radios promoting drug non use or warning against the problem of addiction or getting trapped in a drug lifestyle. The most active NGOs have been UYDEL and Serenity Centre. Despite the continued steady increase in drug and alcohol use, there has been a decline in NGOs operating in this field in Uganda due to limited access to funding. The media, health and NGO professionals on occasion participate in drug abuse awareness on TV, radio and print media. Drug education is incorporated in curricula at primary, secondary schools and higher education. Lectures and drug awareness talks and seminars on issues relating to drugs in which students' participation is encouraged are also held with the aim of reducing drug abuse problems among young people.

Treatment and Rehabilitation:

The treatment guidelines largely focus on rehabilitation and conducted at the refurbished National Mental Hospital Butabika and related regional units. Drug dependence is not cured but controlled and thus future abstinence is critical to rehabilitation. The number of facilities in the country has increased because the Ministry of Health embarked on a programme to establish Alcohol Drug Units at each of the Regional hospitals. Likewise there is increased number of private specialized facilities including those of NGOs. Lack of a policy limits comprehensiveness of programmes and areas like community based rehabilitation and social re-integration is largely underdeveloped. Government hospitals have psychiatrists, doctors, and social workers whose tasks are to provide treatment and mental rehabilitation to patients, arising out of drug and substance abuse. Cases being treated in psychiatry arising from drug abuse are now estimated at 25% of those seen.

Hospital admissions are high. Approximately 20%-30% of beds at Butabika National Mental Referral Hospital are occupied by alcohol/drug related cases. The hospital sees on average 25 patients every week. Of these 60% are in continuing out patient care and 40% new cases. The hospital treats about 240 patients per year, 10% female. The commonest age group is 16-21.

Kenya:

In Kenya, national surveys have been done by NACADA since its inception and passing the anti drug abuse law. These findings have shown that drug and substance abuse is on increase in Kenya and has a complex cause and effect relationship. Drugs are easily available on the market and cheap to buy. Cocaine and heroin which are more costly are less accessible. Commonly abused drugs in Kenya are alcohol, ***bhang***, glue, ***miraa*** (khat) and psychotropic drugs. The prevalence of HIV/AIDS among injection drug users is estimated at 68-88 percent (UNODC 2004). The UNODC report documents a relationship between injecting drug use and HIV/AIDS. Nairobi and Coast provinces were most affected with an estimated 10,000 heroin users in Nairobi and 8,000 in Coast province. Cocaine has high acceptability ratings in Nairobi and the majority of people are not aware of the available drugs and substance abuse treatment facilities. Kenya has a coordinating body NACADA which coordinates all participants in the fight against drug abuse and its involvement in Kenya have increased drug law enforcement, prevention and treatment as well information management compared to other countries.

Tanzania and Zanzibar Islands:

Zanzibar's health authorities[1] have regularly reported the incidence of drug abuse and how HIV is impacting the island. The reports do warn that the HIV infection rate among drug injectors and sex workers is much higher than in the general population. A 2006 study of 508 injecting drug users found that 26 percent were HIV-positive and that addicts were more likely to initiate their sexual activities as teens; and to have multiple, concurrent sexual partners.

UNODC has been very supportive of efforts to help the states improve their capacities in prevention, law enforcement and treatment. They have undertaken trainings, funded projects and regularly collected data using the annual questionnaire This data has been very useful in monitoring activity and focusing prevention and early intervention programs.

In East Africa, networking among NGOs is still weak, urban based and uncoordinated. Some prevention work to reduce alcohol and drug abuse is supported by IOGT-NTO, Mentor Foundation International and East Africa Alcohol Policy Alliance (EAAPA). Substantial funding has been channeled by WHO and USAID related to drug abuse and HIV/AIDS risk behaviors. Most of these activities are project based, time limited and rarely have good practices been documented. The sub region of East Africa continues to be used as a transit area for cocaine consignments destined for illicit markets in Europe. Heroin continues to enter Africa mainly though the countries

in East Africa. Countries in that sub-region have been identified as both countries of destination of heroin consignments and transit countries; Trafficking and abuse of heroin have recently increased.

In the East African region, National Health-care systems are not able to meet needs of the population with regard to the treatment and rehabilitation of drug-dependent persons, although notable changes have been registered in Uganda. National medical facilities for such treatment and rehabilitation are often seriously inadequate or simply non-existent. Frequently, only small numbers of drug-dependent persons can be accommodated in the psychiatric wards of general hospitals. Treatment and rehabilitation of drug-dependent persons in Africa often depend on assistance provided by relevant international organizations, such as WHO and UNODC, and nongovernmental organizations.

Governments needs to provide adequate support to existing treatment services in order to ensure proper treatment for drug-dependent persons, to provide the support necessary to establish and maintain suitable rehabilitation facilities for such persons and to evaluate the quality of the treatment. Cannabis is generally the most problematic illicit drug used in the region. There is a need to support NGOs efforts to increase prevention in those countries, since governments appear to be concentrating on drug law enforcement and treatment. Programs targeting young people are limited due to limited capacity of NGOs and government. There is critical shortage of educational materials, counseling, training staff and rehabilitation. Training of staff in the region is so limited and capacity is lacking yet numbers of those abusing drugs is increasing.

Substances not under international control:

Khat, which is not currently under international control, continues to be cultivated in some countries of East Africa and is commonly chewed as a stimulant in those areas. Although khat consumption is associated with health risks and may have detrimental social consequences, the prohibition of khat in the region is limited to some countries in East Africa, such as Eritrea, Madagascar, Rwanda and the United Republic of Tanzania. The widespread abuse of cannabis by children is of particular concern. In some countries, even children 7-10 years old are reported to have abused cannabis. Heroin abuse also appears to be increasing in Africa. Heroin is the drug most commonly abused by problem drug abusers in countries such as Kenya, Mauritius, Nigeria, the United Republic of Tanzania and Zambia. Most countries continue to lack proper systems for monitoring drug abuse and national estimates of the prevalence of drug abuse are based only on rapid assessments of drug abuse among specific groups within the drug-abusing population and a limited number of school surveys. The cross-country comparability of national drug abuse estimates is therefore severely limited in Africa.

CHAPTER 1

Drug Abuse

Types, Characteristics and Effects

1.0 Introduction

This chapter gives you information about the types, characteristics and the reasons why young people use drugs, slang names for drugs and effects of drug use on young peoples lives.

1.1 Definition of Drug Abuse

A drug is a psychoactive substance that affects the way a person thinks, feels and behaves and which has physical and psychological effect on the person using it. Drug abuse is the improper use of drugs, that is, taking a substance either industrial or natural into the body, which affects the five senses. Drugs have the power to change a person's mood or the way he/she perceives things "**Drugs**" include medicines, many of which can bring benefit when used appropriately; it includes legal and often socially accepted drugs such as tobacco and alcohol; it includes solvents and substances like khat; and it includes illegal substances such as cannabis, heroin and cocaine. There is a distinction between drug use; drug misuse and abuse; problematic drug use; dependency; addiction. The reality is that all drugs can cause harm even legal and potentially beneficial drugs like medicines and over the counter drugs if misused.

1.2 Reasons for Drug Use among the Youths

There are a range of factors that can contribute towards a young person using drugs.

They include:-

- Peer pressure, being accepted
- Unemployment and redundancy
- Pain relief
- Desire to take risks
- Seeking pleasure
- Confidence and courage
- Wanting to socialize
- Wanting to feel high or a state of euphoria

- Wanting to forget problems or escape from day to day reality
- Wanting to enhance sexual performance
- Mass media influence
- Problems at home or with relationships

1.3 Types of Drugs used by young people

There are different types of drugs used by young people. Some are indigenous substances; some are made from plants; some are man made; some are medicines. They are often classified as follows:-

1. Narcotic Drugs:

Narcotic drugs include substances that are highly addictive and liable to abuse, or are convertible into drugs that are similarly addictive and liable to abuse. Narcotic drugs also include substances that are less addictive and liable to abuse and prohibited internationally. Section 1 of the Uganda National Drug Policy and Authority Act Cap 206 Laws of Uganda attempts a definition similar to that adopted by the Single Convention on Narcotic Drugs by referring to the class of drugs considered to be narcotic. However it should also be noted that the East African countries have their domestic laws regarding narcotic drugs.

These substances are addictive and are prohibited internationally. Examples include:-

a. Heroin
b. Cocaine
c. Marijuana

2. Socially accepted Drugs

a. Alcohol
b. Tobacco
c. Khat
d. Kuber

3. Prescription only drugs

a. Pethidine
b. Codeine
c Valium
d. Phenobab

4. Others

a. Petrol
b. Paint Thinner

Uganda is increasingly witnessing the emergency of new drugs of substance being used by young people such as:-

Kuber:-

It is a powdered sachet packaged highly addictive drug being openly sold in shops and supermarkets. It is disguised a mouth freshener and packed in sachets similar to tea leaves. This CNS nicotine rich stimulant is being widely consumed by secondary school students and taxi drivers to get high. Kuber is believed to contain cocaine, heroine, marijuana, cannabis or combinations of these. Kuber is often chewed with khat (mairungi leaves), sucked or taken with hot water as a beverage resulting in feeling drunk. It impairs memory and can cause depression and have mental illness outcomes.

1.4 How are drugs used?

- **Smoking:** e.g tobacco, cannabis, opium and cocaine
- **Drinking, chewing or eating:** e.g pills, alcohol, cannabis and traditional drugs
- **Sniffing or snorting the drugs through the nose:** e.g cocaine, heroin and glue
- **injection:** e.g heroin and cocaine. This is the most dangerous way of taking drugs because of the risk of infections and HIV/AIDS through contaminated needles.

1.5 Drug Trafficking

Drug abuse and illicit drug trafficking are now considered to be a serious problems in Uganda, East Africa and the world over. In Uganda there is increased cultivation, production and consumption of illicit drugs such as cannabis. Uganda which has been a transit country for hard drugs like cocaine, heroin and other psychotropic substances is unfortunately transforming into a consumer of these hard drugs.

1.6 Characteristics of drugs

- Act primarily on the brain, particularly the developing brain of the young person
- Can produce reversible (treatable) symptoms
- Can produce initial pleasurable rewards (relief from unpleasant feeling and alteration of sensory perceptions)
- Often reinforces and induces craving (strong desire) for more.
- Can create tolerance that leads to desire to use more.

- Abrupt interruption may lead to withdrawal syndromes.
- Long period of use can lead to mental/psychological or physical illness.
- Single use of some drugs can lead to harm or even death.
- All drugs have potential for harm or misuse even though some drugs can bring some benefits when used appropriately – and legally. For instance prescription drugs like pethidine.

1.7 Slang names for common drugs of abuse

Drug Name	Mode of consumption	Slang name in:		
		Uganda	Kenya	Tanzania
Marijuana / Cannabis Sativa (Bhangi)	Smoked, sniffed, orally as a beverage	Enwa, Kyewu, Kaladi, White Nile, Essada, Dope, Omukwabi, Nakanwagi, Enkoko, Airtime, Wudi, Vete, Kamwokya, Ekibaaba, Njaga, Kanwa, Bbomu, Gganja, Muti, Namikka, Tomic, Piina, Mukyuusa.	Bangi, Hashish, Marijuana, Ganja, Pot, Shada, Stone, Dagga, Godee	Bangi
Khat / Mairungi	Oral by chewing	Miira, Kabasanda, Sikiyo, Gaati, Akakoola, Kasenge, Kyakasi, Milmiti, Barre, Andasi, Nakati, Bupepa, Akakono, Kasaayi.	Miraa, Alele, Giza, Khat, Mbachu, Shamba, Ketepa, Halwa	Mirungi
Heroin (brown sugar)	Sniffed, smoked, injected	Omuggo, Akachwiiri, Fimbo, Kaloddo.	Brown sugar, Kichuri, Junk, Unga, Stuff, Mzigo, Maponaji, Horse, White stuff, Skag, Daba-daba, Prama	Unga
Cigarettes	Smoked	Embanga, Bewa, Fegge, Taaba.	Fegi, Gasta, C90, Sigara, Mozo, Kiraiku, Doze, Mbaki, Chavis, Shtick, Guff, Chamboki	

Inhalants (petrol/glue)	Sniffing	Kongo, Tina, amasanda, Spirit, Petrol, Gaamu w'engatto, Mafuta g'enyonyi, Nyositi, Mpewo, Dikini.	Mugui, Mangata, Juo, Doso, Kabiere, Bien.	
Cocaine	Injected, sniffed	Konka	Coke, Rock, Flake, Bazooka, Snow birds, Nose candy, Marymary, Big G, Blow, Startdust, Crack	
Kubber	Oral by sucking	Kubba	Dawa, Wawa, Mounth freshener	
Alcohol	Oral by drinking	Kasiquine, Kabawo, Kill me quick, Doze, Ngwaa, Suupu w'enkoko, Vubiriza.	Keroro, Gauge, Maji, Booze, Pint, Gede, Kill me quick.	
Presrciption drugs			Matap tap, Maduya, Yellow pill, More fire.	
Manichani	Oral by sucking	Manichan		

1.8 Effects and consequences of drug use among young people

There can be physical health, social, economic, political and psychological effects from drug use. They include the possibility of the following negative outcomes:-

Health effects

- Affecting the central nervous system, immune system,
- Reproductive system, liver, and kidney.
- Overdose
- Malnutrition
- Heart problems
- Mental health disorders, depression, suicide
- Hormonal changes leading to menstrual irregularity, impotence in males
- Impaired brain development
- High risk sexual behaviors.
- Risk of dependence
- Withdrawal symptoms when use is reduced or stopped.

Social effects

- Divorce, broken family, prostitution etc.
- Unemployment.
- Crime (theft, robbery, rape, defilement and forgery)
- Violence
- Traffic accidents
- Extortion (use force to get what you want).
- Arson (burning)
- Decrease in social stability
- Loss of friends and family
- Legal, relationship and work problems

Economic effects

- Low productivity
- Job accidents
- Absenteeism
- Poor spending habits
- Unemployment
- Cost to government
- Heavy cost to fight crimes
- Environmental pollution
- Health costs for treating drug related consequences
- Vast area of land for illicit cultivation hence decreases in cash crop.

Political effects

- Corruption, bribery, mafia network, murders.
- Breaching of law and order
- Money laundering

Psychological effects

- Poor self esteem
- Depression
- Overt mental illness

Physical effects

- Overdose
- Fever, vomiting

Behavioral effects

- Accidents and injury
- Aggression and violence
- Unintended sex and unsafe sexual practices
- Reduced work performance

1.9 Degree of harm

The harm that drugs can cause depends on various things:-

- Depends on strength, quantity consumed, frequency and duration of use of drug
- Depends on sex, body size, personality, genetic constitution, speed with which the drug is taken and route of administration.
- It depends on the environment where the drug is used.
- It depends on the mood of the person using.

1.10 Myths and misconceptions about alcohol and drugs

Over the years many falsehoods about alcohol and drug consumption have been invented and spread. Some of the common myths and messages are listed below:-

	Myth	Fact
1	**Young people use drugs as a phase when growing up.**	There are many young people who grow up without using drugs.
2	**When you use drugs, you perform better in class, sex, work place and become a star.**	The fact is that young people do not need to use drugs to perform better in either way intoxication and/or addiction will severely affect ability and performance in the long run.
3	**You get drunk faster with hard liquor than with a beer or wine cooler.**	Alcohol is alcohol. Your blood alcohol content determines how drunk you are, not what type or flavor of alcohol you chose.
4	**Alcohol makes sex better.**	Alcohol lowers your inhibitions and can make you feel more comfortable having sex with someone. However, it does not improve your performance in any way. In fact it may cause impotence and delayed ejaculation and thus poor sexual satisfaction.
5	**I can drink and still be in control.**	Drinking impairs your judgment, which increases the likelihood that you will do something you'll later regret such as having unprotected sex, being involved in date rape, damaging property, or being victimized by others.

1.11 Messages portrayed by the alcohol industry

	Message	The message communicated by the industry	Explanation:
1	**The damage done by alcohol is caused by a small group of deviants who can not handle alcohol.**		Once individuals develop alcohol problems, these problems affect them and those around them in the family and the community be it poverty, violence, job loss, crime, sexual abuse, and absenteeism.
2	**Consuming alcohol is normal, common, healthy and very responsible.**	The regular consumer of alcohol is social, enjoys and is at the centre of a vibrant social life. Alcohol is a natural part of a life of health, luck and prosperity as well as good habits and traditions.	To bring this message home, alcohol advertisements nearly always associate alcohol consumption with health, sportsmanship, physical beauty, romanticism, having friends and leisure activities. That alcohol is also related to serious health problems, traffic accidents, unemployment, violence, child abuse and suicide is something you will never see in advertisements.

1.12 Summary

Chapter 1 highlights the nature of drug abuse, the types of drugs, effects and mode of use. It is important because it provides a foundation of understanding and information related to drug abuse and gives material that the Peer Counsellor needs to know.

CHAPTER 2

The Developing Brain, Adolescence and Vulnerability to Drug Abuse

Adolescence is period of profound brain maturation. Maturation is not complete until about age 25. Drug use starts early and peaks in the teen years. There is significant new research concerning adolescent brain development and the effects of alcohol and other drug use on the developing brain. This emerging science is providing new insights about how teenagers make critical and life influencing decisions, including their decisions about drug use. Brain imaging studies suggest that the brain continues to develop through adolescence and into young adulthood (age 25 years). The developing brain of the teenage years can provide clues as to why adolescents may be more prone to take risks and why teenagers are particularly vulnerable to the effects of drugs. These new scientific discoveries provide valuable lessons for parents, and for adults that work with youth. They reinforce the importance that teenagers benefit from guidance provided by adults, and that careful and regular monitoring of their behavior is a high priority for parents.

During adolescence, the parts of the brain that are responsible for expressing emotions and for seeking gratification tend to mature sooner than the regions of the brain that control impulses and that oversees careful decision making. As one expert puts it the teenage brain **"has a well-developed accelerator but only a partly developed brake"**.

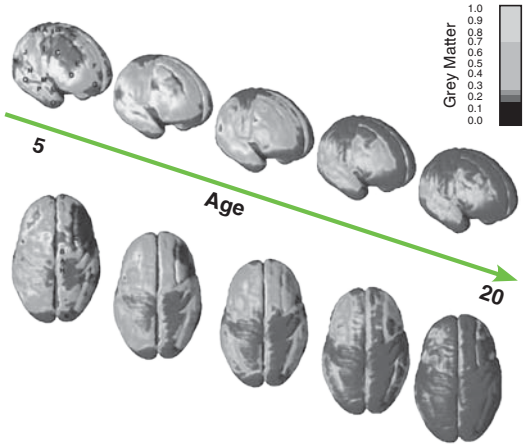
The maturing brain of the adolescent may also pose a particular risk toward drug abuse. There is some evidence that the developing brain is prone to the deleterious effects of alcohol. One study showed that memory ability may be negatively affected by about 10% as a result of alcohol abuse.

Brain Development

Maturation occurs from back to front of the Brain

Images of the Brain Development in Healthy Youth (aged 5 - 12).

The Darker parts represent maturing of Brain areas.



Source: Gogty, Giedd, *et al.*, 2004

Source: Gogty, Giedd, *et al.*, 2004

From a scientific standpoint, the central question that has received the most research attention by scientists is this; **"Are adolescents more susceptible to alcohol compared to adults?"** For several reasons it is easier for scientists to study the effects of alcohol compared to other drugs, so there is a lot more alcohol research on this topic. Given that ethical reasons prohibit collecting direct evidence from underage drinkers, the effects of alcohol have been studied using adolescent and adult rats in controlled experiments. Some studies by Professor Spear (2002) have indicated that adolescent rats are less sensitive to the effects of intoxication than adult rats. Adolescent rats typically consume two to three times as much alcohol for their body weight as adults. Adolescent humans also show this diminished sensitivity to intoxication; their higher metabolic rates allow them to consume higher amounts of alcohol. A lower sensitivity to alcohol's effects would be consistent with the observation that young people are capable of drinking large amounts of alcohol before feeling intoxicated.

General findings from laboratory animal studies suggest that adolescence is a developmental period during which time alcohol is experienced quite differently compared to how adults handle alcohol. The tendency for youth to have a diminished sensitivity to the negative effects of drinking and yet to have an enhanced sensitivity to the positive effects of alcohol suggests a "recipe" for binge drinking.

The work from Professor Spear's laboratory suggests that the memory region of the brain –the hippocampus -is particularly sensitive to alcohol, especially during adolescence. Adolescent rats exposed to various amounts of alcohol have significantly more brain damage in their frontal cortex than their adult counterparts. They also show greater damage to their working memory. With long-term use, adolescent rats have shown massive neuronal loss in other regions of the brain - the cerebellum, basal forebrain, and neocortex.

Take Home for Parents and Counsellors

Promote activities that capitalize on the strengths of the developing brain

Assist your child with challenges that require planning

Reinforce their seeking advice from you and other adults

Educate about risk taking and negative consequences

Never underestimate drug effects on developing brain

Tolerate "oops" behaviors common during the teens

CHAPTER 3

Peer Education and Peer Counselling

The term Peer Education and Peer Counselling include:-

- The process of imparting knowledge and practices by a peer educator to people of similar age, interests and social background.
- It involves those of the same or similar societal group or social standing educating each other.
- It's the sharing of our experiences and learning from others like us.
- The process of sharing information among members of a specific community.
- The term describes education of young people by other young people.

3.1 Who is a Peer?

Peers have the following characteristics:

- Shared characteristics such as age, gender, ethnicity, culture, subculture and place of residence.
- Similarities in experience including, lifestyle and educational background and may include drug related experience.
- Group membership among his agemates

3.2 Qualities of a good peer educator include:-

- Good role model in society
- Creative and innovative
- Non judgmental
- Practices confidentiality of clients information
- Able to refer clients
- Counsellor and listener
- Knowledgeable and friendly
- Credible and influential
- Smart and good role model

3.3 Roles and responsibilities of Peer Educators

These roles can be categorized as:-

- Supportive role which places the peer educator and other young people as equals. The peer may engage in organized activities like health

education and promotion initiatives, or in other situations such as resource centers.

- Leadership role, which is more directive. The peer educator is placed in the position of a leader or "**expert**".

3.4 Roles of peer educators

- Identification and referral of youths with drug related problems to appropriate centers.
- Provides initial and basic Counselling and Guidance.
- Promoting life skills among youths.
- Championing the formation of **Drug Free Clubs** in his/her community.
- Advocating for acceptance of adolescent parents at the community level.
- Acting as a link in relationship and problems between affected groups ie adolescent parents and adolescents themselves.
- Involvement in activities that improve his/her economic and education status.
- Provision of health education on nutrition, hygiene, contraception, drug abuse and other related issues.

A case study of a good peer educator imagine scenario

John, 15 years, *had dropped out of Primary Seven and come to the slums with his auntie who had promised to help him identify a job in Kibera slums. For 2 years John wondered around in the slums and got in touch with a group of 6 young boys who introduced him smoking cannabis and use of solvents. Initially he resisted but because he wanted to be part of the group he eventually ended up using the drugs. John now cannot spend a whole day without using drugs. One day as the boys were at a garbage pit, an NGO social worker recognized them and talked to them about their experience and told them the reasons why they need to come to the rehabilitation centre. John and other 2 boys accepted, the other 3 refused. After 2 days at the centre John enrolled to be a peer educator and was oriented to be able to counsel and talk to other boys in the slums about drug abuse and why they need to join the rehabilitation programmes for the slum boys.*

John says peer education is not easy because some boys take time to believe and accept what you are telling them. Other boys believe you and accept to join the rehabilitation programme. From time to time John and other peer educators brief the social worker about their challenges and success……..

3.5 Delivery of Peer Education

Peer education can be delivered through;

- Informal, unstructured group discussions.
- Dissemination of resources advice at events.
- Activities that draw on popular culture such as music, dance and drama, Art, etc
- Conversations with friends or family members

3.6 Settings under which peer education can occur

- Educational institutions e.g. Schools, universities, colleges, etc
- Community settings such as youth centers, drug agencies, clubs, shelters, workplace and juvenile justice centers.
- Social settings like sports and recreation venues, entertainment events
- Drug use locations like clubs, raves, parks, ghettos, etc

3.7 Aims of Peer Education and Counselling

Its aims to promote knowledge about:-

- Social and physical effects of various drugs
- Legal and ethical issues concerning drugs
- Prevalence of drug related harm
- Consequences of drug use
- Sources of help

It aims to promote skills of the peer leader and person being helped to:-

- Respond to drug related problems among family, friends.
- Respond to drug overdose
- Make informed decisions
- Resist peer pressure
- Avoid drug using situations

It aims to promote behavioural change to:-

- Prevent, stop or reduce drug use
- Delay onset of drug use

- Prevent increase in drug use
- Prevent resumption of drug use
- Prevent transition to use more harmful drugs or practices.
- Minimize risky behaviour and harmful practices
- Provide protective factors for avoiding use
- Minimize impact of drug use on school, work or interpersonal relationships.

3.8 Rationale for Peer Education

a) **Credibility:** Peer educators are seen as more credible than adults when delivering drug related information because young people are more likely to share characteristics with peer educators.

b) **Decreased Threat:** Young people may perceive peer education as less threatening than adult led education.

c) **Role modelling:** Peer educators are more effective role models because their behaviour can provide social information relevant to the young people.

d) **Ongoing contact:** Offers widespread and long term impact on the target group as educators have ongoing interaction with the target group.

e) **Access to hidden populations:** Peer educators carry their messages beyond the classroom into their social environment.

f) **Cost effectiveness:** Peer education initiatives rely on volunteers.

3.9 Benefits to Peer Educators

- Increased self esteem
- Enhanced sense of self efficacy
- Increased knowledge and skills about health and drug related issues.
- Development of planning and presentation skills
- Development of leadership skills
- Development of skills in accessing and assessing information.
- Development of valuable experience that may facilitate later job seeking efforts.

CHAPTER 4

Life Skills Education

4.1 What are Life Skills?

These are:-

- Qualities needed by an individual in order to operate effectively in society in an active and positive way.
- Strategies one uses to get along with oneself and others.
- Personal and social skills required for young people to function confidently and competently with themselves, with other people and with the wider community.
- Ability to do something where skills are acquired and used through training, experience and exposure.

Types of "Life skills"

These are divided into 3 major categories namely:-

4.2 Skills or abilities of knowing and living with oneself

Self awareness:

Knowing ones strength, weakness, emotional potential and position in life and being able to accept who you are.

Self esteem:

Accepting one self and being proud of what one is and feeling self-confident.

Coping with emotions:

Is the ability to manage a problem or situation using ones emotional feelings positively in response to internal or external stimuli. Emotions include fear, love, shyness, anger and desire to be accepted.

Coping with stress:

Ability to deal with problems such as; lack of a family, broken relationship, death of close friend or relative, lack of food, police harassment and other stressful situations including peer pressure and the offer to use drugs.

Assertiveness:

Knowing what one wants and feels and how to achieve and communicate it without being aggressive.

4.3 Skills of knowing and Living with Others

These include:-

Friendship formation:

Being able to relate with people who will be mutually beneficial in a positive way.

Empathy:

Putting oneself in some other person's position or shoes, walk a mile in them and then leave that person to proceed.

Non- violent conflict resolution:

Consider options, which yield best possible results without using violence.

Peer resistance:

Resisting negative peer pressure without necessarily losing your friends.

Negotiation:

Ability to bargain, get others on your side without them feeling that you have infringed on their rights.

Effective communication:

Being able to transmit the message you would like to convey in a way that the receiver understands.

4.4 Skills of making Effective Decisions

Creative thinking:

Being able to come up with new ways and ideas of doing things or dealing with different situations.

Critical thinking:

Ability to think through situations so as to take appropriate decisions concerning people or one's environment.

Decision making:

Being able to look at options and choosing healthy and positive alternatives.

Problem solving:

Solving problems in a way that provides acceptable healthy and positive - outcomes for all involved.

4.5 Skills of making Effective Decisions

Life skill education aims to promote the following abilities:-

- Enabling youth make positive health changes in their lives.
- Enabling youth make informed decisions about their lives and behaviour.
- Enabling youth recognize and avoid risky health situations and behaviours.

4.6 Life skills are very important in:-

- Drug and substance prevention.
- HIV/AIDS and STD prevention.
- Protecting young people from abuse.
- Suicide prevention programs.

4.7 Benefits of life skills education

- Enables vulnerable youth have greater control over their own lives.
- Promotes positive health behaviours in pregnancy and high risk of HIV/STL transmission.
- Empowers youth to positively and effectively manage them when confronted with difficult situations.
- Assists children when faced with the loss of parents or guardians.
- Improves the relationship between the child, key actors and the community.
- Increases job seeking strategies and satisfaction for working youths.
- Contributes to making children better citizens.
- Empowers the individual child to promote his/her own health and health of other community members.
- Helps young people avoid risks.
- Promotes youth being protected.
- Enables young people to be better able to make positive and healthy choices and decisions.

Case study

A young boy Moses had just come to the slums and he met some old boys who convinced him to drink the small sachets of alcohol (Changa). In a week's time, Moses had been introduced to drugs (cannabis). In all these situations, Moses never resisted because he wanted to belong to the group and he felt they were more helpful to him. Every time he went back home in his guardians complained of bad smell. Moses had also become aggressive and violent. Moses is introduced to you as a social worker/counselor by a peer to help him.

Questions

1. What life skills did Moses lack?
2. What life skills do you think Moses needs?
3. Role play to show how Moses can acquire the life skills to prevent drug abuse.
4. Explain to the group why those life skills are important.

Hints

To help a young person recognize that he needs life skills to prevent further usage of drugs. For example assertiveness, peer resistance, effective communication, decision making, negotiation and problem solving. Please you may identify other case studies for role play and discussion.

4.8 Summary

Life skills are abilities developed through experience or training to overcome life challenges and also cope positively with demanding situations.

Three major types of life skills are:-

- **Skills of understanding one self**
- **Skills of living with others**
- **Skills of making effective decisions**

Young people who have fully developed these skills, resist drugs and have high self esteem and will never compromise their health or body with harmful substances.

So, as a Peer Counsellor, help young people develop skills.

CHAPTER 5

Peer to Peer Counselling

5.1 What is Peer Counselling?

Peer to peer counselling is the counselling of adolescents by another in their own age group. It is face to face communication, which entails knowledge, skills, givin a hand to a person to enable them overcome the problem, information, active listening - and practice.

5.2 Drug / Alcohol Counselling

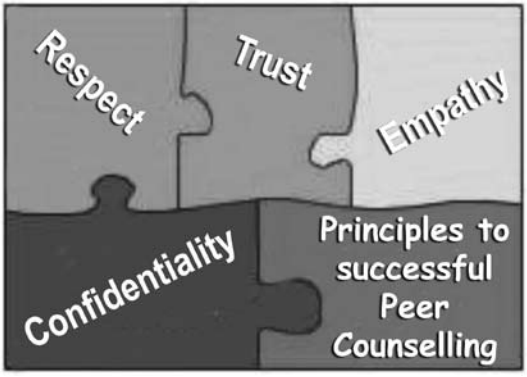
Is an art through which knowledge of human relations and skills in relationships are used to help the individual substance abuser find the personal strength and resources in him/herself and within the community to adjust, cope and lead a productive life free from drug/alcohol abuse.

5.3 Why Peer Counselling?

- Comfortable for young people to talk to some one in their age group.
- Young people understand their problems better than the adults
- Important for shared problem solving.

5.4 What to observe and follow in Peer Counselling

- Keep confidentiality of young person with drug problems (clients) information
- Exclude assigning guilt or innocence of client's responsibility for causing his/her problems
- Recognize adolescents'right and need to freedom of making their own decisions.



- Be trusted and truthful.
- Being able to recognize your limitations in counseling some problems.
- Be sensitive to client's feelings, understand their meaning and respond to them appropriately.

- Perceive and deal with the young person with drug problems (client) as he or she really is.
- Recognize the young person with drug problems (client) need to express his feelings freely without being discouraged or condemned.
- Recognize and understand each adolescent's unique qualities in coping with different situations.
- Ability to listen and show empathy
- Give correct information and avoiding giving a lot of information at one go.

5.5 Challenges of Peer Counselling among young people

- The young person with drug problems refusal to talk to the peer
- The young person with drug problems being very talkative.
- The young person with drug problems cries every time
- The young person with drug problems threatens with suicide
- The young person with drug problems under influence of drugs.

5.6 Stages of counseling Preparation and entry

Prepare the young person, create an equal environment and ensure privacy.

Attending

Greeting, appropriate sitting posture, eye contact and creating a relationship with the young person.

Responding

Understand the young persons feeling and psychological needs.

Personalizing

The young person understands where he/she is in relation to where he/she wants to be. The young person is left to deal with his/her contribution to the problem not other people's contribution.

Initiation Action

Helps the young person to come up with systematic steps to follow until he/she reaches the goal.

Summarizing

You effect on what has been said by the young person and what has been reached at by both parties.

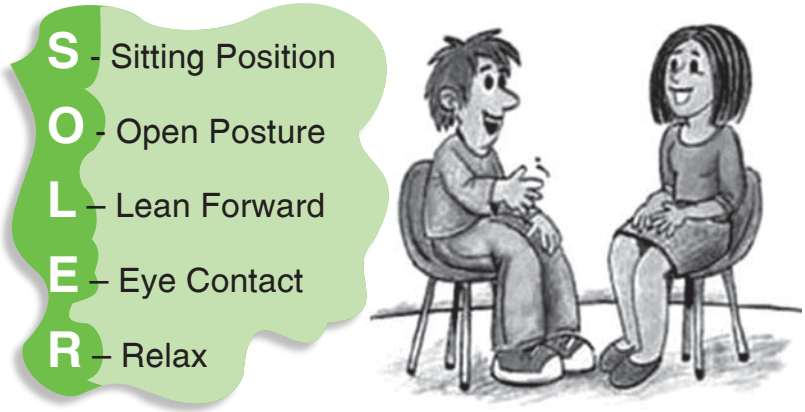
Termination and evaluation

It is the ending of a counselling session and it is done by mutual agreement.

Appointment

Make appointment for the next counselling session by mutual consent.

5.7 The FIVE considerations in counseling



It is important to remember that the peer counsellor is not a trained expert, doctor or psychologist. They cannot and should try to be so. They should know when to ask for help and realize that they will also make mistakes in their role.

5.8 Questions to ask the young person using Drugs

- Which drugs are you using? How often do you take drugs? This will tell you about the type and frequency of drug abuse.
- How do you take the drugs? If by injection, ask: Do you share needles? If so, have you had an HIV test or hepatitis B test?

  Certain methods of how drugs enter the body have certain effects on the user.
- Have you tried to stop the drugs on your own? What happened? People who have tried to stop may be more motivated to accept your help.
- How is the habit affecting your health? Your family life? Your work?
- Would you like to stop using the drugs? Why now? Being motivated is an important sign that the person may succeed in giving up the habit.
- Who are the people whom you trust and who would support you now? They may play an important role in helping the person stay off the drug.

5.9 Things to look for during the interview with young person

- Signs of poor self care
- Signs of injection use, such as marks on the arms
- Signs that the person is intoxicated, such as looking drowsy or slurred speech

- Jaundice, which may be a sign of hepatitis B.

5.10 When does a Peer Educator refer the young person

Refer young people to specialists when the:-

- Are abusing large amounts of drugs, such as more than a gram of heroine a day.
- Are unable to stop the drugs despite your guidance
- Have developed severe physical or mental health problems due to the drugs abuse
- Are injecting drugs and cannot stop this habit

Role play 1

*A young boy Moses had just come to the slums and he met some old boys who convinced him to drink the small sachets of alcohol **(changaa)**. In a week's time, Moses had been introduced to drugs (cannabis). In all these situations, Moses never resisted because he wanted to belong to the group and he felt they were more helpful to him. Every time he went back home in his guardians complained of bad smell. Moses had also become aggressive and violent. Moses is introduced to you as a social worker/counselor by a peer to help him.*

Role play 2

Four boys of Amani Secondary school have been arrested by the sports teacher at the play ground smoking cannabis and this is big offence in the schools rules punishable by dismissal. They are brought to the staff room and on pleading the staff meeting suggests that you counsel them. Create a role play to show the necessary skills and knowledge required to counsel this group and also one to one.

Case Study

A mother presented her son who was complaining of headache, abdominal and muscle pains to a counselor. On further examination and assessment, it was discovered that the boy was using drugs (cannabis). The mother pleaded with the counselor to help counsel her son who was on his way to addiction. As a counselor;

1. *How would you help this young boy?*
2. *What life skills was the son lacking?*
3. *What life skills does the mother need to have?*

Hints

To help a young person recognize that drugs are not good for himself and explore ways of overcoming the problem.

Note:

This is one of the core skills a peer counsellor / educator must posse. It provides the young person with drug problems to be able to communicate with peer counsellor / educator.

CHAPTER 6

Alcohol and Alcoholism

6.1 Introduction and Aims of this chapter

This chapter highlights the problems of alcohol and alcoholism and its effects on a young person. Alcohol is a substance/drug that requires special attention. It is legally available and socially accepted and used by many people. However, there are laws about young people's use and it can cause significant physical, social, and psychological harm as the previous chapters indicated. For some people alcohol use can become a real problem and cause dependence and addiction as well as result in illness and be fatal. This is often referred to as alcoholism and Peer Councellors need to be helped to understand this.

6.2 What is meant by "alcoholism"?

Alcoholism, also known as "alcohol dependence", is a disease that includes alcohol craving and continued drinking despite repeated alcohol-related problems, such as losing a job or getting into trouble with the law. Alcoholism is likely when an individual experiences at least 3 of the following symptoms during any 12-month period:-

- Tolerance *(increasing amounts of alcohol are required to achieve a desired effect)*; withdrawal symptoms (such as nausea, sweating, shakiness, and anxiety); drinking larger amounts over a longer period of time than intended.
- A persistent desire to drink, or unsuccessful efforts to control drinking.
- Giving up or reducing important social, occupational or recreational activities in favor of drinking.
- Spending a great deal of time obtaining alcohol, drinking or recovering from drinking.
- Continued drinking despite knowledge of having a persistent or recurring physical or psychological problem either caused or exacerbated by drinking.

6.3 Is alcoholism a disease?

YES. Alcoholism is a chronic, often progressive disease, and, like many other diseases, it has a generally predictable course, recognized symptoms, and is influenced by both genetic and environmental factors that are being increasingly defined.

6.4 Is alcoholism inherited?

Alcoholism tends to run in families and genetic factors partially explain this pattern. Currently, researchers are on the way to finding the genes that influence vulnerability to alcoholism. A person's environment, such as the influence of friends, stress levels, and the ease of obtaining alcohol, also may influence drinking and the development of alcoholism. Still other factors, such as social support, may help to protect even high-risk people from alcohol problems. Risk, however, is not destiny. A child of an alcoholic parent will not automatically develop alcoholism - and a person with no family history of alcoholism can become alcohol dependent.

6.5 Can alcoholism be cured?

NOT YET. Alcoholism is a treatable disease through treatment plans of therapy, medication, or a combination of both, but a cure has not yet been found. This means that if an alcoholic has been sober for a long time and has regained health, he or she may relapse and so must continue to avoid all alcoholic beverages and ensure professional mental health care help is always readily available to provide any necessary professional support.

6.6 Does alcohol treatment work?

Treatment outcomes for alcoholism compare favorably with outcomes for many other chronic medical conditions. The longer an individual abstains from alcohol, the more likely they are to remain sober. Ongoing support from mental health professionals, family members and others are extremely significant for recovery. It is important to remember that many people relapse once or even several times before achieving long-term sobriety. Relapses are common and do not mean that a person has failed or cannot eventually recover from alcoholism. If a relapse occurs, it is crucial to once again stop drinking and to get whatever professional help is needed to continue abstaining from alcohol.

6.7 Does a person have to be alcoholic to experience problems from alcohol?

NO. Even if you are not alcoholic, abusing alcohol can have negative results. Alcohol related problems show if an individual exhibits at least one of the following traits:-

- Continued use despite social or interpersonal problems by drinking.
- Recurrent drinking when alcohol use is physically hazardous.
- Recurrent drinking resulting in a failure to fulfill major obligations at work, school or home.
- Recurrent alcohol-related legal problems.
- Under some circumstances, serious problems can result from even

moderate drinking, for example, when driving, during pregnancy, or when taking certain medications.

6.8 If I have trouble with drinking, can't I simply reduce my alcohol use without stopping altogether?

IT DEPENDS. If you are diagnosed as an alcoholic, the answer is **"NO"**. Studies show that nearly all alcoholics who try to merely cut down on drinking are unable to do so indefinitely. Instead, receiving the necessary professional support for cutting out alcohol (that is, abstaining) is nearly always necessary for successful recovery. And anyone - moderate drinkers included - who finds it difficult to stay within their drinking limit should consider seeking professional care before what seems like a small problem becomes a serious one.

6.9 What is a safe level of drinking?

Most adults can drink moderate amounts of alcohol - up to two drinks per day for men and one drink per day for women and older people. Safe drinking is not easy to determine. Hence young people **SHOULD NOT** drink alcohol at all.

One-Drink is Equivalent to:-

A bottle of Beer = One glass of Wine = a Liquor Tot

However, certain individuals should not drink at all particularly in certain situations. They include:-

- Recovering alcoholics.
- Anyone suffering with a psychological condition, just a few examples of which are extreme distress, depression, anxiety disorders or personality disorders.
- People who plan to drive or engage in other activities requiring alertness and skill.
- People taking certain medications, including some over-the-counter medications.
- People with medical conditions that can be worsened by drinking.
- Any woman who is pregnant or planning on becoming pregnant.
- Young people are particularly vulnerable to the negative consequences

of using alcohol and their developing brain can be effected as well as all the other negative consequences and harms that can result from drinking too much.

6.10 How much drinking is "too much"?

When alcohol use starts causing health or social difficulties for the young person, then the person is drinking too much. Some people may drink too much yet manage to live normally. You must be concerned about such people as well, since sooner or later; the drinking problem can affect their health. Some drinkers say that they can "hold their drink" well, as if this means that they do not have a problem. In fact, when the body becomes used to the effects of alcohol, this is called **tolerance**. Thus, the early detection of a drinking problem is an important part of health promotion and illness prevention.

6.10.1 Binge drinking

This is drinking very heavily on one occasion or over a few days at a time. For example some young people only drink at weekends but then consume a large amount of alcohol. This can be very problematic behaviour and have very significant health and other social consequences.

6.11 What does drinking too much do to a person and the family?

It seriously damages ones health. Some of the extreme symptoms of problem drinking could be:-

- Blackouts – when a person has no memory of what happened after a drinking bout.
- Withdrawal reactions such as becoming tense and shaky and in severe cases, becoming confused and having fits.
- Accidents especially while driving.
- Bleeding in the stomach
- Liver disease
- Sexual impotence
- Depression and suicide
- Sleep problems
- Delusions and hallucinations
- Brain damage
- Recurrent exposure to sexually transmitted diseases and HIV/AIDS because of greater risk to unsafe sexual behaviour.
- Damage to an unborn baby (in cases where pregnant women drink).

6.12 Social effects of problem drinking

- Increased poverty due to reduced ability to work and spending money on alcohol.
- Violence in the home and community
- Loss of job
- Neglecting the family leading to family break up
- Legal problems

6.13 When should you suspect that a person has a drinking problem?

- Unexplained accidents or injuries.
- Burning in the stomach area or vomiting blood
- Relationship problems in the family or with friends
- Repeated sickness and absence from work
- Mental health problems such as depression and anxiety
- Sleep difficulties
- Sexual difficulties (impotence)

6.14 Why is it unsafe to drink during pregnancy?

Drinking during pregnancy can cause a number of seriously harmful pre-natal effects to the unborn child, as early as during the first several weeks of pregnancy and continuing until childbirth. Risks to the child include mental retardation, organ abnormalities, hyperactivity, and eventual learning and behavioural problems. While it is not yet known how much alcohol is required to cause these problems, it is known that they are 100% preventable if a woman does not drink at all during pregnancy.

6.15 As people get older, does alcohol affect their bodies differently?

YES. As a person ages, certain mental and physical functions tend to decline, including vision, hearing, and reaction time. It is also true that other physical changes associated with aging can make older people feel "**high**" after drinking fairly small amounts of alcohol. These combined factors make older people more likely to have alcohol-related falls, automobile crashes, and other kinds of accidents. In addition, older people tend to take more medications than younger persons, and mixing alcohol with many over-the-counter and prescription drugs can be dangerous (even fatal), and many medical conditions common to older people, including high blood pressure and ulcers, can be worsened by drinking.

6.16 Does alcohol affect a woman's body differently from a man's body?

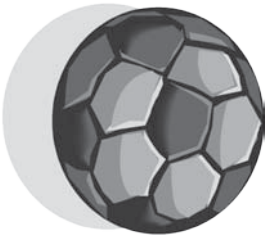
YES. Most women become more intoxicated than men after drinking the same amount of alcohol, even when differences in body weight are taken into account. This is because women's bodies typically have proportionately less water than men's bodies and, because alcohol mixes with body water, a given amount of alcohol becomes more highly concentrated in a woman's body than in a man's. In addition, chronic alcohol abuse takes a heavier physical toll on women than on men and alcohol dependence and related medical problems, such as brain and liver damage, progress more rapidly in women than men.

6.17 If I am taking over-the-counter or prescription medication, do I have to stop drinking?

POSSIBLY. More than 100 medications interact with alcohol, leading to increased risk of illness, injury and, in some cases, death. The effects of alcohol are increased by medicines that slow down the central nervous system, such as sleeping pills, antihistamines, antidepressants, anti anxiety drugs, and some painkillers. In addition, medicines for certain disorders, including diabetes and heart disease, can be dangerous if used with alcohol. To be on the safe side, always ask your prescribing physician whether it is advisable to drink alcohol while taking any medication.

6.18 Alcohol treatment involves:-

- Counselling about stopping or controlling the drinking habit.
- Treatment for withdrawal symptoms.
- Referral to Alcoholics Anonymous.
- Support to and from the family.



6.19 AA- Alcoholics Anonymous In Uganda- Meetings and Their Contacts

Area/place	Contacts
Central Communication Office	Email: alcoholicuganda@yahoo.com Mob: +256-772-674013
Kampala	**New Life Group:** at Christ The King Church, Cardinal Wamala Hall Level 2 Rm 3; Tuesdays & Fridays at 1:00pm (English) Contact: +256-772-674013; +256 702-589658
	At National Care Centre (Rehab) Kasenyi Rd. off Gaba Rd, Katuso, Buziga Saturday, at 3:00pm; Open meeting; (English); Contact: +256-711-577422; +256-772-674013
	AA at Butabika Mental Referral Hospital, at Alcohol and Drug Unit/Ward Thursdays – 12:00pm (English) Contact: +256- 712-634129
	AA at Big Tym-Top Nosh Restaurant Wednesdays 7:00pm (English) Contact: 0752-962844, 0701-674040
	AA at Nsambya House A15 is every Saturday at 3pm-4pm.
	AA at Mbuya Catholic Church is every Thursday 6pm-7pm
Jinja	**AA NKABI in Jinja**, at Nkabi Catholic Centre, Church Hall Tuesdays and Fridays; 1:00pm; (English & Luganda), Contact: +256-782-627970
Masaka	**AA Masaka**, at Kimanya Parish, Mugigi Hall; Thursdays, 4;00pm (Luganda) Contact: +256-711-577422; +256-772-605503
	AA Makondo Group, at Medical Missionaries Dispensary Fridays of the month; 9:00am; (Luganda); Contact: +256-754-149942
Mbarara	**AA At KKT Advocates Office**, Mbarara Town Saturdays at 10;00 am), **At St. Francis project**, Nyamitanga Sunday 10:00am. Contact: +256- 752646604. (English)
Bushenyi	**At National Care Centre (Rehab)**, Bushenyi Town Saturday, 5:00pm; (English & Runyankole) Contact: +256-772- 613832; +256- 752-622443

Kabale	**AA Kabale at Rugarama Health Centre**, Board room Thursdays, 4:00pm, (English) +256-787-390445
Gulu	**AA Gulu**, at Gulu Cathedral, Hall, Saturdays & Sundays, 5:00pm (Luo and English) Contact: +256-772-945440
Rukungiri	**AA-Rukungiri**, at Bethel Home Contact:+256-712-010494

6.20 Locations of Alcoholics Anonymous (AA) and other meetings in Kenya

NAIROBI AREA			
No.	**Place**	**Week Day**	**Time**
1	**Lutheran Church (University Way Nairobi)**	Monday	12.30pm
2	**Jericho (Jericho Catholic Church) Nairobi**	Monday	6.00pm
3	**St John's Ambulance**	Monday	6.15pm
4	**Candle light – Karen Don Bosco boys town near Karen roundabout (Nairobi)**	Tuesday	6.00pm
5	**Touch Stone (The book room),** *Gen Mathenge Drive (Westlands)*	Tuesday	7.00pm
6	**Keep It simple *(Consolata Church) Classroom (Chiromo Road Westlands)***	Wednesday	12.15pm
7	**St. Patrick Catholic Church (Thika)**	Wednesday	5.30pm
8	**St. Peter and Paul Catholic Parish Kiambu**	Wednesday	6.00pm
9	**Serendipity** *(St. Johns Ambulance Hqs) County/ off Harambee Avenue (Nairobi)*	Wednesday Friday	6.15pm 6.15pm
10	**Big Book Study (Hekima College)** *Ngong Road past Adams Arcade, Near Telcom Mast*	Sunday	4.00pm
11	**ALL ANON GROUPS** *For Alcoholics: Parents County Lane off Harambee Avenue. Spouse/ Adult children/ brothers/ sisters/ workmates/ school mates/ friends*		
12	**Codependency (Westlands)** *The bookroom (Gen Mathenge Drive)*	Monday	6.30pm
13	**Dandora 3 Alanon Holy Cross Catholic Church**	Wednesday	11.00am
14	**Nairobi Hospital (Sisters Mess)** *Next to Silver Springs Hotel*	Thursday	2.30pm

15	**Codependency (Westlands)** *The bookroom (Gen Mathenge Drive)*	Friday	12.30pm
16	**Korokocho St. Johns Catholic Church**	Sunday	3.00pm
17	**St. Paul's Chapel** *(State House Road)* *Near University Way Roundabout (Nairobi)*	Thursday	12.30pm
18	**Buruburu Phase I (Holy Trinity Church)** *Mumias Road Nairobi*	Thursday	6.15pm

COAST AREA			
No.	**Place**	**Week Day**	**Time**
1	**Mombasa Hospital (Sisters Mess) Mombasa**	Monday	12.30pm
2	**Malindi – Lutheran Church Hall**	Tuesday	5.00pm

MERU AREA			
No.	**Place**	**Week Day**	**Time**
1	**Igoji Training Center - Igoji**	Wednesday Sunday	3.00pm 3.00pm
2	**Malindi – Lutheran Church Hall**	Tuesday	5.00pm

6.21 Locations of Alcoholics Anonymous (AA) and other meetings in Tanzania

No.	Place	Telephone	Week Day	Time
1	**Inder Bajaj**	0754284850		
2				
3				
4				
5				
6				
7				

6.22 Summary

This chapter has given you an insight of the problems and issues young people may face when they take alcohol. Young people need to be helped to stop or avoid the use of alcohol so as to promote a healthy lifestyle.

CHAPTER 7

Drug Abuse: Risk and Protective Factors

7.1 Introduction

This chapter highlights the risk and protective factors that young people need to be aware of and understand in order to avoid risky behaviours.

7.2 Factors

These are the "**reasons**" or "**causes**" that lead young people to begin using substances. It is rarely one cause or reason that leads to drug abuse but usually a combination of factors.

It is important for the Peer Counsellors to be aware of this and to identify and discuss them when necessary with the young people they work with.

Risk factors:

Characteristics or features in a person or in a person's environment (e.g., home, neighborhood) that increases the potential for a person to use substances.

Protective factors:

Characteristics or features in a person or in a person's environment (e.g. home, neighborhood) that decreases the potential for a person to use substances.

7.3 Risk Factors

These include:

- Use of substance by family members
- The "**rebelliousness**" of youth
- Curiosity
- Seeking adventure
- Natural part of adolescent development
- Weak attachments or bonds to the family
- Uncontrolled aggression and violence.
- Poor school performance/achievement.
- Association with deviant peers who use drugs.
- Availability and use of drugs in the neighbourhood
- Easy access of substances in an environment Weak laws
- Residing in areas where drug use is common.

7.4 Protective Factors

These include:-

- Young people with strong attachments or bonds with their family or with positive adult role models
- Positive peer/friend influence.
- Monitoring and agreed firm rules and guidelines set by parents.
- Success in school performance.
- Strong bonds with churches, school and NGO staff.
- Strict regulation and rules about substance abuse.
- Identifying and destroying sources of substance.
- Counselling, listening and support within family members.
- Involvement in other alternative activities like sports, Music, Dance and Drama.

7.5 How to avoid risky behaviours and promote protection among the youths.

The following have been shown to be useful for different people:

- Being in presence of good peer groups.
- Listening to parents / elder advice.
- Attending Spiritual Ministry.
- Apply life skills
- Engage in recreational activities like sports, MDD, art and theatre etc.
- Avoid isolation tendencies
- Avoid idleness.
- Associate with positive friends
- Avoid being on your own in social settings
- Think and plan – assess potential risks

CHAPTER 8

Drug Abuse and the School Environment

8.1 Introduction

Most drug users begin taking drugs during adolescence or even younger. This is the time when the body and brain is still forming. Unfortunately these drugs interrupt the normal maturity process, when a child can be significantly damaged by drugs; the life and future of the child can be changed substantially and negatively.

Drug use in school undermines a student's academic ability and performance. When many students in class are under the influence of drugs or are absent because of drug abuse, the progress of students is impaired. It also has an effect on family, friends and society including the school community itself. Recent media reports have indicated an increase in alcohol and drug abuse among students with new emerging trends of drugs such as Kuber. Drug abuse has also been attributed to the upsurge of school fires and violent strikes by students across the country.

8.2 How students access alcohol/drugs of abuse in schools

- Through their fellow students especially in day and boarding schools
- Through the non teaching staff such as cooks, gate keepers, etc
- Some students escape from school to the neighbouring communities where they buy alcohol/drugs from known clandestine suppliers.
- The drugs are sneaked into the schools in school bags, shirt sleeves, stockings, suit cases, mattresses, and any other form provided they are not caught by the administration.

8.3 How to detect drug abuse in school environment

a) Signs of drugs and drug related items can include;

(Beware some adolescent changes and even disturbing behaviour is "normal"- be careful not to jump to conclusions that the young person is on drugs!)

- Possession of drug related paraphernalia like rolling paper, unexplainable leaves, powder, pills, syringes, straws.
- Odour of drugs and cover up scents

b) Identification with a drug culture

- Drug related magazines, slogans /tattoos on body and clothing
- Conversations and jokes that are always on drugs
- Some hostility when discussing drugs

c) Signs of physical deterioration

- A person has slurred speech
- Shaking of the body
- Injection marks
- Dark/stained figures
- Sleeping too much
- The eyes become extremely red
- Deterioration in personal hygiene

d) Changes in behaviour

- Dishonesty (stealing and cheating)
- Violence i.e. fighting at school and on way back home
- Constant trouble with the police
- Often breaks school rules
- Possession of large unexplained amounts of money that cannot be accounted for or constant demands for money with household items disappearing.
- Indiscipline and low self esteem moving totally in company of new set of friends/mysterious friends
- Reduced motivation and energy hence reduced interest in extra curricular activities.
- Increasing and inappropriate anger, hostility, irritability and secretiveness.
- Leaving home often early morning with a sense of urgency and returning at odd hours.
- Sudden mood changes.

e) Dramatic changes in performance

- Reduced work output (a marked down turn in academic performance)
- Increased job related accidents and poor workmanship.

8.4 Role of schools in drug prevention

- Establish adequate security measures to check the infiltration of drug abuse in their compounds and vicinity.
- Identify drug peddlers and take appropriate measures against them.
- Provide possible feasible alternatives like MDD clubs, sports clubs, debating clubs which act as anti drug abuse clubs.
- Institute a professional counselor to provide counselling and guidance to students.

- Referrals to health services points such as Butabika Hospital, police, churches, CSOs.
- Train peer drug counselors to help in spreading drug abuse prevention messages.
- Conduct regular health talks and integrate drug abuse prevention messages in school curriculum.
- Create a platform to disseminate drug abuse prevention messages to pupils at school assemblies and gatherings.
- Ensure a health/drug education programme including life skills is developed as part of the curriculum provision.
- Train teachers and others to be aware of the issue and how to respond and how to educate the students.
- Inform parents and help them to be aware and support the school.
- Have a sound policy on drug use and drug prevention education.

8.5 Four Core Rules of monitoring children/youths movements

1. Know where your child or teen is at all times. Make sure he/she knows you're asking out of love, not because of a lack of trust.
2. Get to know all of your teen's friends personally. Know their faces and their voices. Interact with them whenever possible - without actually forcing them to "hang out" with you.
3. Find out how your teen plans to spend her day. Looking for something to discuss during dinner? This is a great one. "**So…what are you up to tomorrow?**" Easy. Right?
4. Limit the time your child spends without adult supervision. The afterschool hours are the most dangerous time for teens to be on their own. Greater peer pressure or boredom can lead to an after-school alcohol or drug use. If you or another adult you trust can't be home for your teen, find out about after-school programs she can get involved with.

8.6 Summary

This chapter is very important because students may use drugs which affect their performance. Peer Councellors need to know how to detect drugs, signs of physical deterioration, changes in behaviour and performance and how to monitor youths movements.

Peer Councellors should put this in mind and always look out for these signs as they help their peers.

CHAPTER 9

Relationship between Drug Abuse and HIV/AIDS

9.1 Introduction

Young people with alcohol use disorders are more likely than the general population to contract HIV (Human Immunodeficiency Virus). Similarly, people with HIV are more likely to abuse alcohol at some time during their lives. Alcohol/drug use is associated with high-risk sexual behaviours and injection drug use, two major modes of HIV transmission.

9.2 Associated risky behaviours

- Unprotected sex is still the major HIV transmission mode.
- There is a strong link between being high on drugs/alcohol and unsafe sex.
- Alcohol and drugs take away fears and encourages taking risks.
- Injecting drugs exposes blood exchange through needles.
- Men under influence of alcohol are at high risk of engaging in rape, marital rape, defilement, sexual harassment leading to unprotected sex and HIV transmission.
- Commercial sex work tendencies by both married and young women.
- Poor parenting and lack of parental control of young girls exposes them to substance use and unsafe sex.
- Children in production/sale of alcohol are at risk of consumption and sexual abuse by intoxicated customers.
- Intoxication makes people lose sense of judgment and may result in unsafe sex.

9.3 Alcohol/Drug Use and Sexual Activity among young people

- Young people who use alcohol are seven times more likely to have had sexual intercourse than those who do not use alcohol.
- Young people who use drugs are five times more likely to have had sexual intercourse than those who do not use drugs.

9.4 Young people Under 15 of age

- Young people under 15 who have ever used alcohol are twice as likely to have had sexual intercourse as their peers who have never used alcohol.

- Young people under 15 who have ever used drugs are almost four times as likely to have had sexual intercourse as their peers who have never used drugs.
- 20% of Young people who initiated alcohol use prior to age 14 reported having had sexual intercourse at age 14 or younger. In comparison, only 7% of teens who had not initiated alcohol use prior to age 14 reported having had sexual intercourse at age 14 or younger.

9.5 Multiple Partners

- Young people who use alcohol are twice more likely to have had intercourse with four or more sexual partners in their lifetimes than their peers who do not use alcohol.
- Similarly, young people who use drugs are three times as likely to have had sexual intercourse with four or more partners during their lifetime as their peers who do not use drugs.

While it is clear that young people who drink and use drugs are more likely to have sexual intercourse at earlier ages and with more partners, it is not clear which behaviour starts first-sexual intercourse or drinking/drug use.

It's recommended that schools, health providers, and social service programs create comprehensive prevention programs that address both substance use and sexual activity. Such programs should offer age-appropriate education about the impact of substance use on sexual pressure, risk-taking, sexual violence, and sexual inhibition.

Programs should help young people manage alcohol and sexual activity by providing practical skill-building exercises such as role playing, negotiation skills, strategies to resist pressure, and ways to avoid risky situations.

9.6 Are Substance Abusers who do not inject at High Risk of Infection?

YES. While it is clear that young people who drink and use drugs are more likely to have sexual intercourse at earlier ages and with more partners, it is not clear which behaviour starts first-sexual intercourse or drinking/drug use.

It's recommended that schools, health providers, and social service programs create comprehensive prevention programs that address both substance use and sexual activity. Such programs should offer age-appropriate education about the impact of substance use on sexual pressure, risk-taking, sexual violence, and sexual inhibition.

Programs should help young people manage alcohol and sexual activity by providing practical skill-building exercises such as role playing, negotiation skills, strategies to resist pressure, and ways to avoid risky situations.

9.7 Alcohol, drugs and condom use

As researchers gather more data, they may be able to refine their understanding of the relationship between substance abuse and condom use. It is possible that drinking or drug use by themselves, for instance, may not sufficiently explain inconsistent condom use. However, studying people who use multiple substances over the course of their lifetimes – or who use of multiple substances within a given time period – may yield more useful information. One recent analysis of data about young adults aged 18 to 30 found that the more different substances a person had ever used, the less likely he or she is to have used a condom at last sex. Similarly, people who use multiple substances – such as alcoholics who also use drugs – do appear to be less likely to use condoms.

9.8 Drug/alcohol abuse among HIV infected persons

Substance use is associated with increased risk for HIV transmission by HIV-positive people to uninfected partners through sexual contact. In persons already infected, the combination of heavy drinking and HIV has been associated with increased medical and psychiatric complications; delays in seeking treatment; difficulties with HIV medication compliance and poorer HIV treatment outcomes as ARVS tend to become ineffective. The developmental changes that occur during adolescence, coupled with HIV infection, can increase the use of alcohol and other substances. These patients may feel a sense of vulnerability, which may further place them at risk for substance use. Understanding adolescent development is critical to helping adolescents mature into well-adjusted adults.

The use and abuse of alcohol and other mood-altering substances can be particularly problematic for young people infected with HIV. Since substance use patterns for young people are different, screening, assessment, and treatment of substance use in young people requires unique considerations, including the following:-

- Social factors, particularly strong peer influences, have a significant impact on adolescent substance use.
- Experimentation with substances, especially with alcohol, is common among young people and is often considered normative behavior.
- HIV-infected adolescents presenting for treatment typically demonstrate a high degree of co-occurring mental health symptoms or prior mental health diagnoses, which frequently precede the onset of problem substance use.

Table 1: Potential Risk Factors for Substance Use in HIV - Infected young people

Risk Factor	Comment
Mental health diagnoses	Young People with diagnoses of depression, anxiety, post-traumatic stress disorder, attention-deficit/hyperactivity disorder, and conduct disorder are more likely to use substances than young people with no mental health diagnosis.
Sexual, emotional and physical abuse	Abuse and neglect in childhood is consistently associated with a high likelihood of substance use during adolescence in both males and females. Violence associated with dating is also linked to high levels of alcohol and marijuana use in Young People. Some studies have shown that Young People with a history of being sexually abused by adults were more likely to use substances than their peers.
Homelessness or street involvement	Early experiences of homelessness may predict substance use in Young People. Homelessness is associated with the use of a variety of substances, including alcohol, and injection drug use.
Parental substance use	Parental substance use predicts early and increased levels of alcohol and substance use in Young People. Protective factors for young people's substance use in families with parental substance use include close sibling relationships and parental disapproval of children's substance use.
Incarceration	Young People's incarceration is associated with increased substance use.
Early puberty	Early puberty is associated with both increased substance use and adolescent pregnancy.
Adolescent pregnancy	Adolescent mothers use substances more often than their peers, and this difference persists into young adulthood.
Peers who use substances	Peer influence is important in predicting substance use in adolescents, and adolescents who use substances are likely to have friends who also use substances.
Educational experience	Lack of educational attainment or school attendance is a marker for substance use in young people. Inversely, some young people may experience pressure to increase their academic performance, which can place them at risk for using cognitive-enhancing substances.
Body image and athletics	Some young people may experience pressure to alter their appearance through body-building or increase their athletic performance, both of which can place them at risk for using performance-enhancing substances, such as steroids.
Tobacco use	Tobacco use has been consistently reported in young people receiving treatment for alcohol and substance dependence, and smoking has been suggested as an indicator for both alcohol use and dependence.

CHAPTER 10

Drug Abuse and Sexual Reproductive Health

10.1 Introduction

Reproductive Health is a state of complete physical, mental, emotional and social well-being in all matters related to the reproductive system, its functions and processes. Reproductive health implies that people are able to have a satisfying and safe sex life, the capacity to reproduce and the freedom to decide if, when and how often to do so. The relationship between drug abuse and reproductive health is evident and has impacted so much on the young people sexual lives that has led them to engage in behaviours that increase their risk to practice unsafe sex exposing them to RH problems including HIV infection. Therefore it is important for young people to know the dangers associated with drugs / substance abuse for them to understand the possible link between drug abuse and unprotected sex and consequently HIV/AIDS. The ultimate goal of peer educators passing on information to young people on RH is to improve their knowledge, attitude and behaviours regarding the interface between drug abuse and RH. But also effective peer education has to have an impact on the peer educators themselves, helping them examine their own attitude towards sexuality, drug abuse and other behaviours regarding reproductive health and HIV/AIDS prevention.

10.2 First it is important for young people to know the Reproductive Health Rights

- The right of all individuals and couples to decide freely and responsibly the number, spacing and timing of their children.
- Right to information and means to make the informed decision.
- The right to attain the highest standard of sexual and reproductive health services.
- Right to make decision concerning reproduction, free of discrimination, coercion and violence.
- Right to choice of a partner.
- Right to friendly services.

10.3 Components of Reproductive Health

1. Safe motherhood including breastfeeding and nutrition, pre-natal care, safe delivery and post-natal care, information, education and counseling on reproductive health and sexuality;
2. Abortion and post abortion care.
3. Family planning

4. Infertility prevention and treatment
5. Adolescent reproductive health (menstruation, hygiene, libido)
6. STI, HIV/AIDS prevention, diagnosis, treatment and care. The most common STIs include gonorrhoea, chlamydia, syphilis, chancroid, genital herpes, genital warts, HIV/AIDS. STIs are dangers especially if not treated immediately as they may cause infertility.
7. Prevention of violence against women and female genital mutilation (FGM)
8. Reproductive health cancer prevention, diagnosis, treatment and care
9. Menopause and adropause.

10.4 Major Reproductive Health Problems among boys/ male young people

- Erectile dysfunctions (impotence)
- Loss of libido (lack of sexual desire),
- Orgasmic failure,
- Premature ejaculation,
- Poor genital hygiene,
- STIs (urethral itching and discharge, swollen and painful testes).

10.5 Major Reproductive Health Problems among Girls or female youth

- Unwanted sex
- Unwanted pregnancies and abortions
- STIs including HIV/AIDS
- Miscarriage
- Complications of pregnancy
- Improper use of contraceptives
- Gynecological disorders
- Sexual coercion,
- Vaginal bleeding (menstruation/menstrual irregularities).

Menstruation is triggered by hormones that cause the ovaries to mature and to start releasing an egg about every 21-35 days. The menstrual period is a sign that the girl's body; is developing and working normally in a new way & will be able to conceive a baby if she has unprotected sex. The vagina and hips or pelvic bones are fully grown 1-2 years following the onset of menstruation. Menstruation continues until menopause at the age 45 to 50.

- Bleeding after intercourse.

- Early pregnancies
- Infertility

10.6 Key messages:-

- Irregularities in menstrual cycles are very significant. Girls cannot use the timing of their cycle to prevent pregnancy.
- Menstrual blood is clean. But when it comes out of the body and is exposed to air and bacteria, it can smell.
- Menstruation is normal for all females
- During periods, girls need to keep extra clean, change the pad when it becomes heavy.
- For female sex during menstruation increases her risk of being infected with any STD, including HIV.

10.7 Family planning information and services

Family planning is the practice of having the number of children you want when you want them. "**Children by choice, not by chance**".

10.7.1 Condom

The condom is a strong thin rubber sheath which when properly worn over an erect penis prevents:-

- The male sperms from entering the woman's vagina and thus effectively avoiding pregnancy
- Prevents the transmission of most sexually transmitted diseases including HIV.

10.7.2 How to use a condom

- Ensure that the condom has not expired and packing is intact.
- Carefully tear the packet and remove the condom.
- Hold on and gently squeeze the '**teat**' to expel the air.
- Gently roll the condom all the way to the root of the erect penis.
- After sexual intercourse, withdraw the penis while it is still erect. Hold on to the base of the condom to avoid it slipping off.

10.7.3 Emergency contraception

This is very helpful to young people in particular female/women who have had unprotected sex and do not want to become pregnant, they can use emergency contraceptives (pills) as soon as possible (less than 3 days) after the unprotected sex. However this does not stop them from getting infected with STIs including HIV/AIDS.

The other methods of family planning including, pills, the Injectable, Norplant implant, the Intra-Uterine Contraceptive Device (IUCD), vasectomy and Tubal Ligation (Female sterilization) are available and need to be prescribed by medical personnel.

10.8 Message points on Family Planning

- Family planning services are free in government health facilities.
- Having menstrual periods is an indication of being capable to become pregnant.
- Family planning does not stop women or young people from having children, but help them to have children by choice.
- Use of modern Family Planning methods is the surest way to have children at the right time (age).
- Modern family planning is safe, reliable and effective.

10.9 Message points on Adolescent Health are:

- Alcohol and drug use increases young people's risks of unprotected sex.
- Delay sex; abstain, if you can't use a condom correctly and consistently as away of avoiding STDs, HIV/AIDS and teenage pregnancies.
- Unprotected sex leads to unwanted pregnancies and leads to dropping out of school.
- Avoiding early pregnancy will ensure opportunities for education that can lead to a bright future.

10.10 Role of peer educators in promoting healthy sexual practices among youth:

- Provision of Sexuality information and counselling
- Condom promotion for dual protection through distribution and education.
- Provide basic information on safe sex, pregnancy, men's health.
- Family planning counselling to fellow young people.
- Sensitize young people on the link between drug abuse and reproductive health.
- Refer young people who have reproductive health problems to health centers/clinics for treatment.
- Lead focus group discussion on Reproductive Health and drug abuse.

10.11 Reproductive Health institutions in Uganda:-

	Institution	Address
1	**Naguru Teenage Information and Health Centre**	Opposite Shell Bugolobi, P. O. Box 27572, Kampala - Uganda. Phone: +256 414 288304 +256 414 288097 Toll free line: **0800112222**
2	**Reproductive Health Uganda (RHU)**	Headquarters and Katego Clinic Plot 2 Katego Road *(Off Kira Road Opp. the Uganda Museum).* P. O. Box 10746, Kamwokya. Tel: +256 (0)414 - 540 658 / (0)414 - 540 665 Fax: +256 (0)414 540 657 **E-mail: rhu@rhu.org**
3	**Uganda Youth Development Link (UYDEL)**	Sir Appollo Kaggwa Road, Opposite MBI. P. O. Box 12659, Kampala - Uganda. Tel: +256 414 530353 Email: uydel@uydel.org **Website: www.uydel.org**
4	**Marie Stoppes Uganda**	Plot No. 1020, Kisugu Muyenga. PO Box 3557 Phone: + 256 414 510 337/516 **Branches:** *Kampala Kavule, Hoima, Lira, Gulu, Arua, Soroti, Tororo, Fort Portal, Kabale, Mbarara, Masaka, and Mbale districts.*
5	**Kamwokya Christian Caring Community (KCCC)**	Po Box 25432, Kampala. Tel:+256 414 532600 Email: kamccc@kamccc.org
6	**AIDS Information Centre (AIC)**	Plot 1321 MusajjaAlumbwa Road, P.O Box 10446, Mengo - Kisenyi Phone: + 256 414 231528 Branches: Kampala, Jinja, Mbarara, Mbale, Arua, Soroti, Kabale and Lira districts.
7	**The AIDS Support Organization (TASO)**	Old Mulago Complex, Po Box 10443, Kampala, Phone: 256-414-532580/1 Email: mail@tasouganda.org **Branches:** Mulago, Mbarara, Masaka, Entebbe, Jinja, Rukungiri, Tororo, Mbale, Gulu, Masindi.
8	**Pediatric Infectious Diseases Clinic** *(Baylor College of Medicine Children's Foundation-Uganda)*	Block 5, Mulago Hospital P.O. Box 72052, Clock Tower Kampala – UGANDA Phone: +256 417 11 9100/200 Email : admin@baylorugandа.org

9	**Kampala City Council Health Centers**	• Kawempe Health Center in Kawempe Division. • Kitebi, and Kawaala Health Centres in Rubaga Division. • Kiswa Health Center in Nakawa Division. • Komamboga, Kiruddu, and Kisugu Health Centers in Makindye Division. • Kisenyi Health Center in Central Division.

10.12 Reproductive Health institutions in Kenya

	Institution	Address
1	**Center for Adolescent Health and Development**	Chiromo Lane, Westlands. Tel: 3862901
2	**Family Health Options-Kenya**	Family Health Plaza, Langata - Mbagathi Rd. P O Box 30581 –00100 Nairobi. Tel: 603923/296
3	**National Organization of Peer Educators**	Riverside Drive, Westlands, P.O. Box 10498-00100 GPO, Nairobi, Kenya Tel: +254 20 4451201
4	**National Council of Churches in Kenya**	Head office Jumuia Place Lenana Road Tel: 254-2-2711862 / 2721249 / 2723445 / 2724099 **Or** Tel: 6761064/7852 E-mail: ncckhuruma@yahoo.com
5	**Christian Community Services (CCS)**	Anglican Church Headquarters, Bishops Garden House, Bishops Rd, P O Box 40502 – 00100, Nairobi. Tel: 271 4753 / 271 6085 Fax (020) 271 1782 / (020) 2714750
6	**The Kenya AIDS NGOs Consortium (KANCO)**	Chaka Road, Off Argwings Kodhek Road. P.O. Box 69866 –00400, Nairobi - Kenya. Tel: 254-20-2717664, 254-20-2715008 Fax: 254-20-2714837 Mobile: 0722 203 344, 0733 333 237 Email: kenaids@iconnect.co.ke
7	**Mathare Youth Sports Association MYSA**	Juja Road. Tel: 780494/780148/780517
8	**Kenya Scouts Association**	Rowallan Camp. Tel: 3870794/3873799
9	**Kenya Girl Guides Association**	Tel: 2711426
10	**WOFAK**	Tel: 2730952/2725455/0725715506
11	**Kangemi Women Empowerment Center**	Kangemi Shopping Center Complex. Tel: 631904
12	**Youth to Youth**	DSW plaza, Lenana Road Tel: 3871245
13	**Young Christian Men's association YMCA**	Central YMCA, State House Road. Tel: 2724116/7

14	**Africa Alive (Kenya Chapter)**	UNHCR Compound Chiromo Rd. Tel: 4441499
15	**Engender Health**	ABC Place Westlands Waiyaki Way. Tel: 4444922/4440100
16	**African Youth Parliament**	DSW plaza, Lenana Road
17	**Population Council, Frontiers in Reproductive Health**	General Accident House. Tel: 2713480
18	**PATH, Kenya**	ACS plaza Lenana Road. P O Box 76634 –00508 Nairobi, Tel: 3877177/3877180
19	**Family Health International (FHI)**	Chancery Building Valley Road. Tel: 2713913/4
20	**African Medical Research Foundation (AMREF)**	AMREF Headquarters, Langata Road. Telephone: 6993000 Fax: 609518
21	**Pathfinder**	International Life House, Mezzanine Fl. Tel: 224154/222419/222397
22	**Christian Children's Fund**	Westlands next to Viking House. Tel: 4444890/93
23	**Population Services International**	Office Park, Westlands Waiyaki Way. Tel: 4440126/7/8
24	**JHPIEGO**	Peponi Plaza, Peponi Rd Westlands. Tel: 3751882/4
25	**USAID-APHIA 11**	USAID complex, Gigiri
26	**Family Care International, Kenya**	Riverside Court Flat #3, , Riverside Drive, P.O. Box 45763, Nairobi, Kenya. Tel: (254-20) 44-43-167 or 44-43-204, Fax: (254-20) 44-17-43, E-mail: fcikenya@africaonline.co.ke
27	**Kenya Medical Educational Trust (K-MET)**	Tel: 0721 722 170
28	**Maendeleo ya Wanawake**	Tel: 0733972044
29	**ACE Communications**	
30	**University of Nairobi, Illinois and Manitoba (UNIM)**	
31	**Omega Foundation**	TEL-057202062
32	**Support for Tropical Initiatives in Poverty Alleviation (STIPA)**	
33	**Community Initiative Support Service (CISS)**	Tel: 057-21635
34	**Tuungane Youth Centre (Central)**	
35	**Kisumu Urban Apostolate Programme (KUAP)**	

36	**Teenage Mothers & Girls Association of Kenya (TEMAK)**	TEL: 0722426698
37	**Last Generation Theatre Group (LAGNET)**	
38	**St. John Ambulance**	
39	**Women in Fishing Industry project (WIFIP)**	Tel: 2024579
40	**Kisumu Initiative for Positive Empowerment (KIPE)**	Tel: 0723712069
41	**Program for Appropriate Technology in Health (PATH)**	Tel. 0722938583 OR 0572023726
42	**Mildmay International**	Tel: 0721849258
43	**Family Health Options of Kenya (FHOK)**	Tel: 0722 646 320
44	**Merlin**	Tel: 0726 968 216
45	**Mobile VCT in Bondo (ACE)**	Tel: 0734 956 892
46	**World Vision (Winam project)**	Tel: 2027463
47	**CDC/KEMRI**	Tel: 0722998470
48	**Christian Children Fund (CCF)**	
49	**Plan International**	
50	**Adventist Development Relief Agency (ADRA)**	
51	**Marie Stopes International**	Tel: 0721848722
52	**Population Services International (PSI)**	Tel: 0721257568
53	**Engender Amkeni**	

10.13 Reproductive Health institutions in Tanzania

"Fill in as appropriate to the country"

	Institution	Address
1		
2		
3		
4		
5		

10.14 Summary

Alcohol intake and substance abuse appears to be a mojar cause of reproductive health problems. When intoxicated, yound people can end up in risky behaviuos especially unprotected sex.

Young people need to educated on how drug abuse can lead to reproductive health problems.

CHAPTER 11

Alcohol and Drug Abuse Prevention

11.1 Introduction

Prevention of drug abuse is a critical component of any drug abuse intervention. This is aimed at identifying those at high risk of drug and substance abuse, and addressing those high risk factors to ensure such youth do not abuse drugs although it is relevant to all young people as all are "**at risk**" of drug abuse. An appropriate prevention package could include provision of popular recreation activities, individual skills development, appropriate utilization of media and having supportive community/family members. Some of the preventive approaches for drug abuse include:-

11.2 Involvement of media

Involvement of print and audio- visual media can achieve remarkable success in drug abuse prevention, since mass media is a strong influence on young people. This would require careful consideration of key factors that include choice of media, costs involved, coverage, timing, popularity and access.

11.3 Specific targeting

Ensure the categories of high risk youth are identified and targeted for prevention. Some of these could be street children, slum youths, juvenile delinquents, the homeless, IDPs, young women, or children engaged in commercial sex.

11.4 Cross generational participation

Drug abuse prevention activities that involve youth and adults foster mutual understanding and communication. Social interaction is one avenue that leads to a better understanding of the factors that push youth to drug abuse.

11.5 Involvement of young people

Young people from the area where drug abuse interventions are being implemented should be involved in all stages: design, implementation and monitoring. This encourages ownership, participation, acceptance and sustainability.

11.6 Promotion of positive alternatives

Youth at high risk should be supported to identify, discuss and opt for positive alternatives that will significantly reduce or remove the risks that expose them to dangers of drug abuse. Some of these alternatives could be vocational skills, games /recreation and activities that encourage community values and practices.

CHAPTER 12

First Aid for Drug Abuse

12.1 What are the signs and symptoms of the injury?

12.1.1 Overdose/drug use problem symptoms include:-

- Abnormal pupil size and pupils that do not change when exposed to light
- Agitation and terror
- Convulsions or tremors
- Difficulty breathing
- Drowsiness
- Excessive sweating
- Hallucinations, paranoia, or violent behaviour
- Inability to coordinate movement
- Nausea and vomiting
- Staggering or unsteady walk
- Unconsciousness
- Abnormal behaviour
- Physical appearance changes
- Mood swings

12.1.2 Symptoms associated with drug withdrawal include:-

- Abdominal cramping
- Agitation, restlessness, irritability
- Cold sweats
- Convulsions
- Delusions, or believing something despite evidence that it is not true
- Depression
- Diarrhea
- Hallucinations
- Personality change
- Shaking

12.2 What can be done to prevent the injury?

To prevent a drug overdose, a person should:-

- Abstain from the use of illegal drugs altogether
- Inform his or her healthcare provider about all of the drugs he or she is taking in order to prevent drug interactions.
- Seek professional help if drug abuse is a problem and take prescribed and over-the-counter medicines only as directed by a professional

12.3 How is the injury recognized?

The diagnosis is made by examining the person and asking about drug intake if the person is conscious. Blood and urine tests may be ordered.

12.4 What are the treatments for the injury?

First aid for a person with a drug overdose includes several steps:-

- Check for signs of circulation and respiration, such as a pulse or heartbeat, and normal breathing, or coughing.
- Contact the emergency medical system immediately.
- Start cardiopulmonary resuscitation, if the person stops breathing.
- Stay with the person until medical assistance arrives.
- If an overdose is suspected, try to keep the person from taking more drugs.

CHAPTER 13

Drug Abuse: Rehabilitation and Treatment

13.1 Introduction

Treatment rehabilitation and social integration are ways of assisting young people in their transition to a meaningful way of life. These approaches commence when a drug dependant young person seeks help to overcome his habit in making that transition. Many professionals are employed in the process e.g. doctors, nurses, social workers, psychologists, occupational and family therapists.

- Treatment is expensive.
- Control is possible, not cure. A former drug user is always at higher risk for using drugs again
- Drug addicts require over two years to fully recover.

13.2 Steps in rehabilitation

- The Doctors deal with the presenting problem e.g. mental confusion, anemia, fits etc.
- Detox for one week
- Counselling
- Social care and support
- Occupational therapy
- Rehabilitation
- Mainstreaming drug abuse messages in HIV/AIDS etc.

13.3 Butabika National Mental Referral Hospital

- Has an Alcohol Drug Unit (ADU) which was launched on 26th June 2006 and has a capacity of 32 beds that are currently full all the time.
- The hospital sees on average 25 patients every week. Some of these 60% are in continuing care and 40% new cases.
- Per year the hospital sees about 240 patients, 10 % female.
- Commonest age group is 16 - 21.

13.3.1 Mental Health Referral Hospitals in Kenya

Kenya	**COAST PROVINCE**		
	No.	**Hospital**	**Telephone**
	1	**Coast Provincial General Hospital**	**Physical Location:** Kisauni Road. Box: 90231 - 80100 Mombasa. Tel: (41) - 2314204 Fax: (41) - 2220161
	NAIROBI PROVINCE		
	2	**Chiromo Lane Treatment Center**	**Physical Location:** Chiromo Lane, Muthithi Road. Box:1501- 00606 Nairobi Phone: 3749979, 0722789698, 0202164288, **Fax:** 3746103 Email: clmcpyc@insightkenya.com
	3	**Kenyatta National Hospital-Patient Support Centre** **Rehabilitation Services**	**Physical Location:** Kenyatta National Hospital Box: 20723-00202 KNH Phone:HOU-0722829509, 2726300-9 ***Ext.*** 44115, 44101 Fax: 2725272 Email: pscentre14@yahoo.com, Email: knhadmin@knh.or.ke
	4	**Mathari Hospital Drug Rehabilitation Unit**	**Physical Location:** Muthaiga off Thikard opposite Muthaiga police station Box: 40663 - 00100 Phone: 3763316/7/8, 0721336017

13.3.2 Mental Health Referral Hospitals in Tanzania

	No.	**Hospital**	**Telephone**
Tanzania	1	**Muhimbiri Mental Referral Hospital**	Dar Es Salaam
	2	**Department of Psychiatry NMH**	O784706261

13.4 Treating Prescription Drug Addiction

Years of research have shown us that addiction to any drug, illicit or prescribed, is a brain disease that can, like other chronic diseases, be effectively treated.

But no single type of treatment is appropriate for all individuals addicted to prescription drugs. Treatment must take into account the type of drug used and

the needs of the individual. To be successful, treatment may need to incorporate several components, such as counselling in conjunction with a prescribed medication, and multiple courses of treatment may be needed for the patient to make a full recovery.

The two main categories of drug addiction treatment are behavioural and pharmacological. Behavioural treatments teach people how to function without drugs, how to handle cravings, how to avoid drugs and situations that could lead to drug use, how to prevent relapse, and how to handle relapse should it occur. When delivered effectively, behavioural treatments - such as individual counselling, group or family counselling, contingency management, and cognitive-behavioural therapies - also can help patients improve their personal relationships and ability to function at work and in the community.

Some addictions, such as opioid addiction, can also be treated with medications. These pharmacological treatments counter the effects of the drug on the brain and behaviour. Medications also can be used to relieve the symptoms of withdrawal, to treat an overdose, or to help overcome drug cravings. Although a behavioural or pharmacological approach alone may be effective for treating drug addiction, research shows that a combination of both, when available, is most effective.

13.5 Rapid Detox

The rapid detox process is generally conducted in a hospital setting and under general anesthesia. Also referred to as 'ultra rapid opiate detox', rapid detox for opiate based substances and addictions such as heroin, vicodin, methadone, or any prescribed narcotic pain killers. Other narcotic opiate-based substances that can be treated through the rapid detoxification process include: codeine, dilaudid, morphine, percocet, percodan, lortab, oxycontin. The rapid opiate detox process is generally conducted in a hospital setting and under general anesthesia. In fact, the process is most often overseen by certified and qualified anesthesiologists and a nursing staff that specializes in such procedures. While under anesthesia, the patient is administered medications that accelerate the physical reactions to the rapid withdrawal process which can last from 4 to 6 hours.

CHAPTER 14

Handling Relapse and Seeking Support

14.1 Introduction

Relapse is when a recovering young substance abuser starts to use drugs or alcohol after a period of abstinence / non use.

14.2 Relapse Prevention

- The process of relapse is often ignored or misunderstood to mean that many young people with relapses are receiving ineffective or inappropriate treatment.
- The cost of relapse is high because chronicle relapse patients will eventually die from alcoholism.
- Repeated exposure to treatment methods that have failed is not the answer.
- Logically this repeated exposure to treatment will result in a population of professional patients who never attain full recovery for themselves and who complicate the treatment process for others.

14.3 Who are prone to relapses and why do they relapse?

These may be young people who have no choice but to drink; people who have been coerced into treatment but have no self motivation to recover; persons assaulted by major situational crisis during recovery. For all those who attempt recovery from alcoholism, 40% relapse in spite of their best efforts and they are blamed for relapsing. This compounds the guilt and sense of helplessness and reinforces the tendency to relapse again. Relapse prone patients suffer from alcoholism in its most severe form. Stigma must be removed before successful interventions can be found for those who relapse. Alcoholism is a disease that has two cutting edges. The first attacks while the person is still drinking. The second is the part of the disease that extends into sobriety and takes a vicious toll on individuals attempting to recover.

14.4 Warning Signs of Relapse

The most common symptoms of relapse are:-

1) **Apprehension about well being:** Sense of fear, uncertainty, lack of confidence to stay sober.
2) **Denial:** In order to cope with anxiety and stress.
3) **Adamant commitment to sobriety and self conviction never to drink again:** This is overbalance, fear of sharing this conviction, diminishing of the urgency of pursuing daily program of recovery.

4) **Compulsive attempts to improve sobriety on others:** This is the over imposition of individual standards on others, focusing on what others are doing than their own.

5) **Tendencies towards loneliness:** Someone exhibits patterns of isolation and avoidance, valid excuses and reasons for isolation with episodes of intense loneliness at increasing interval.

6) **Loss of constructive planning:** Here one's life planning skills diminish and attention detail subsides/declines.

7) **Plans begin to fall:** This is where there is evidence of failure to follow through and lack of attention to detail.

8) **Idle daydreaming** and wishful thinking with diminished concentration.

9) **Easily angered:** This manifests in increased anger frustration, resentment and inevitability, frequent over reaction, fear of over reaction to the point of violence and increased level of stress.

10) **Periods of deep depression:** There are more severe frequent, disruptive and longer depression, depression amplified by fatigue and hunger, isolation, reaction with inevitability and anger to human contact, complaints that nobody cares.

11) **Irregular attendance at treatment meeting or complete abandonment of AA:** This is characterized with sporadic AA attendance and missed therapy appointments. In other instances, there may be discontinuing of all treatment.

14.5 Causes of Relapses among young people

These include:-

- Easy access to drugs of abuse.
- Being in company of drug abusers.
- Spending time on a drug using site.
- Experience of strong negative feelings such as anger, sadness, monotony, stress, blame and fear.
- Strong physical pains following injuries in the past medical and addiction history.
- Sudden availability of large sums of money e.g. wining a lottery, inheritance and gambling etc.
- Strong social pressures.
- Belief that one is completely cured and that one can use alcohol or drugs occasionally.
- Negative attitude to some drug free people.

14.6 The Stages of Relapse

Relapse is a process, it's not an event. In order to understand relapse prevention you have to understand the stages of relapse. Relapse starts weeks or even months before the event of physical relapse. In this chapter you will learn how to use specific relapse prevention techniques for each stage of relapse. There are three stages of relapse.

- Emotional relapse
- Mental relapse
- Physical relapse

14.6.1 Emotional Relapse

In emotional relapse, you're not thinking about using. But your emotions and behaviors are setting you up for a possible relapse in the future.

The signs of emotional relapse are:-

- Anxiety
- Intolerance
- Anger
- Defensiveness
- Mood swings
- Isolation
- Not asking for help
- Not going to meetings
- Poor eating habits
- Poor sleep habits

The signs of emotional relapse are also the symptoms of post-acute withdrawal. If you understand post-acute withdrawal it's easier to avoid relapse, because the early stage of relapse is easiest to pull back from. In the later stages the pull of relapse gets stronger and the sequence of events moves faster.

14.6.2 Early Relapse Prevention

Relapse prevention at this stage means recognizing that you're in emotional relapse and changing your behavior. Recognize that you're isolating and remind yourself to ask for help. Recognize that you're anxious and practice relaxation techniques. Recognize that your sleep and eating habits are slipping and practice self-care.

If you don't change your behavior at this stage and you live too long in the stage of emotional relapse you'll become exhausted, and when you're exhausted you will want to escape, which will move you into mental relapse.

14.6.3 Practice self-care.

The most important thing you can do to prevent relapse at this stage is take better care of yourself. Think about why you use. You use drugs or alcohol to escape, relax, or reward yourself. Therefore you relapse when you don't take care of yourself and create situations that are mentally and emotionally draining that make you want to escape.

For example, if you don't take care of yourself and eat poorly or have poor sleep habits, you'll feel exhausted and want to escape. If you don't let go of your resentments and fears through some form of relaxation, they will build to the point where you'll feel uncomfortable in your own skin. If you don't ask for help, you'll feel isolated. If any of those situations continues for too long, you will begin to think about using. But if you practice self-care, you can avoid those feelings from growing and avoid relapse.

14.6.4 Mental Relapse

In mental relapse there is a war going on in your mind. Part of you wants to use, but part of you doesn't. In the early phase of mental relapse you're just idly thinking about using. But in the later phase you're definitely thinking about using.

The signs of mental relapse are:-

- Thinking about people, places, and things you used with
- Glamorizing your past use
- Lying
- Hanging out with old using friends
- Fantasizing about using
- Thinking about relapsing
- Planning your relapse around other people's schedules

It gets harder to make the right choices as the pull of addiction gets stronger.

14.7 Techniques for Dealing with Mental urges for Alcohol and drugs

14.7.1 Play the tape through

When you think about using, the fantasy is that you'll be able to control your use this time. You'll just have one drink. But play the tape through. One drink usually leads to more drinks. You'll wake up the next day feeling disappointed in yourself. You may not be able to stop the next day, and you'll get caught in the same vicious cycle. When you play that tape through to its logical conclusion, using doesn't seem so appealing.

A common mental urge is that you can get away with using, because no one will know if you relapse. Perhaps your spouse is away for the weekend, or you're away on a trip. That's when your addiction will try to convince you that you don't

have a big problem, and that you're really doing your recovery to please your spouse or your work. Play the tape through. Remind yourself of the negative consequences you've already suffered, and the potential consequences that lie around the corner if you relapse again. If you could control your use, you would have done it by now.

14.7.2 Tell someone that you're having urges to use.

Call a friend, a support, or someone in recovery. Share with them what you're going through. The magic of sharing is that the minute you start to talk about what you're thinking and feeling, your urges begin to disappear. They don't seem quite as big and you don't feel as alone.

14.7.3 Distract yourself.

When you think about using, do something to occupy yourself. Call a friend. Go to a meeting. Get up and go for a walk. If you just sit there with your urge and don't do anything, you're giving your mental relapse room to grow.

14.7.4 Wait for 30 minutes.

Most urges usually last for less than 15 to 30 minutes. When you're in an urge, it feels like an eternity. But if you can keep yourself busy and do the things you're supposed to do, it'll quickly be gone.

14.7.5 Do your recovery one day at a time.

Don't think about whether you can stay abstinent forever. That's a paralyzing thought. It's overwhelming even for people who've been in recovery for a long time.

One day at a time, means you should match your goals to your emotional strength. When you feel strong and you're motivated to not use, then tell yourself that you won't use for the next week or the next month. But when you're struggling and having lots of urges, and those times will happen often, tell yourself that you won't use for today or for the next 30 minutes. Do your recovery in bite-sized chunks and don't sabotage yourself by thinking too far ahead.

14.7.6 Make relaxation part of your recovery.

Relaxation is an important part of relapse prevention, because when you're tense you tend to do what's familiar and wrong, instead of what's new and right. When you're tense you tend to repeat the same mistakes you made before. When you're relaxed you are more open to change.

14.7.7 Physical Relapse

Once you start thinking about relapse, if you don't use some of the techniques mentioned above, it doesn't take long to go from there to physical relapse. Driving to the bar or pub. It's hard to stop the process of relapse at that point. That's not where you should focus your efforts in recovery. That's achieving abstinence through brute force. But it is not recovery. If you recognize the early warning

signs of relapse, and understand the symptoms of post-acute withdrawal, you'll be able to catch yourself before it's too late.

14.8 Effective Treatment Suggestions

- Identify the warning signs.
- Educate the patient about the warning signs.
- Teach the patient and significant others to be alert for the relapse warning signs.
- Develop a treatment plan that will intervene at the first indication of relapse warning signs.
- Intervene before the patient return to drinking.

14.9 How to help prevent relapses among young people.

These include:-

- Hang around with good friends.
- Keep way from drugs and drug sites completely.
- Avoid all forms of self medication.
- Deal with social pressures adequately with support from others.
- Manage negative feelings.
- Avoid celebrating one positive event for a few hours in company of close friends. Relatives only suffer alone for months following a relapse.
- Building other protective factors and avoiding known risk factors.

14.10 Benefits of stopping Drug use among young people

There are many potential benefits from avoiding problematic use of drugs:-

- Harmony in families.
- Safe job and self development.
- Reduction in STD/STIs spread.
- Reduction in violence and crime.
- Good school performance.
- High productivity.

14.11 Positive Alternatives of Drug use

- Music, Dance and Drama
- Employment and volunteer services
- Religious activities
- Attending school
- Hanging out with good peer groups.
- Reading educational literature
- Debates and quizzes
- Story telling.
- Finding a new hobby or interest

14.12 Places where young people can seek help in alcohol and substance abuse counselling in Uganda

(whether public or private)

	Place	Address
1	**Uganda Youth Development Link (UYDEL),**	Sir Appollo Kaggwa Road, Opposite MBI. P. O. Box 12659, Kampala Phone: +256 414 530353 Email: uydel@uydel.org Website: www.uydel.org
2	**National Care Centre**	House A15 Nsambya Housing Estate, Nsambya Hill Po Box 33508, Kampala. Email: nationalcare1@yahoo.com Phone: +256 772 674013
3	**Serenity Centre**	KabulamuliroNamulanda towards Akright Project (Entebbe Road) at Bwebajja. Phone: +256 414 267580/ +256 312 298842
4	**Victory Rehabilitation Center**	Kirinya - Kireka Email: kabananukye@yahoo.com kabananukye@gmail.com
5	**The Haven**	Najjanankumbi, Entebbe Road Phone: +256 772 561144 Email: salvundru@yahoo.com
6	**Prevention of Alcohol and Drug Abuse, and HIV/AIDS in Uganda (PADA-Uganda)**	St. Joseph's Community Hall, Mulago.Plot 1117, Church Road Po Box 3807 Kampala Phone: +256 772 619334 Email: padauganda@gmail.com
7	**Youth Aid Uganda**	P.O. Box 33718 Kampala - Uganda Plot 297 Salama Road Kipamba Zone Makindye, Near Winners Primary School. Telephone +256 (0)202-617-872 Email: info@youthaiduganda.org
8	**Uganda Children's Center**	Salama Road-after Kagodo Feeds Po Box 24127, Kampala Phone: +256 414 268979 Email: kakembofred@yahoo.com
9	**Katwe Youth Development Association**	Phone: +256 772 555574 Email:kaydaa@yahoo.com
10	**Kawempe Youth Development Association**	Phone: +256 752 368332 Email:otal_kawempeyouth2006@yahoo.com
11	**Health For Youth With Parents Involved (HEY-PI)**	Nansana - Wakiso Phone: +256 772 463197 Email: clydemycho@yahoo.co.in
12	**Family Life Network**	Kansanga - Kampala. Phone: +256 772 476071

13	**Butabika National Mental Referral Hospital**	Luzira - Kampala, Po Box 7017, Kampala Phone: +256 414 230938
14	**Mental Health Clinic**	Mulago Hospital
15	**Alcohol Anonymous groups**	
16	**All existing health facilities in the country**	

14.13 Places where young people can seek help in alcohol and drug abuse counseling in Kenya *(whether public or private)*

CENTRAL PROVINCE		
No.	**Place**	**Address**
1	**Fountain Of Hope Addiction Treatment Centre**	**Physical Location:** Ondiri Area off Kikuyu Road. Box: 16546-00100 Phone: 0208081333, 0731393772 Email: fountainofhoperehab@yahoo.com
2	**Freedom From Addiction Organization**	**Physical Location:** Kiambu Box: 2088-00900 Phone: 3755219, 0720277447, 0721381280, 0728334014 Email: www.nasuawaibu.org, freeaddorg@yahoo.com
3	**Good Hope Rehabilitation Centre**	**Physical Location:** Nyeri Box:1223, Karatina Phone: 0722-909 478 or 0737 155 448 Email: <gmagape@yahoo.com>
4	**Jorgs Trust And Jorgs Sober House**	**Physical Location:** Tigoni Box: 1047 - 00621 Phone: 066-73558, 020-3573083, 0723692848, 0721712968 Email: admin@jorgs.org, Email: jorgstrust@yahoo.com Website: www.jorgs.org
5	**Redhill Place-** **The Raphaelites**	**Physical Location:** Redhilll Limuru 5 Km off Limuru Road. Box: 8667-00100 Nairobi Phone: 066-51551, 2721498, 0722714300, 0722837627, 0733805510 Fax: 2721513 Email:theraphaelites@wananchi.com

6	**Smarash**	**Physical Location:** Murang'a Box:744-10200 Murang'a Phone: 0723434845 Email: smarash05@yahoo.com
7	**Teens Challenge**	**Physical Location:** Ridgeways Estate, Nairobi. Box: 27 - 00900, Kiambu Tel: 2077691, 0711627087 Email: info@kenyatc.com
8	**The Bridge Centre**	Box: 746-00600 Tel: 0722574125, 0724830821 Email: info@bridgecentre.or.ke
9	**The Retreat**	**Physical Location:** Off Limuru Road, 5 Km before Limuru Conference. Box:1501- 00606, Nairobi Kenya Phone: 0723565529,+254 0208081739 Email: info. the retreat@gmail.com Website:www.theretreatkenya.org

COAST PROVINCE		
No.	**Place**	**Telephone**
1	**Good Hope Rescue Centre**	**Physical Location:** Mtito Andei Box:216 Mtito Andei Phone: 0715334224 Email:crosan08i@yahoo.com
2	**Lamu Anti- Drugs**	**Physical Location:** Lamu Box: 44 Lamu Phone: 0711459102, 0424633222 Email:saidk@yahoo.com
3	**Mewa Rehabilitation Centre**	**Physical Location:** Mtopanga (opp. Kisauni post office) Old Malindi Road. Box: 89427- 80100 Mombasa Phone: 041473197, 2493157, 0722819795, 0711104297 Website: www.mewa.or.ke Email: secretariat@mewa.or.ke
4	**Omari Project**	**Physical Location:** Malindi, Sea Breeze , Msabaha residential centre Box: 1658 Malindi Phone: 0423160220065, 0728896797, 0733231547, 0721648151 Email: theomariproject@yahoo.co.uk
5	**Reach Out Rehabilitation Centre**	**Physical Location:** Junction corner of Mtongwe Mombasa Box:34211 Mombasa Phone:0202408282/ 0722415475/ 0722796287/ 0729766481 Email: Reachout977@yahoo.co.uk

6	**Good Hope Rehabilitation Centre**	**Physical Location:** Mtito Andei Box:116, Phone: 0722-909 478 or 0737 155 448 Email:goodhope.rehabilitationcentre@gmail.com

EASTERN PROVINCE		
No.	**Place**	**Telephone**
1	**Blue Cross**	**Physical Location:** Embu and Mtito Andei Box:160, Nzeeka. Phone: 0720652024, 0722231273 Website: www.ifbc.info Email: <bejahman@yahoo.com>
2	**Forward Resolutions Trust**	**Physical Location:** Embu Municipality, Njukiri Estate ox: 2698-00202 Nbi Phone: 0729560191 Email: info@forwardresolutions.com/mndegwas@yahoo.com/www.forwardresolutions.com, forwardresolutions@yahoo.com
3	**Mwangaza Rehabilitation Centre/ Esvak**	**Physical Location:** KataniMachakos Box:64331 – 00620 Nbi Phone: 0721494823, 0729062403 Email: esvak@skyweb.co.ke

NAIROBI PROVINCE		
No.	**Place**	**Telephone**
1	**Asumbi Treatment and Rehabilitation Centre (Karen)**	**Physical Location:** Karen Box: 34374-00100 Nairobi Phone: 020-2322497, 0721287822 Email:dohbasumbiproject@yahoo.com
2	**Asumbi Treatment Centre (Ridgeways)**	Box: 34374 00100 Phone:0721287822 Email:dohbasumbiproject@yahoo.com
3	**Brightside Treatment and Rehabilitation Center**	**Physical Location:** Kitusuru, Kirawa Rd Box:16942 -00620 Phone: 0722847130 Email: brightsidedart@yahoo.com
4	**Conquerors With Christ Trust Rehabilitation Centre**	**Physical Location:** Kahawa West P.C.E.A church, House Number 961 Box: # 78414-00507, Nairobi Phone: 0727268232, 0716108511, 0729128814 Email:conquerorstrust@gmail.com

5	**Eden Village /Eden Halfway House**	**Physical Location:** lower Kabete Box:41187 -00100 Nairobi Phone: 0722867693, 0726552476, 0722901804 Email: justin.farrar@yahoo.com, bonifacendirangu@yahoo.com
6	**EARYN Recovery Centre**	P.O.Box 47239 – 00100 Tel: 020 – 234 83 93 Mobile: 0712 – 500 048 Email: earyn.kenya@gmail.com
7	**Students Campaign Against Drugs (SCAD)**	Phone: +254720563217 Email: mosesw@scad.or.ke
8	**Maisha House, Rongai**	**Physical Location:** Rongai Box:1207-00502 Nairobi Phone: 0723695167
9	**Masaa Home**	**Physical Location:** Hurlingham, Jabavu Road. Box:10241-00100 Nairobi Phone: 0202724192, 0720939348, 0720316019 Email:home@masaa.org
10	**Nairobi Outreach Services- NOSET Maisha House**	**Physical Location:** Ngara Box:1207-00502 Nairobi Phone: 0733901657, 0720401793, 07228525932098451 Email: nairobioutreach@yahoo.co.uk
11	**Nairobi Place Addiction Treatment and Specialized Medical Centre**	**Physical Location:** 116 Marula lane off Karen Road, Karen. Box: 139-00502,Karen Phone: 254 20 3882 448 / 254 203 884 352, , 0735550000, 0733440000 Fax:(020) 3884352 Email: admin@nairobi-place.org, enquiries@nairobi-place.org, Website: www.nairobi-place.org
12	**STEVFO Treatment and Counselling Centre**	**Physical Location:** Next to Kamiti, Kahawa West, Kiambu Road. Box:65-00100 Nairobi Phone: 0721952642/0721428368 Email: stevtrust@gmail.com
13	**STEPAWA Halfway House**	**Physical Location:** Umoja Road, Ongata-Rongai Box:22-00100 Nairobi Phone: 0724346769, 0725237255,0734171046 Email: stepawahouse@hotmail.com
14	**SAPTA**	**Physical Location:** Kibera Box: 21761-00505 Nairobi Phone: 0203875045,0722216032 0724511709 Web: www. sapta.or.ke

NYANZA PROVINCE		
No.	**Place**	**Telephone**
1	**Anti-Abortion And Drug Abuse-Kenya (Adak)**	**Physical Location:** Nyamira town opposite to Equity Bank Nyamira. Box: 282 Nyamira Phone: 0735987043/0728748180 Email: adakafrica@yahoo.com
2	**Asumbi Treatment and Rehabilitation Centre (Homa Bay)**	**Physical Location:** (Homa Bay) Box: 49 Asumbi 40309 Phone: (020)2700126, 0736091565, 0727151813 / 0721553814 Email:dohbasumbiproject@yahoo.com

RIFT VALLEY PROVINCE		
No.	**Place**	**Telephone**
1	**Psycaca**	Box: 17138 Nakuru Tel:, 0720797260 Email: joseph_mwai@yahoo.com
2	**Serenity Treatment Centre**	**Physical Location:** Rungiri, next to Rungiri Secondary School, on Nairobi – Nakuru highway Box: 23360-00100 Nairobi Tel: 0724499853 Email: Serenitycentre@ymail.com
3	**Eldo Care Recovery Centre**	**Physical Location:** Kimumu Estate, Eldoret. Box:4985-30100 Eldoret Phone: 0720494483, 0731477831 Email: eldocarecentre@yahoo.com
4	**Freedom Homes**	**Physical Location:** Eldoret. Box: 7001 Eldoret Phone: 0722453115, Email:homesfreedom@ymail.com
5	**Oasis Of Hope Rehabilitation Centre**	**Physical Location:** Kiserian- Isinyard, 4km from Kiserian town. P. O. Box:7219-00200 Kiserian (K). Phone: 020-2609857, 020-2609851 Email: oasisrehabilitation@gmail.com : oasisrehabilitation@yahoo.com : qusomq@yahoo.com
6	**Script Resource Centre**	**Physical Location:** Kiserian Town. Box: 69516-00400 Nairobi Phone: 0720278415, Email: scriptresource@yahoo.com
7	**Serenus Centre**	Box: 2730 Kitale Phone: 0722707833 / 0208098788 / 0710967322 Email. serenuscentre@yahoo.com
8	**U-Turn 4 Christ**	**Physical Location:** Ngong, Kiserian. Box: 51164- 00200 Nairobi Phone: 0729861738 Email: godallowsuturns@yahoo.ca

14.14 Places where young people can seek help in alcohol and drug abuse counseling in Tanzania

(whether public or private)

No.	Place	Telephone
1	**Sober Tanzania**	P.O. Box 1925, Dar es Salaam, Tanzania Tel: +255 744 377651 Email: sober_tz@yahoo.com
2	**Iringa Development for Youth Disadvantages and Children care (IDYDC)**	P.O. Box 795, Iringa, Tanzania Tel: +255-26-2701592 Fax: +255-26-2701592 Email: idydc42@hotmail.com
3	**Lake Tanganyika Development and Relief Organization (TADERO)**	P.O. Box 1136 Kigoma Tanzania. Kilungwe Road, Phone: +255 744765421 Email: laketadero@yahoo.com.
4	**AGAPE Women's Group**	C/o PO Box 6051, Dar Es Salaam.
5	**Change and Save Lives Association (CASLA)**	PO Box 76955, Dar Es Salaam - Tanzania Phone: (255 51) c/o 842319 Fax: (255 51) 181099 E-mail: ngocasla@urgentmail.com
6	**Green Belt and Better Living Movement**	P.O. Box 23433, Dar Es Salaam - Tanzania Phone: (255-51) 720 91
7	**Journalists Environmental Association (JET)**	P.O. Box 15674, Dar Es Salaam - Tanzania Phone: (255-51) 208 85 Fax: (255-51) 865 577
8	**Liberty Desk**	P.O. Box 3885, Uhuru Street, Dar Es Salaam - Tanzania Phone: (255-51) 349 55
9	**Mental Health Association (MEHATA)**	P.O. Box 65293, Dar Es Salaam - Tanzania. Phone: (255-51) 262 11 Fax: (255-51) 462 29, 461 63
10	**Mental Health Rehabilitation Society**	P.O. Box 65293, Dar Es Salaam - Tanzania. Phone: (255-051) 151 343
11	**Mission for Preventive Education Against Drug Abuse**	P.O. Box 1140, Dar Es Salaam, Tanzania. c/o Archdiocese of Dar Es Salaam Phone: (255-51) 435 45, 486 02 Fax: (255-51) 435 45, 435 81
12	**Muungano Wa Vijana**	P.O. Box 7206, Dar Es Salaam, Tanzania. Phone: (255-51) 333 10 Fax: (255-51) 844 320, 210
13	**Organization for Prevention of Drug Abuse and Trafficking to School Children in Tanzania (PREDAC)**	P.O.Box 71212 Dar Es Salaam, Tanzania. Phone: (00255) 22 744 363498 E-mail: ndamgoba@yahoo.com

14	**Parents' Association for Student Development**	PO Box 65063, Dar Es Salaam, Tanzania. Phone: (255 51) 18045 Fax: (255 51) 461 06
15	**Society for Aid to Accident Victims**	P.O. Box 21806, Dar Es Salaam, Tanzania. Phone: (255-51) 360 25
16	**Women and Child Vision (WOCHIVI)**	Arusha Tanzania Phone: +255 716 597 412 +255 788 552 269 Email: wochivitz@yahoo.com
17	**Student Development Association**	P.O. Box 65063, Dar Es Salaam, Tanzania. c/o African Christian Rural Services Phone: (255-51) 351 04 Fax: (255-51) 461 06, 07, 08
18	**Tanzania Social Workers Association**	P.O. Box 7732, Dar Es Salaam, Tanzania. Phone: (255 022) 218 3082 Fax: (255 022) 218 2129
19	**Youth Development Trust (YDT)**	P.O. Box 5806, Dar Es Salaam, Tanzania. Phone: (255-51) 123 671 Fax: (255-51) 123 671 E-mail: ncomfort@gpol-posta.africaonline.com
20	**ZAIADA**	P.O. Box 615, Dar Es Salaam, Tanzania. Phone: (255) 4 747 41 1049 Fax: (255) 54 230 195
21	**Department of psychiatry MNH**	Dr Philli - Tel:O784706261
22	**SOBER IOGT**	
23	**EMAU**	

CHAPTER 15

Screening and Brief Intervention for Young People Affected by Drug Abuse problems

15.1 What is screening?

It is a series of questions undertaken in a single event so as to inform subsequent diagnosis and treatment of young people affected by alcohol and drug abuse problems. It is a preliminary assessment that indicates probability that a specific condition is present.

15.2 Benefits and importance of screening

- Provides an opportunity for education and early intervention.
- Alerts provider to risks for interactions with medications or other aspects of treatment.
- Offers opportunity to engage patient further.
- Has proved beneficial in reducing high risk activities for people who are not dependent.

15.3 Types of screening tools

1. **Self report:** This could be an interview or self administered questionnaires. Self reports are more accurate when people are drug free when interviewed; given written assurances of confidentiality; interviewed in a setting that encourages honest reporting; asked clearly worded, objective questions and provided memory aides (calendars, response cards). Self report tools provide a historical picture of the young person with addiction problems and it is highly sensitive for detecting potential problems or dependence.
2. **Biological markers:** For example breathalyzer testing, Blood alcohol levels, Saliva or urine testing and serum drug testing. These tools are quick to administer and provide immediate results.

15.4 Characteristics of a good screening tool

- Brief (10 or fewer questions)
- Flexible and quick administer
- Addresses alcohol and other drugs
- Indicates need for further assessment or intervention of other methods.
- Has good sensitivity (ability of the test to correctly identify those people who actually have a problem) and specificity (ability of the test to identify people who do not have problem).

15.5 Brief Screening Instruments

There are several brief screening instruments but for purposes of this guide, we shall concentrate on two instruments namely:-

a) CAGE: This consists of 4 questions (yes/no) which help detect hazardous drinking and is usually self administered. CAGE questions include:-

1. Have you ever felt you should **C**ut down on your drinking?
2. Have people **A**nnoyed you by criticizing your drinking?
3. Have you ever felt bad or **G**uilty about your drinking?
4. Have you ever taken a drink first thing in the morning (**E**ye opener) to steady your nerves or get rid of a hangover?

Your score:

Score one point for each yes answer (2).

If you scored 1, there is an 80% chance you're addicted to alcohol.

If you scored 2, there is an 89% chance you're addicted to alcohol.

If you scored 3, there is a 99% chance you're addicted to alcohol.

If you scored 4, there is a 100% chance you're addicted to alcohol.

b) The Alcohol Use Disorders Identification Test (AUDIT)

This test has ten (10) questions which helps identify problem use and dependence. It can be used with adolescents and young adults and has been validated cross culturally and translated into many languages.

NOTE:

To correctly answer some of these questions you need to know the definition of a drink. **For this test one drink is:** equivalent to:- A bottle of Beer, One glass of Wine or a Liquor Tot. *(see chapter 6.9 page 37)*.

1. How often do you have a drink containing alcohol (Score)

Never (0)

Monthly or less (1)

Two to four times a month (2)

Two to three times a week (3)

Four or more times a week (4)

2 How many drinks containing alcohol do you have on a typical day when you are drinking?

1 or 2 (0)

3 or 4 (1)

5 or 6 (2)

7 to 9 (3)

10 or more (4)

3. How often do you have six or more drinks on one occasion?

Never (0)

Less than monthly (1)

Monthly (2)

Weekly (3)

Daily or almost daily (4)

4. How often during the last year have you found that you were not able to stop drinking once you had started?

Never (0) (0)

Less than monthly (1)

Monthly (2)

Weekly (3)

Daily or almost daily (4)

5. How often during the last year have you failed to do what was normally expected from you because of drinking?

Never (0)

Less than monthly (1)

Monthly (2)

Weekly (3)

Daily or almost daily (4)

6. How often during the last year have you needed a first drink in the morning to get yourself going after a heavy drinking session?

Never (0)

Less than monthly (1)

Monthly (2)

Weekly (3)

Daily or almost daily (4)

7. How often during the last year have you had a feeling of guilt or remorse after drinking?

Never (0)

Less than monthly (1)

Monthly (2)

Weekly (3)

Daily or almost daily (4)

8. How often during the last year have you been unable to remember what happened the night before because you had been drinking?

Never (0)

Less than monthly (1)

Monthly (2)

Weekly (3)

Daily or almost daily (4)

9. Have you or someone else been injured as a result of your drinking?

No (0)

Yes, but not in the last year (2)

Yes, during the last year (4)

10. Has a relative or friend, or a doctor or other health worker been concerned about your Drinking, or suggested you cut down?

No (0)

Yes, but not in the last year (2)

Yes, during the last year (4)

Your score:

If you scored 8 - 10 or more, you are probably addicted to alcohol.

It may seem like the **AUDIT** questionnaire is an easy test to fail. If you applied this test to other aspects of your life you will almost certainly come up as being addicted to something. For example, most people watch too much television, or eat too much of their favorite food. But those are so-called **"soft addictions"**, and the AUDIT questionnaire was not designed to assess them. It is extremely reliable when it comes to assessing alcohol addiction. The AUDIT (Alcohol Use Disorders Identification Test) was developed by the World Health Organization (WHO). The test correctly classifies 95% of people into either alcoholics or non-alcoholics. It was tested on 2000 people before being published.

15.6 Overview of Brief Interventions

A brief intervention is low intensity, short-duration counselling for those who screen positive fro drug use. It uses motivational interviewing style, includes feedback and advice.

15.7 Components of Brief Intervention

a) **Feedback** is given to the individual about personal risk or impairment

b) **Responsibility** for change is placed on the patient.

c) **Advice** to change is given by the provider

d) **Menu** of alternative self help or treatment options is offered to patient.

e) **Empathetic** style is used in counselling.

f) **Self efficacy** or optimistic empowerment is engendered in the patient.

15.8 Summary

Screening and brief intervention tools help the peer counsellor to make a rapid assesment of the extent of addiction of the young person.

CHAPTER 16

Anti-Drug Abuse Advocacy

16.1 Advocacy means;

- **Working with other people** and organizations to make a difference.
- **Process of supporting** a cause of issue.
- **Speaking up**, drawing a community's attention to important issue and directing decision makers towards a solution.
- **Pleading for**, defending or recommending an idea before other people.

16.2 Purpose of Advocacy in Drug Abuse

- Helps to draw attention to the drug issue.
- To achieve change in the personal lives of the young people and the community at large.
- Direct policy and decision makers towards a drug abuse solution.
- Helps in networking with fellow youths, communities and other concerned NGO's.

16.3 Basic Elements of Advocacy in Drug Abuse

- Select advocacy objective e.g. prevention, types of drugs.
- Collect information on drug abuse.
- Identifying advocacy target audiences by age, problem, area and gender.
- Prepare your talk and other educational materials on the topic of discussion.
- Building networks with fellow youths and concerned parties.
- Making persuasive presentations.
- Look for necessary resources to conduct the advocacy campaigns.
- Evaluating advocacy efforts.

16.4 Qualities of a Good Advocate

- Have an interest in the group you are talking to.
- Influential or known in the community.
- Acceptance and respected.
- Have good leadership skills.
- Knowledgeable and committed.
- Have sound integrity
- Patient and persistent.

- Generous
- Good communicator
- Non-judgmental.

16.5 Advocacy Activities to Promote anti-drug abuse messages.

- Demonstrations
- Information Educational and Communication materials
- Media campaigns
- Public rallies
- Use of village meetings to give talks
- Seminars and workshops
- Focus group discussions
- Peer to peer influence
- Mainstreaming drug messages in HIV/AIDS e.t.c.

16.6 National Drug abuse advocacy days

- Uganda celebrates the International Day Against Drug Abuse and Illicit Trafficking on 26th June every year.
- Uganda celebrates the International Mental Health day on 10th November every year.
- World No Tobacco Day is celebrated every year on 31st of May.

16.7 Summary

Advocacy is important if we are to increase awareness and see changes about drug and alcohol problems and how they affect young people. For example one of the core objectives of the East Africa Alcohol Policy Alliance is to lobby and advocate for restrictive alcohol policies in the region.

CHAPTER 17

Evaluation Resources for Drug Prevention Programmes

17.1 Introduction

Evaluation involves more than collecting, analyzing, and providing data. It makes it possible for an individual to gather information and to use the information to learn continually about and improve your program. Developing and using an evaluation plan is an important step in strengthening community capacity and promoting community involvement. Identifying and measuring outcomes provides program participants with a clear path of the way forward and can help promote their active engagement in the program (W.W. Kellogg Foundation, 2004).

Provided below are several resources and starting points for building an evaluation plan or strengthening your current program evaluation. Each resource is summarized and then followed by either its web-based source or the link to a supporting document.

17.2 Center for Substance Abuse Prevention (CSAP) Prevention Tool

This resource provides full coverage for evaluating a prevention program. It is aimed at helping the novice evaluator as well as an experienced one. The resource has the following tools:

Prevention Platform:

A comprehensive tool for designing an outcome or process evaluation and identifying data collection strategies.

Prevention Pathways:

Technical assistance to answer questions related to evaluation, assist with planning evaluation efforts, and identify data collection instruments.

Prevention Management Reporting and Training System:

This Web site provides a single point of access to a variety of content and core services. The Prevention Management Reporting and Training System will provide all of CSAP education, data collection and training systems through one web portal.

Source: *prevention.samhsa.gov/evaluation*

17.3 Logic Model Development Guide

A popular, scientifically-tested and effective model for evaluating a program is the logic model. As a learning and management tool, the logic model provides a guide for effective program planning, implementation, and evaluation. Using evaluation and the logic model can strengthen your program by documenting your outcomes and allowing sharing knowledge about what works in your program and why it works.
Source: *W.K. Kellogg Foundation*

17.4 Prevention Plus

This very detailed handbook provides a step-by-step approach to assessing drug prevention programs at the school and community level. Program evaluation is presented according to a four-step model:

a) Goal and desired outcome identification;

b) Process assessment;

c) Outcome assessment; and

d) Impact assessment.

Source: *ERIC - Education Resources Information Center*

17.5 Identifying and Selecting Evidence-Based Interventions

Revised Guidance Document for Strategic Prevention Framework

The purpose of this guide book is to assist community planners to identify and select evidence-based prevention programs that address local needs and reduce substance abuse problems. There are 6 sections to this resource:

a) Section I sets the stage for selecting evidence-based interventions to include in a comprehensive strategic plan.

b) Section II focuses on two analytic tasks: 1) assessing local needs, resources, and readiness to act; and 2) developing a community logic model.

c) Section III details how prevention planners can apply the community logic model to determine the conceptual fit or relevance of prevention strategies that hold the greatest potential for affecting a particular substance abuse problem.

d) Section IV discusses the importance of strength of evidence to inform and guide intervention selection decisions. Presents three definitions of "evidence-based" programs.

e) Section V summarizes the process of working through three considerations that determine the best fit of interventions to include in comprehensive prevention plans.

f) Section VI discusses expectations for selecting and implementing evidence-based, community prevention programs.

Source: *Substance Abuse and Mental Health Services Administration. Click here for a PDF copy of the document.*

17.6 European Monitoring Centre for Drugs and Drug Addiction (EMCDDA)

EMCDDA provides two major resources for identifying best practices and evaluating programs.

- The Evaluation Instruments Bank (EIB). This is an online archive of freely available instruments for evaluating drug-related interventions. Details regarding copyright and/or possible use restrictions are specified for each instrument. Instruments are generally classed according to the intervention field they are designed to be used in (treatment, prevention, or harm reduction), though some instruments may be usable in more than one field. Also, there is an additional link that provides prevention evaluation support and tools for a wide range of different target groups and prevention related issues, for different target groups and with both process and outcome evaluations.
- Prevention and Evaluation Resources Kit (PERK). This resource compiles basic but evidence-based prevention principles, planning rules and evaluation tips. Additionally, it provides related documentation or references for download; it is hoped that this additional material will be particularly useful for readers who have difficulty accessing the scientific prevention literature. To illustrate the theoretical discussion, an intervention example, partly based on a real-life situation, gives a practical perspective. Finally, an additional aim of the PERK exercise is to develop a first common draft of minimum prevention principles and standards for the European Union, similar to the NIDA's 'Red Book'.

17.7 UNODC

Two resources are provided by UNODC.

a) Monitoring and Evaluating Prevention Activities with the Active Involvement of Youth and the Community

This resource contains tools to help you plan, implement, monitor and evaluate prevention activities that are effective and that involve youth at each stage of the project. Tools are provided to help monitor and evaluate prevention activities with the active involvement of youth and the community. Commenting ***"Ideally, you should think about monitoring and evaluation already while you are planning your prevention activities"***, the page provides general guidance on planning an effective prevention response to the substance abuse situation of a target group or a community.

b) Youth Substance Abuse Prevention Programmes

This is a handbook for practitioners who want to improve the monitoring and evaluation of their programmes for the prevention of substance and drug abuse among youth. It was prepared on the basis of the available literature and of the experience of the members of the Global Youth Network. The handbook discusses how to improve the monitoring and evaluation of your programme and how to go about it.

17.8 Evaluation and Assessment of School Drug Education Programmes

Another tool provided by UNODC is this resource. It defines different kinds of evaluation methods, both formal and informal, that teachers or facilitators of drug education programmes can use to assess the quality of programme implementation and its effects on student knowledge, attitudes and behaviour. It includes a checklist for evaluating skills-based drug education programs.

17.9 Evaluation of the Drug Prevention Activities

Theory and Practice

This publication was developed by the Prevention Platform of the Pompidou Group (PG) of the Council of Europe. This resource is intended to assist ***"policymakers and their advisors in the decision-making process about the allocation of scarce resources for drug prevention"***. As the authors note, it is important for policy makers to understand the limitations for evaluation of drug prevention interventions and address the ways that evaluation can be made more effective. Thus, this work goes to great lengths to educate its readership as to ways an evaluation is a cost-effective and useful tool The manual consists of two main sections: Evaluation of the Drug Prevention Activities: Theory (by Alfred Uhl) and Evaluation of the Drug Prevention Activities: Practice (by Richard Ives).

CHAPTER 18

International and National Legislations

Uganda has two categories of legislations controlling the narcotic drugs. These are; United Nations Conventions as International laws and National Drug Policy and Authority Act, 2000 as our National law.

18.1 UN Conventions

i. United Nations 1961 Single Convention on Narcotic drugs as amended 1972. 183 States are parties to this convention.
ii. UN Convention on Psychotropic Substances and Precursors Chemicals (1971). 179 States are parties to this convention.
iii. UN Convention Against Illicit Trafficking in Narcotic Drugs and Psychotropic Substances – 198 Protocol.
iv. UN Convention Against Organized Transitional Crime 2000.

18.2 Agencies implementing and enforcing the UN laws

i. United Nations Office on Drugs and Crime (UNODC)
ii. Interpol
iii. International Narcotics Control Board (INCB) Vienna
iv. World Health Organization
v. Governments of partner States

18.3 National Law

The national law is National Drug Policy and Authority Act 2000 which does not provide for drug illicit trafficking. A new Bill (The Narcotic and Psychotropic Substances Bill, 2007) has been drafted and is before parliament for discussion.

18.4 Role of police and Community

- Detect and investigate drug crimes
- Arrest and prosecute offenders
- Identify drug addicts and refer then to rehabilitation/treatment centers.
- Sensitize the public on dangers of drug dealing and abuse.
- Report to international agencies the Narcotic drug situation in the country.
- Report to the government the drug situation and draw up strategic plans for drug demand and supply reduction programmes.
- The community works in partnership with police to fight crimes of all kinds including drug crimes.

18.5 New Developments at Policy Level in Uganda

a) National Drug Control Master Plan:

This is a document prepared by stakeholders and adopted by government detailing out all national concerns in drug abuse and laying out strategies for control. Its overall objectives are; to establish a national coordinating body on drug control, to advocate for enactment of comprehensive illicit drug control legislation and strengthening national and international coordination and cooperation in drug control.

b) The Narcotic and Psychotropic Substances Bill (2007):

This Bill comes at a time when Uganda has increasingly become a transit route for drug traffickers and consumers of drugs because of the weak drug and immigration controls/laws that have been exploited by criminal elements. The Bill is aimed at amending the former Narcotics Act and adopt measures to criminalize drug related offenses under domestic law. The Bill is also intended to make provision for a mechanism to generate resources for law enforcement agencies through the confiscation of money and properties obtained from illicit trading of drugs. The Bill provides a life sentence and a fine for persons found guilty of trafficking drugs. The Bill only permits persons with a license under the National Drug Policy and Authority Act such as dentists, veterinary surgeons or registered pharmacists to use narcotic drugs. If passed into law, the Bill will also put in place mechanism for the rehabilitation of drug addicts.

APPENDIX

Useful Websites for further studies:

1. www.uydel.org
2. www.mentorfoundation.org
3. www.prevention-smart.org
4. www.drugfree.org
5. www.mentorfoundation.org/evaluation.php?nav=4-194
6. www.drugabuse.gov
7. www.youthnet.org
8. www.iogt.or.tz
9. www.wfad08.org
10. www.drugfx.org
11. www.add-resources.org

References

1. http://www.plusnews.org/Report.aspx?ReportId=73465
2. A Drug Counselor's Handbook, published by United Nations International Control Program.
3. United Nations Office on Drugs and Crime; Drugs education Newsletter vol. 01. No.01 June 2003.
4. United Nations Office on Drugs and Crime; Treatnet 11 Training package Volume A, 2010.
5. Rogers Kasirye; Drug and substance abuse, Education of Children, Adolescents and communities in Uganda. (Unpublished).
6. Joane McDonald, Ann Roche etal (2003: Peer Education, from Evidence to Practice: An Alcohol and other Drugs Primer. National Centre for Education and Training on Addiction.
7. UNODC brochures on Drug and Substance Abuse.
8. UYDEL (200): Choices for Healthy and safe Life Peer to Peer school learning Activities.
9. UYDEL (2003): Assessment of the extent; knowledge and Attitudes of drug abuse among secondary school students in Kampala and Wakiso District.

10. http://www.addictionsandrecovery.org/relapse-prevention.htm. Accessed on 4th May 2011.
11. www.AddictionsAndRecovery.org

Glossary of words

1. **Abstinence:** The condition of not taking or using a substance. When a drug abuser usually after treatment, stops taking drugs and remains drug free, that person is abstinent.
2. **Addiction:** Is the physical and psychological habit or feeling of need, which comes from repeated use of a drug.
3. **Alcoholism:** Condition in which there is chronic drinking of Alcohol.
4. **Cannabis/Marijuana:** An addictive drug made from leaves or flowers of an Indian hemp plant.
5. **Cocaine:** It is a white bitter substance originally obtained from the cocoa leaves, a South American shrub and later synthesized.
6. **Client Co-independence:** A relationship between two or more people who rely on each other to meet and provide for their needs, particularly unhealthy ones.
7. **Confidentiality:** Preservation of private, personal information concerning the client which is disclosed in a professional relationship. This is a client basic right.
8. **Depressant:** A drug or medication that lowers the nervous and physical activity of the user. Depressants can cause weariness, sadness and sleepiness.
9. **Detoxification:** The treatment of withdrawal symptoms.
10. **Drug Dependency:** Is an emotional, physical and a person's feeling of compulsion to take the drug on a regular basis, to feel its effects and to avoid the discomfort of its absence.
11. **Drug:** Any natural or synthetic substance which when taken into a living organism affects and alters its body functioning.
12. **Habituation:** Condition of being psychologically addicted to drugs.
13. **Hallucination:** Perception without external stimuli for instance seeing or hearing in absence of external objects or sound.
14. **Hangover:** The after effects of taking a drug of dependence especially alcohol such as anxiety, headache, dizziness, stomach upset, thirst, feeling or depression etc.

15. **Inhalation:** Method of introducing drugs in the body by way of sniffing through the nose or sucking through the mouth into the body.
16. **Insomnia:** State of sleeplessness of unknown origin.
17. **Intoxication:** Is a temporary state caused by use of psychoactive substances.
18. **Misuse:** Refers to a non medical or inappropriate use of psychoactive drugs.
19. **Peer pressure:** Is the influence of one's friends or equal experts in him/her and hence affects his/her behaviour positively or negatively.
20 **Psychotropic:** Having an altering effect on the mind e.g. LSD (Lysergic acid and diethlamide)
21. **Rehabilitation:** Process of recovering those capacities that have been administered due to illness or injury. The person becomes him/herself again and re-integrates into the community.
22. **Relapse:** Is when a recovering drug or alcohol abuser starts to use drugs again after a period of abstinence.
23. **Syndrome:** A set of characteristics that a client may have that reveals a certain condition or disease.
24. **Tolerance:** The repeated use of a drug leads to changes in the brain and nervous system so that the user needs more of the drug in order to get the expected effect.
25. **Withdrawal:** When the drug is not taken, then the drug addict suffers from physical and mental discomforts called withdrawal symptoms.

Marijuana/Cannabis

UYDEL

Partners in Prevention

Mentor
Prevention • Opportunity • Protection
www.mentorfoundation.org

Prepared by:

Uganda Youth Development Link

Sir Apollo Kaggwa Road, Bifro House (Opposite MBI).
P. O. Box 12659, Kampala, Uganda.
Phone: +256 (0)414 - 530 353
E-mail: uydel@uydel.org
Website: www.uydel.org

Partners in Prevention Project for Eastern Africa