Republic of Kenya

Office of the President

National Alcohol Policy

June 2011

Republic of Kenya

Office of the President

National Alcohol Policy

June 2011

Published by: Office of the President
Department of Internal Security and Provincial Administration
National Campaign Against Drug Abuse Authority
NSSF Building, Block 'A' Eastern Wing
Bishops Road
P.O. Box 10774, GPO 00100
Nairobi, Kenya
Email: nacada@mail2world.com
Website : www.nacada.go.ke

Contents page

List of Tables and Figures

Foreword

The National Alcohol Policy contains critical policies which provide the overall direction to the Kenya Government as well as other stakeholders involved in the alcohol industry regarding the production, distribution, consumption and regulation of alcohol. It also details the intentions of the Kenya Government towards alcohol and the conditions and problems associated with its misuse. The National Alcohol Policy recognizes that alcohol-related problems arise out of a complex relationship between the individual consumer, alcohol, and the broader cultural, political, social, economic and physical environment.

The purpose of this policy is to provide a foundation on which to base initiatives with respect to alcohol policy interventions and to facilitate the involvement of the public health sector and the alcohol industry in alcohol policy issues. This Policy was prepared through multi-sectoral consultations involving a wide range of government officials from relevant government ministries, industry and other private sector institutions and stakeholders involved directly or indirectly in all aspects of the alcohol field. It is intended to provide a framework through which interventions that address all aspects of the misuse of alcohol in the country can be rationalized and coordinated.

A common theme that runs in all chapters is emphasis on the need to implement alcohol-related harm reduction interventions that are evidence-based. Five categories of these interventions standout clearly: those that focus on *restricting availability of and accessibility* to alcohol especially to the youth, those that focus on particular *risk behaviours* (such as drink-driving and binge drinking), those that focus on particular *risk groups* (such as the young people), those that focus on particular *alcohol drinking contexts* (such as bars, clubs and other settings in which alcohol drinking takes place), and those that focus on *alcohol product safety* (e.g. illicit alcohol).

The goal of the National Alcohol Policy is to contribute to the improvement of the overall health and socio-economic well-being of the Kenyan society through a significant reduction of the negative consequences associated with the abuse of alcohol. The policy also proposes the establishment of the necessary institutional and implementation framework to facilitate effective coordination of the relevant government ministries, industry, the private sector and civil society in addressing the problems resulting from abuse of alcohol in Kenya.

The government is committed to effectively disseminating the policy document to all stakeholders in order to obtain their commitment to implement the policy intentions and above all chart a common path with all key stakeholders including the alcohol industry for monitoring and evaluating the impact of the alcohol policy on society in general and among specific target groups in particular.

The Government is committed to creating an enabling environment to make it possible for all stakeholders with a role to play in alcohol policy to channel resources towards reducing alcohol misuse and the associated personal and societal negative consequences. It is anticipated that the proposed polices whose formulation was informed by the magnitude of the alcohol abuse related problem and evidence based international best practices in reducing alcohol-related harm will improve the quality of life of Kenyans.

Hon. Prof. George Saitoti, EGH, MP
Minister of State for Provincial Administration and Internal Security

Acknowledgments

Many institutions and individuals were involved in formulating the National Alcohol Policy. The Permanent Secretary in-charge of Internal Security and Provincial Administration (OOP), the Chairman NACADAA Management Board (Dr. Frank Njenga) and the National Coordinator of National Campaign Against Drugs Abuse (NACADAA) – Ms Jennifer Kimani, wish to thank all those persons who played important roles at various stages of formulating the National Alcohol Policy. In particular, the drafting team led by Dr. Sobbie Mulindi and Mr. Kiragu Wachira are thanked for having completed the task within a very short time. The institutions listed below are acknowledged for having participated in the various workshops, meetings and activities undertaken towards the formulation of the National Alcohol Policy:

List of Institutions at the Standards Enforcement Workshop at Green Hills Hotel, Nyeri
Kenya Bureau of Standards, Office of the President, International Trade Advisory Services, PARAGON, Judiciary, Provincial Administration and Internal Security, NACADAA, Kenya Revenue Authority, Ministry of Health, Pharmacy and Poison Board, Teachers Service Commission, SCAD, NYC, Going Home Dotcom, Ministry of Youth Affairs, Kenya Scouts Association, Ministry of Education, Kenya Prisons Service, Mathari Hospital (MOH), Asumbi Teachers College, Office of the Solicitor General, MASAA and ICPA KENYA UEB.

List of Institutions at the Nakuru Workshop
PERAK/ENTER., PR MASTERS, Judiciary, Provincial Administration and Internal Security, GCAP/EFW, EMPIRIS, Attorney-General's Chambers, PARAGON, GGHHT, University of Nairobi, Kenyatta National Hospital, NABAK, KWAL, PERAK/KAHC, Kenya Scouts Association, Division of Environmental Health (Ministry of Health), KUPPET and MOTI, and NACADAA.

List of Institutions at the Alcohol Policy Stakeholders' Meeting at Serena Hotel, Nairobi
Australian Government, International Centre for Alcohol Policies, Kenya Police Department, Department of Defence, East African Breweries Limited, Diageo Parallel Media, Attorney General's Office, Going Home Dotcom, Immigration Dept, Emerging Leadership, Kenya Broadcasting Corporation, SAPTA Centre, NCBDA, London Distillers Ltd, Office of the Vice President & Ministry of Home Affairs, CLMC, Kenya Scouts Association, Waumini Radio, B. Dowly, Standard Group, Kenya Times, Business Daily, Biblia Husema, Citizen TV, KASS FM, Citizen Radio, Times Newspaper, Baffin Ent., ECBO, Njugi BG Advocates, CHAN, Ess-Green, National Youth Service, Anglican Church of Kenya, Keroche Industries, CFYD, Ministry of Trade and Industry, Upper Hill High School, Ministry of Agriculture, Lobbying Associates, Ministry of Youth Affairs, International Trade Law Advisory Services, Kenya Revenue Authority, Ministry of Health, National AIDS Control Council, Agro-Chemical & Food Company Ltd, People Daily, Probation & Aftercare Department, Ministry of Education, and NACADAA.

List of Institutions at Alcohol Policy Media Consultative Group Meeting - Serena Hotel, Nairobi
Kenya Wines Agencies Ltd (KWAL), London Distillers Kenya Limited, APA, East Africa Breweries Ltd (EABL), Advertising Standards Committee / Media Owners Association, University of Limpopo (South Africa), Kenya Broadcasting Corporation, Anglican Church of Kenya, NACADAA Advisory Board, Marketing Society of Kenya, Provincial Administration & Internal Security (Office of the President), University of Nairobi, Kenyatta National Hospital, Lobbying Associates and Emerging Young Leaders.

The workshops, meetings and other process activities that facilitated the development of this National Alcohol Policy were supported by the Governance, Justice, Law and Order Sector (GJLOS) reform programme, NACADAA, UNODC and the Private sector. These institutions are thanked most sincerely and others that provided material and financial support. Mr. Wilson Liambila is specifically thanked for generously reviewing, reorganizing and editing the draft policy document.

Executive Summary

Alcohol misuse in Kenya poses a major health, social, economic and political challenge that requires urgent attention by its citizens. A central concern for the government is the development of a sound policy that can be implemented in a collaborative and coordinated manner. The World Health Organization recognizes that alcohol abuse has negative impact on the development of any country.

The National Alcohol Policy, which has been developed through a process of consultations with all stakeholders, sets out general principles regarding the use and abuse of alcohol in society. It addresses individual and social responsibilities with respect to alcohol and its consumption. The goal of this policy is to contribute to the improvement of the overall health and socio-economic well-being of the Kenyan society through a significant reduction of the negative consequences associated with the misuse of alcohol at both individual and societal level.

The main objective of the National Alcohol Policy is to minimize the incidences and prevalence of alcohol-related harm by addressing the underlying demand, supply and environmental factors. The specific objectives of this policy are to:

a) Regulate access to and availability of alcohol especially to the underage;

b) Reduce the risk of alcohol-related problems that may occur in a variety of settings such as the home, workplace, community or drinking environment;

c) Reduce both the breadth and depth of alcohol-related harm such as fatalities, accidents, violence, child abuse and neglect, and family crises;

d) Generate greater awareness and provide information, education and communication in support of public health policies that address the prevention of harm associated with the misuse of alcohol;

e) Appropriately regulate the advertising and promotion of alcoholic beverages;

f) Provide greater protection for children, young people and those who choose not to drink alcohol; and

g) Provide accessible and effective intervention, treatment and rehabilitation services for people with hazardous and harmful alcohol consumption problems and those with alcohol dependence.

This policy's components for reducing alcohol-related harm and for regulating the availability, accessibility and consumption of alcohol are: strengthening legislation to control accessibility to and availability of alcohol, measures to curb drink driving or driving while under the influence of alcohol, initiatives to make drinking environment safer, appropriate regulation of the advertisement and promotion of alcohol, information education and communication, minimizing alcohol related health impacts and care, guaranteeing quality and standards for alcohol products, curbing alcohol access and use among adolescents and the youth, addressing illicit alcohol (moonshine), controlling binge drinking and drunkenness, collaboration and partnerships and resources to support policy implementation.

For effective implementation and operationalization of the policy, an all-inclusive management and coordination structure is proposed. In addition, key issues regarding monitoring and evaluation as well as operational research activities are outlined.

Abbreviations and Acronyms

AG	Attorney General
AIDS	Acquired Immunodeficiency Syndrome
ANU	Anti-Narcotics Unit (Kenya Police)
ARV	Antiretroviral medication for HIV/AIDS
CBOs	Community-based Organizations
CID	Criminal Investigation Department
HIV	Human Immunodeficiency Virus
ICAP	International Centre for Alcohol Policies
IDUs	Injecting Drug Users
IEC	Information, Education and Communication
KBS	Kenya Bureau of Standards
KDHS	Kenya Demographic Health Survey
KHRC	Kenya Human Rights Commission
KIE	Kenya Institute of Education
KNBS	Kenya National Bureau of Statistics
KNUT	Kenya National Union of Teachers
KWS	Kenya Wildlife Services
M& E	Monitoring and Evaluation
MOE	Ministry of Education
MOH	Ministry of Health
MOHA	Ministry of Home Affairs
MOYA	Ministry of Youth Affairs
NACADAA	National Campaign Against Drug Abuse Authority
NDCS	National Drug Control and Prevention Strategy
NDP	National Drug Policy
NGOs	Non-Governmental Organizations
NHIF	National Hospital Insurance Fund
NSIS	National Security Intelligence Service
OOP	Office of the President
OVP	Office of Vice President
PPB	Pharmacy and Poisons Board
SIDA	Swedish International Development Agency
TSC	Teachers' Service Commission
UNAIDS	United Nations Programme on HIV/AIDS
UNODC	United Nations Office on Drugs and Crime
WHO	World Health Organization

Chapter 1 – Preamble

The National Alcohol Policy is intended to provide a framework through which interventions that address all aspects of the use and abuse of alcohol in the country in terms of production distribution, consumption and regulation can be addressed in a systematic and coordinated fashion. This document recognizes the fact that alcohol is harmful to some people, while others find it enjoyable when used in moderation. No attempt is made to try to ridicule either group and emphasis is laid on the importance of choice, while safeguarding the interests of the vulnerable members of society. The preparation of the National Alcohol Policy involved an extensive process of consultation among a wide range of stakeholders including the alcohol industry.

This Policy identifies and promotes the complementary interests of the public health and scientific communities, the alcoholic beverage industry, government, the non-governmental as well as the private sectors. The policy elaborates on the relevant provisions of the National Strategy on Prevention, Control and Mitigation of Drug and Substance Abuse (2008 – 2013) whose vision is to secure a healthy and prosperous Kenyan society free from drug and substance abuse.

The purpose of the National Alcohol Policy is to serve the interests of public health through its impact on drinking patterns, the drinking environment and the health services available to treat the consequences of alcohol abuse. Public health concepts provide an important vehicle to manage the health and safety of populations in relation to the use and misuse of beverage alcohol.

The Kenya Government has for a long time recognized the negative impact of alcohol abuse on society, for instance, as a result of increased accidents due to drunken driving and a great impact on the insurance industry.

The Government of Kenya established the National Agency for the Campaign Against Drug Abuse (NACADA) in 2001 to initiate public education campaigns against drug abuse especially among the youth in schools and other learning institutions. In October 2006, NACADA initiated a key stakeholders' workshop and started the process of developing a comprehensive National Strategy on Drug and Substance Abuse. The strategy acknowledged the need to develop a policy to regulate alcoholic beverages. NACADA subsequently organized a stakeholders' consultative forum on the development of the National Alcohol Policy Framework on 13th March 2007. The current policy document is a product of this effort.

Some of the challenges that are likely to undermine the implementation of the policies associated with production, distribution, consumption and regulation of alcoholic beverages will be addressed through measures outlined in the National Strategy on Prevention, Control and Mitigation of Drug and Substance Abuse (2008-2013). Implementation of the various policy measures requires a collaborative, multi-sectoral approach involving the government and non-governmental stakeholders including those involved in the production, distribution and retailing of beverage alcohol. The formulation of the National Alcohol Policy also drew experience from international specialized institutions, some of which are outlined hereunder:

World Health Organisation (WHO) - has been committed to reducing the burden of alcohol-related problems and to strengthening global action on the prevention of alcohol-related harm

since the 1970s. In a book titled *Alcohol Policy and the Public Good* published in 1994, the broader term 'alcohol policy' rather than 'alcohol control policy' was introduced with a more wide-ranging meaning befitting a public health response to alcohol-related harm. A more recent book titled *Alcohol: No Ordinary Commodity* was published in 2003, and takes into account new and emerging evidence and considers 21st century implications such as globalization. Another WHO document titled *Health 21 – Health for All in the 21st Century* (WHO, 1999) includes alcohol as WHO Target No. 12 which states that "by the year 2015, the adverse health effects from the consumption of addictive substances such as tobacco, alcohol and psychoactive drugs should have been significantly reduced in all member states." It also states that "in all countries, per capita alcohol consumption should not increase or exceed 6 litres per annum, and should be close to zero in under 15-year-olds."

European Alcohol Action Plan (EAAP) - designed during the 1992-93 period to meet Target 17 of the WHO Health for All by the Year 2000, which stated that "by the year 2000, the health-damaging consumption of dependence producing substances such as alcohol, tobacco and psychoactive drugs should have been significantly reduced in all member states" (NHS, March 2005). For alcohol, the document stated that well-balanced policies should be implemented to reduce consumption by 25%, with particular attention to reducing harmful use. The Action Plan considered health and social problems and economic and cultural issues, in order to find a balance to reduce alcohol-related harm.

The *Dublin Principles of Co-operation* among the alcohol industry, governments, scientific researchers, and the public health community, adopted in 1997, were designed to provide guidance for mutually acceptable means of co-operation, based on ethical principles, among all those concerned with alcohol consumption and its effects. The Principles seek to identify the appropriate roles of the major actors in preventing misuse and minimizing the health, social, and safety risks to the individual drinker, to others, and to society as a whole.

The *Geneva Partnership on Alcohol* was formulated in 1999 to promote the complementary interests of the public health and scientific communities, the private sector, governments and non-government organisations. The document identifies strategies to reduce alcohol-related harm in a number of areas: alcohol and society; public policies; access and availability; advertising and promotion; information and education; health care; responsible service; ensuring product quality and integrity and dissemination of results.

Chapter 2 – Guiding Principles

The following principles guided the development of the National Alcohol Policy:

a) The excessive use of alcoholic drinks over time is associated with a range of health and social problems, including liver and heart disease, road traffic fatalities, industrial and domestic accidents, suicides, sports and leisure injuries, violence and reduced productivity in the workplace Hence measures promoting the responsible use of alcohol are a necessary part of any effective population health strategy (Edwards et al., 1995; West et al., 1995).

b) It is acknowledged that alcohol use can impair workplace and traffic safety, increase the risk of certain cancers and harm the development of the fetus (Jernigan, 2001).

c) Personal choice is not the only factor influencing alcohol-related problems; the consumption of alcoholic beverages is related to a range of social, cultural, economic and environmental determinants (Edwards et al, 1995; Jernigan, 2001; *National Forum on Health*, 1996). Effective measures to address social, cultural, economical and environmental determinants should be developed Policies, programs and other initiatives should strive to build self-esteem; promote healthy living; strengthen the ability of individuals, families and communities to care for one another; and help prevent and reduce alcohol-related harm.

d) Communities with high rates of poverty and unemployment, and limited access to health, recreational and other services are particularly vulnerable to alcohol-related social problems (Mosher et al, 1994). Persons responsible for the development and implementation of alcohol policies need to recognize and address these broader issues.

e) Alcohol is a drug with attendant physiological effects. Excess consumption over time increases the risk of liver and heart disease, several forms of cancer, damage to the central and peripheral nervous systems, and other chronic health problems (Ross, 1995).

f) Alcohol has potential of being an addictive substance. Repeated high volume consumption leads to reduced sensitivity to the effects (tolerance). Removal is accompanied by recognized withdrawal syndrome, and a proportion of all individuals who consume alcohol become dependent. Alcohol abuse is a major factor in thousands of preventable injuries and premature deaths due to crashes, falls, suicides, fires, drowning and homicides.

g) Comprehensive access and controls on alcohol availability, complemented by targeted harm reduction strategies, have been shown to be effective in minimizing alcohol related harm to individuals and society.

h) Both the government and society at large have a critical role to play in reducing alcohol related harm and in preventing alcohol abuse and misuse including the associated negative consequences. The Government has a duty to help protect society against the adverse consequences of alcohol misuse provided that it does this on the basis of the best available evidence and uses policy measures that are based, as far as possible, on broad consensus within society including all stakeholders.

i) All persons under the age of eighteen should be protected from the adverse influence of alcohol products as well as deceptive advertisements, and they should be prevented and protected from accessing, consuming or associating themselves with any alcohol consumption as a lifestyle.

j) Alcohol abuse and alcoholism has negative impact on family and society. The Government and all stakeholders have a duty to inform and educate society on all matters regarding alcohol use, abuse and its health and socio-economic impact.

k) Overall, the following key principles should underpin the National Alcohol Policy:
   (i) Pursuing a multi-sectoral approach and using participatory ways to develop strategic partnerships to mainstream alcohol- harm minimization activities in all key sectors;
   (ii) Targeting vulnerable groups and focusing on children and youth.

l) Using evidence-based interventions which include:
   (i) a balanced approach comprising legislation and law enforcement and personal responsibility; and
   (ii) a strong emphasis on alcohol related education.

m) A national level legislative and regulatory framework is essential to the promotion of effective measures to curtail alcohol-related problems.

n) No single alcohol policy can operate independently or in isolation from other policy measures. Complementary system strategies that seek to address alcoholic drink consumption, context and environment are more likely to be effective than single strategies.

Chapter 3 – Situation Analysis

3.1 Background

In many countries, the production and sale of alcoholic beverages generates profits for farmers, manufacturers, advertisers and investors. The Government also taxes alcohol manufacturers who are registered for the purpose. However, only 45% of the alcohol consumed in Kenya is taxed, the rest falling outside of the formal tax bracket. This Policy seeks to harmonise the regulation of the two main sources, not only to increase the Government tax revenue, but also to ensure the maintenance of standards of health, safety and hygiene. The alcohol industry provides employment for people in bars and restaurants, brings in foreign currency for exported beverages, and generates tax revenues for the government. Alcoholic beverages are, by any reckoning, an important economically embedded commodity. However, the benefits connected with the production, sale and use of this commodity must be balanced against the individual and societal costs associated with the misuse of beverage alcohol.

3.1.1 Alcohol and Society

Traditional society
Alcohol is consumed in almost all Kenyan communities. Previously, consumption was limited to ceremonial situations and rites of passage. Traditional beer brews played an important role in social cultural events. Alcohol was consumed by tribal chiefs and council of elders in celebration of success in hunting or harvesting, during dowry payment and wedding, during birth ceremonies, victory over an enemy, during circumcision and other socially important occasions. Consumption was highly regulated and limited to only certain age groups. Alcohol was primarily consumed by men but was available to the women in special situations or circumstances.

Colonization era
During the period of colonization from the early 19th century to independence in 1963 the use of alcohol increased tremendously. This has been partly attributed to migrant labour, urbanization and dislocation of communities. Drinking was perceived by colonial masters as a source of misbehaviour and debauchery among the indigenous inhabitants of the country.

From the1930s up to the late 50s, there were rapid socio-cultural mutations as a result of displacement and erosion of African cultural values that led to substantial changes in the drinking patterns. The colonial period caused serious psychological stress and frustrations among the indigenous communities leading to high alcohol consumption. The colonialists perceived alcohol consumption by Africans as evil, sinful and criminal. This perceived negative consequence of alcohol abuse was used by colonial masters to introduce the Traditional Liquor Act to regulate the production and commercialization of “illicit” traditional brew.

The beer industry in Kenya dates back to 1922 when two brothers from England, George and Charles Hurst, started brewing beer in Kenya. The two formally incorporated their business as a private company under the name of Kenya Breweries Limited. In 1929, the first malted barley beer was brewed and the first batch delivered to New Stanley Hotel in Nairobi where it was opened with mixed reaction. In 1930, the first lager beer was brewed and released into

the market. Bottled beer consumption was exclusive for white colonialists and settlers until 1947 when Africans were allowed to drink formal sector beer.

Post-independence era
The attainment of independence for Kenya in 1963 brought about rapid industrialization coupled with socio-cultural mutations. This significantly changed the drinking patterns of the local populations in the urban areas. Drinking in the rural areas became less of a social–cultural activity and fell outside its customary role and functions. Rapid urbanization led to overcrowding, poor housing, and emergence of informal settlements (slums) which contributed to increased intake of "illicit" traditional brews.

3.1.2 Alcoholic Beverages in Kenya

Beer - Among various types of beer, lager beer is the most commonly produced and consumed though other types of beers are also available in the market. Kenya leads with beer production of 2.8 million hectoliters (hl) for the year 2003, Tanzania 2.1million hectoliters and Uganda 1.3 million hectoliters.

Spirits - Various types of spirits are sold in the market and are regulated by the Kenya Wine Agencies Limited (KWAL) and the Kenya Bureau of Standards.

Wines - A variety of wines are consumed in Kenya mainly from South Africa, France, Italy, Spain, Germany, Austria, Chile and America. There is also local production of wine mainly from the Naivasha area.

Chang'aa - *Chang'aa* is a distilled beverage consumed in much of the Kenya communities. *Chang'aa* can be made from a variety of grains, malted millet and malted maize being the most common. Its alcoholic content ranges from 20 to 50%. This illegal liquor is produced in clandestine distilleries (both in rural and urban areas) and is consumed by people who cannot afford beer or those who want to experience the effect of alcohol more quickly and at a lesser cost.

Busaa - is a traditional beer made from finger millet malt and is consumed in many parts of the country though rampant in the Western region. Palm wine *(Mnazi)* is consumed especially along the coastal region.

Muratina **-** is an alcoholic drink made from sugarcane and sun-dried *Muratina* fruit. The fruit is added to a small amount of sugar-cane juice and incubated in a warm place. The fruit is removed from the juice after 24 hours and sun-dried. The fruit is then added to a barrel of sugar-cane juice which is allowed to ferment between one and four days. The final product has a sour alcoholic taste.

Banana – Banana beer is made from ripe bananas, mixed with cereal flour (often sorghum flour) and fermented to an orange, alcoholic beverage. It is sweet and slightly hazy with a shelf life of several days under correct storage conditions. *Urwaga* banana beer is made from bananas and sorghum or millet.

3.1.3 Heterogeneity of drinking patterns

Today, although alcoholic beverages are consumed widely in Kenya, certain socio-economic, cultural, and behavioral factors as well as ethnic and gender differences are among key determinants of drinking patterns. Studies indicate that illicit brew is quite common among the youth, adults, working class and the unemployed in urban areas.

A NACADAA Rapid Situation Assessment of Drugs and Substance Abuse in Kenya – 2006/2007 indicated that: -

- 9% of all young people aged 15 – 24 years are currently using alcohol
- Male youth are more likely to be current users compared to females (12% and 6% respectively)
- The median age of first use of alcohol is 9 years
- There is no difference in the rate of usage of all alcohols between rural and urban settings (39% and 40%)
- 27% of children aged 10 – 14 years, who have ever consumed alcohol have friends who take alcohol compared with only 5% of those whose friends did not take alcohol.

3.1.4 Current legislation on alcohol in Kenya and review of legal framework

Kenya has many Acts of Parliament on alcohol or related substances. These laws are found in over 15 Acts of Parliament which has made it very difficult to effectively implement alcohol policies and related legislation. A major constraint with these Acts is that they do not directly concern themselves with the enforcement or regulation of alcohol policy. For instance, Cap 119 of the Industrial Alcohol (Possession) Act limits itself to possession of industrial alcohol. Existence of many laws has also contributed to having loopholes to address alcohol issues as some of the statutes either overlap or are in conflict with each other. It is recommended that a comprehensive Act that deals with both industrial and non-industrial alcohol should be enacted in place thereof. This is because a single body enforcing alcohol policy would be more consistent and would develop an all-encompassing policy.

Therefore, the government shall review all alcohol related laws to harmonize them and, in addition, bring them in line with this policy. This shall entail making the necessary amendments to the statutes, repealing where necessary and enacting new legislation to cover the areas addressed in this policy.

Currently, some of the alcohol related issues are regulated through various Acts of Parliament. These include, among others:

i) The Compounding of Potable Spirits Act (Cap 123)

ii) The Industrial Alcohol (Possession) Act (Cap 119)

iii) Methylated Spirits Act (Cap 129)

iv) Alcoholic Drinks Control Act (No 4 of 2010)

v) Traditional Liquor Act (Cap 122)

vi) The Use of Poisonous Substances Act (Cap 245)

vii) The Pharmacy and Poisons Act (Cap 244)

viii) The Food Drugs and Chemical Substances Act (Cap 254)

ix) The Standards Act (Cap496)

x) The Chief's Act (Cap 128)

xi) The Public Health Act (Cap 242)

xii) The Trade Descriptions Act (Cap 505)

xiii) Weights and Measures Act (Cap 513)

xiv) The Narcotic Drugs (and Psychotropic Substances) Act (No 4 of 1994).

3.2 Problem Analysis

3.2.1 Alcohol Problem in the World

The World Health Organization estimates that there are 2 billion people worldwide who consume alcoholic beverages and 76.3 million are diagnosed with alcohol-related disorders. Consumption of alcohol has existed in all societies since time immemorial. Alcohol has been used in cultural and traditional societies despite its serious health and socioeconomic implications.

The relationship between alcohol abuse and public health has been studied extensively in many countries and continues to be of great interests to government, public health professionals and the public at large. Major negative consequences of alcohol abuse in the society include increased incidence of HIV/AIDS, avoidable industrial and road traffic accidents, loss of productivity at the workplace, truancy from school, and criminal or violence behaviour.

Alcohol abuse has been shown to be correlated with levels of interpersonal violence, crime and murder. Serious alcohol related health issues include mental illness, liver and kidney diseases, alcohol induced diabetes, stomach ulcers, alcohol related traumatic disorders as well as emotional and behavioral problems in children and adults. There are numerous alcohol related social problems that include family disintegration, increased domestic gender violence, separation and divorce, child abuse and neglect, child molestation and defilement, child prostitution, sexual exploitation of women and children, rape and increased insecurity within communities. Other alcohol-related problems are socio-economic in nature and they include underage drinking, low productivity, idleness, absenteeism from work and disability adjusted life years lost.

The World Health Organization recognizes the existence of a wide range of alcohol policies and notes that ***"these policies are enforced and combined differently in different countries to meet the needs of a particular country".*** The goal of a comprehensive, effective and sustainable alcohol policy can only be attained by ensuring the active commitment of all relevant stakeholders in reaching the goal articulated in the World Health Assembly 2005 resolution on reducing the negative and social consequences of harmful use of alcohol.

3.2.2 Assessment of current situation

Kenya has a flourishing beer industry producing high quality beer recognized internationally. This has been possible due to factors such as good climate for agro-production, availability of barley, affordable labour, local market (beer per capital consumption at 14 litres), access to the regional markets like COMESA and the East African Community, and sound government policies of liberalization.

Kenya's food and beverage processing industry comprises more than 1,232 businesses. It is composed of the following key production sectors: **beer brewing,** dairy and meat products,

bakery goods, grain milling, edible fats and oils, beverages, fruits and vegetables processing, fish processing, **wines and spirits.** Kenya leads with beer production at 2.8 million hectoliters (hl) for the year 2003, Tanzania 2.1 million hl and Uganda 1.3 million hl. It is important to note that besides being a market leader in sub sector, Kenya has extended beer production operations to each of the EAC Member countries.
EABL is currently one of the highest corporate taxpayers with annual turnover of Kshs. 28.9 billion and employs more than 1,600 people across the region. East African Breweries Limited (EABL) currently enjoys trade monopoly in formal sector beer production and sales.

Currently, branded beer accounts for 40% of alcohol market though it faces stiff competition from cheap spirits and illicit / traditional brews. Among key brands of beer available in the Kenyan market are Tusker Lager, Pilsner Lager, Tusker Export, Tusker Malt, Pilsner Ice, Pilsner Ice Light, Allsops, White Cap, Citizen and Guinness Stout. In 1997-1998, the Economic and Social Research Council and British in East Africa sponsored a survey which examined the informal sector of alcohol in Kenya. Among the drinking males, the estimated annual consumption is 14.6 litres of absolute alcohol.

3.2.3 Epidemiological profiles, morbidity, health & social problems

Epidemiological profiles
Acuda (1982/1983/1985), Badia (1985), Onyango (1987), and Obondo (2002) studied differences in patterns of consumption and provided epidemiological profiles of certain communities. Subsequent studies have identified drinking styles and patterns. The economic boom of the 1970s and 1980s of coffee exports triggered an upsurge in alcohol drinking and proliferation of illicit brews like "*Chebukube*".

In Kenya, binge drinking is common at the end of the week especially on Fridays (commonly known as "Members Day"), end of the month when most employees earn their wages or salaries, public holidays, graduation ceremonies and birthday parties, the Christmas period and during national general elections. This correlates well with observed interpersonal violence, coercive sex, road traffic accidents, and criminal activity at these particular times.

Morbidity, health and social problems from alcohol abuse
Alcohol is one of the most commonly abused substances in Kenya. According to a study done by KEMRI, 70% of Kenyan families abuse alcohol in one way or the other. A baseline survey on alcohol and drug abuse done by NACADA and whose results were released in 2004 confirmed that alcohol abuse is widespread, and affects both the young and old. Males were found to be more likely than females to abuse alcohol.

Of the 188 patients evaluated after motor vehicle crashes in all hospitals located in Eldoret, 23.4% were blood alcohol concentration (BAC) positive (5 mg%). and 12.2% were intoxicated (50mg%). Greater proportions of night-time and weekend crashes involved intoxicated subjects. Motor vehicle drivers were the most affected by alcohol (60%), whereas pedestrians (33.3%), passengers (16%) and cyclists (8.3%) were involved to a lesser extent.

A roadside survey in Eldoret of 479 drivers (aged 19 to 65 years) over a one-week period between 19:00 hours and 24:00 hours found a blood alcohol concentration level of 5mg% or greater in about 20% of the drivers. About 8% had a blood alcohol concentration greater than 50mg% and 4% had a blood alcohol concentration level of greater than 80 mg%. Virtually all

drivers with blood alcohol concentrations in excess of 50mg% were men, with age brackets most affected being 25 to 34 years and 45 to 54 years.

The mean annual fatality rate from all traffic accidents in Kenya is estimated at 50 deaths per 10,000 registered vehicles. The annual economic cost of road traffic accidents is 5% of the country's Gross National Product. Traffic police indicate that most road traffic accidents (85%) result from human error. Some of the factors influencing the road accidents include driving at excessive speeds, losing control, improper overtaking and misjudgment. More often than not, alcohol is the underlying contributory factor. Table 1 presents details on specific crimes related to the possession of dangerous drugs and road traffic offences in various parts of Kenya.

Table 1: Possession of dangerous drugs and traffic offences

Categories	Specific Crimes	2004	2005	2006
Dangerous Drugs	a) Possession	4,940	5,244	5,012
	b) Handling	115	124	105
	c) Trafficking	233	246	298
	d) Cultivating	181	204	132
	e) Usage	292	538	274
	Sub-total	5,.761	6,356	5,821
Traffic Offences	Driving under influence of Alcohol	48	34	38

A survey of women in Nairobi found that with regard to alcohol consumption, about 44% of the women reported that their partners drink alcohol. While half of the women considered their partners' drinking habit to be of a social nature, 10% said the habit was intolerable. Women who reported that their partners drink alcohol were significantly more likely to report lifetime violence and violence in the last one year.

Comparing women whose partners were moderate drinkers and those with intolerable drinking, the women of intolerable drinkers had significantly higher reporting of domestic violence. In 2003, women in the Kangemi neighbourhood of Nairobi held public demonstrations to voice a complaint that alcohol had turned their husbands into zombies and asked the government to intervene. There were similar cases of protesting womenfolk in Kiambu, Machakos and Murang'a. In Makueni several people died in 2006 as a result of consuming illicit brew while others were left blind.

In November 2000, at least 140 Kenyans died, many went blind and hundred others were hospitalized after consuming an illegally brewed and poisonous liquor called *kumi kumi* in the poor neighbourhoods of Mukuru Kwa Njenga and Mukuru Kaiyaba. Made from sorghum, maize or millet, the alcoholic drink is common among Kenyans living in the country's low-income urban and rural areas who are too poor to afford conventional legal beer. *Kumi kumi* is poisonous liquor since it is adulterated using methanol or other additives such as battery acid and formaldehyde (formalin).

The abuse of alcohol has been associated with increased HIV infection in several countries (Bryant 2006). Alcohol is thought to fuel HIV transmission by affecting judgment, influencing decision-making and reducing inhibitions, thus diminishing perceived risk or excusing behaviors otherwise considered unacceptable. Those who abuse alcohol are therefore more likely to engage in behaviors, including injecting drug use and sexual-risk

taking that place them at increased risk of contracting HIV (Weiser *et al* 2006; Zablotska *et al* 2006; and Morojele *et al* 2003). In Kenya, data from the Demographic and Health Survey show that HIV prevalence among women who had ever consumed alcohol was 19 percent, compared to 9 percent among their never-drinking counterparts (CBS 2004). In Kisumu, Ayisi *et al* (2000) found that after controlling for confounding variables, women who drank alcohol were 60 percent more likely to be HIV-positive than women who did not drink.

A growing body of evidence also suggests a direct bio-medical link between alcohol consumption and HIV infection and disease progression. Clinical studies suggest that heavy and sustained alcohol use depresses the immune system and can lead to alcohol-induced malnutrition, which can increase vulnerability to HIV infection (Bryant *et al* 2006). Emerging laboratory evidence suggests that alcohol may morphologically alter cellular structure to increase both HIV infectivity, vulnerability to and severity of opportunistic infections in HIV positive patients, and may accelerate progression of the disease (Liu *et al* 2003; Bagby *et al* 2003). Alcohol also interferes with liver function affecting its ability to metabolize certain anti-retroviral drugs (ARVs), particularly protease inhibitors, thus reducing their therapeutic efficacy and increasing the likelihood of drug resistance (Gail-Becker 2005; Bryant 2006).

Problem drinking may also contribute to delays in seeking treatment and deter adherence to ARV therapy. Patient non-compliance to prescribed therapy due to problematic drinking not only results in poorer treatment outcomes but can also contribute to HIV drug resistance.

Gaps in research indicate that a consistent methodology for measuring an association between alcohol use and the risk, progression, and treatment of HIV/AIDS has yet to be adequately developed. The government should commission further research to support additional analyses of patterns of co-morbidity between HIV infection and alcohol abuse and dependence. This will guide the design and development of more coordinated and responsive strategies. Government resources should be directed at interventions that target specific populations and settings, integrated alcohol–HIV/AIDS intervention approaches, and offer tailored prevention and treatment options.

3.2.4 Alcohol health impact and care

The government recognizes that alcohol abuse has a direct medical, social and economic impact on the user, which includes poor health, foetal alcohol syndrome, physical and psychological addiction, diseases such as alcohol induced diabetes, stomach ulcers, kidney and liver diseases, impotence, reduced productivity, malnutrition, lowered immunity, accidents and mental disorders that may finally lead to death.

The abuse of alcohol has also been associated with increased transmission of HIV/AIDS through impaired judgment which can lead to risky behaviour. What is worrisome given the above scenario is that alcohol manufacture in Kenya is reported to have been 222.3 million litres in 2003, which rose to 237.5 million litres in 2004, while in 2005 the quantity stood at 266.3 million litres (CBS). This increase may imply a corresponding increase in the number and nature of medical consequences.

Alcohol abuse also has indirect effects on the non-user. These may include domestic violence, child abuse and neglect, truancy from school, absconding from the work place, road traffic accidents through drunk driving and other mishaps, psychological suffering and distress to the family.

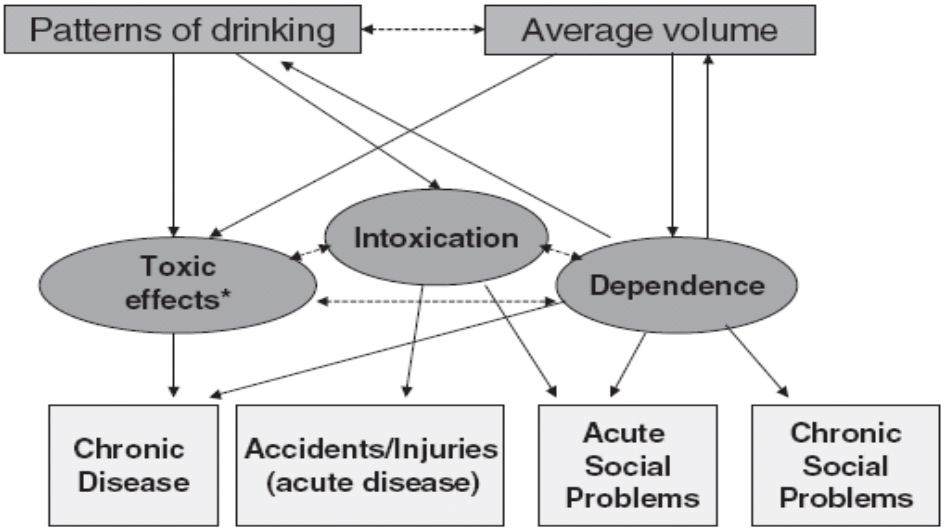
3.2.5 Alcohol consumption, mitigating factors and related consequences

Three important mechanisms explain alcohol's ability to cause medical, psychological and social harm: (1) physical toxicity, (2) intoxication, and (3) dependence. Alcohol is a toxic substance in terms of its direct and indirect effects on a wide range of body organs and systems. Paradoxically, the main cause of alcohol-related harm in the general population is alcohol intoxication.

The link between intoxication and adverse consequences is clear and strong, especially for violence, traffic casualties and other injuries. Alcohol dependence has many different contributory causes including genetic vulnerability, but it is a condition that is contracted by repeated exposure to alcohol: the heavier the drinking, the greater the risk.

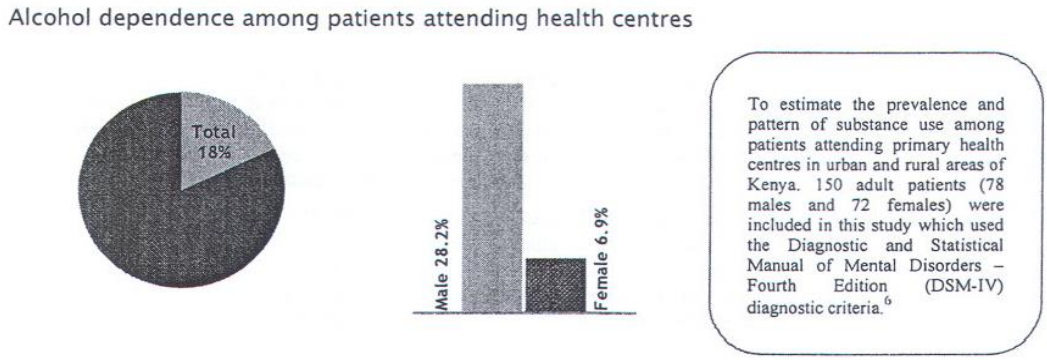
As illustrated in Figure 1, the mechanisms of toxicity, intoxication and dependence are related closely to the ways in which people consume alcohol, called 'patterns of drinking'. Drinking patterns that lead to rapidly elevated blood alcohol levels result in problems associated with acute intoxication, such as accidents, injuries and violence.

Figure 1: Why alcohol is no ordinary commodity. Relationships between excess alcohol consumption, mitigating factors and alcohol-related consequences (Source: Babor *et al* 2003)

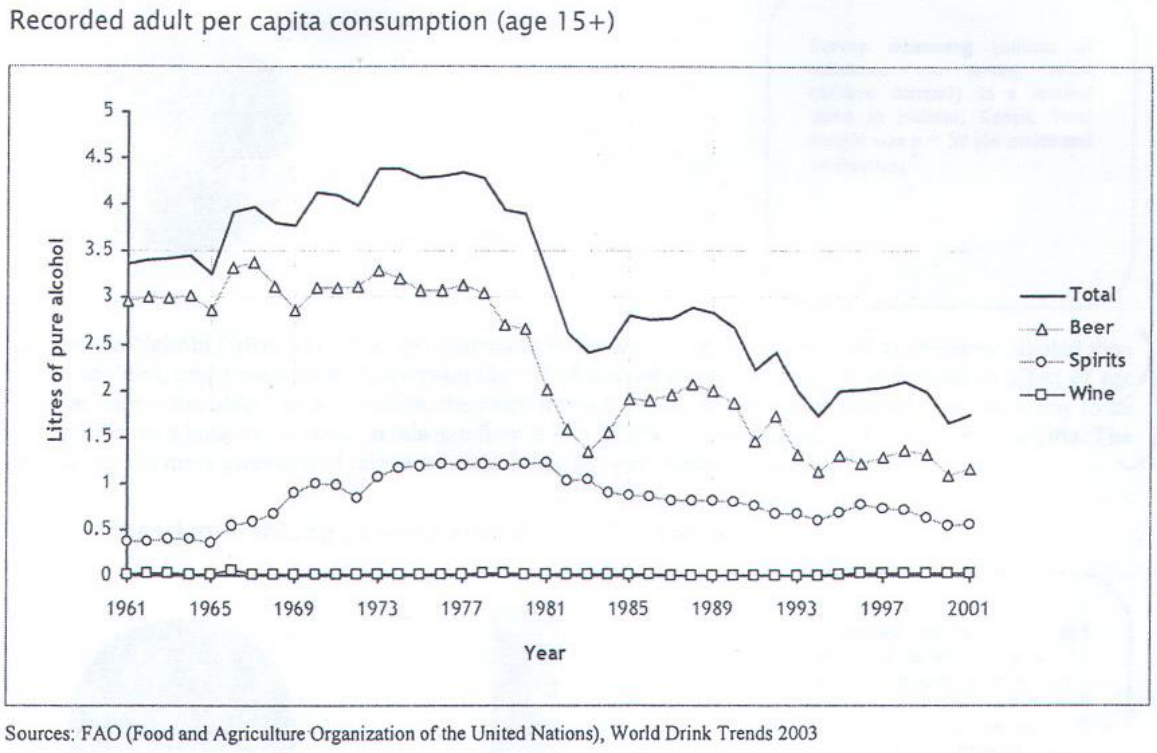


Similarly, drinking patterns that promote frequent and heavy alcohol consumption are more often associated with chronic health problems such as liver cirrhosis, cardiovascular disease and depression. Finally, sustained drinking may result in alcohol dependence (see figure 2). Evidence suggests that males are more predisposed to problems of alcohol dependence when compared to females. Once dependence is present, it impairs a person's ability to control the frequency and amount of drinking. For these reasons, alcohol is not a run-of-the-mill consumer substance. Public health responses must be matched to this complex vision of the dangers of alcohol as they seek better ways to respond to population-level harms.

Figure 2: Patients with Alcohol dependence problem at health centres



Globally there has been a decline in recorded adult per capita consumption of pure alcohol in the past 40 years (figure 3). The trend regarding per capita alcohol consumption in Kenya is not very clear. However, activities of liquor licensing courts indicate that the consumption of alcohol is quite high in some regions.



Sources: FAO (Food and Agriculture Organization of the United Nations), World Drink Trends 2003

Figure 3: Adult per capita alcohol consumption

For example available records for Nairobi Province show that a significant number of applicants get liquor licenses every year (Table 2). Between years 2004 and 2006, a total of 6,684 traditional and conventional liquor outlet license applications were made in Nairobi alone out of which 4.057 (61%) were approved. With an estimated population of 3 million inhabitants in Nairobi, this translates to 449 persons per liquor outlet.

Table 2: Traditional and Conventional Licenses Applications

Year	Total applications	Rejected	Approved
2004	2,339	892	1,447
2005	2,272	1,026	1,246

2006	2,073	708	1,364
TOTAL	6,684	2,626	4,057

Source: Liquor Licensing Court (PC's Office), Nairobi Province, Kenya.

Currently the beer and barley sub-sector is under the control of a small number of large manufacturers. Though beer price is mostly influenced by excise duty, the monopoly can also influence beer prices or manipulate market forces of supply and demand for monopolistic profits. It further eliminates competitive ground that allows product quality improvement and consumer wide choice.

Alcohol is one of the most abused substances in Kenya. According to a study conducted by Halima Mwenesi (KEMRI, 1995) 70% of Kenyan families abuse alcohol in one way or another. A baseline survey on alcohol and drug abuse done by NACADA and released in 2004 confirmed that alcohol abuse is widespread and affects both young and old. Alcohol manufacture in Kenya is reported to have been 222.3 million litres in 2003 which rose to 237.5 million litres in 2004, while in 2007 the quantity stood at 266.3 litres (Central Bureau of Statistics).

A 1990 cross-section survey involving 15,324 household heads, reporting on a population of 68,487 people in Kisumu District, revealed that the reported rate of alcohol use was 6.4% of the study population. Out of the 6,793 respondents who reported at least, one drug user, 66.2% were concerned with the practice. Out of these, 51.5% were concerned about alcohol use in their households.

Based on Nairobi Urban Slum Survey, adolescent males are five times more likely to consume alcohol than girls. In addition being out of school increases the risk of alcohol abuse. The study also showed the effect of age on alcohol use, the older the adolescents, the more likely for them to have used alcohol. Age 14 seems to be the threshold, as a jump is observed at this age from 6.7 to 40.2% for boys and from 4.4 to 16.8% for girls.

3.2.6 Alcohol and the youth

Alcohol abuse is intricately associated with negative social development. Young people's initial forays into the adult world often involve spending time at market and city centres where there are pubs, discos and night clubs. Reasons commonly given by young people for visiting pubs are to date, to socialize and to relieve stress. However, these reasons arise out of ignorance of the negative effects of alcohol on social, educational, physical, psychological, economic and occupational functioning. Table 3 gives details on number of youths convicted on drug related offences.

Table 3: Kenya Prisons Statistics

			Youth Convicts (15 – 25 years)		
Year	Total No. of Convicts	Youth (15 – 25 years)	Illicit Brews	Hard Drugs	% Relapse (for 3rd time)
2000	81,820	50,462 (61.7%)	13,840	4,066	11
2004	75.361	51,606 (68.4%)	11,604 (43.6%)	4,452	6
2006	110,064	60,092 (54.6%)	14,770	3,462	15

Research findings indicate that adolescents initially adopt drinking behaviours of their parents and peers. Parental drinking has been identified as a major risk factor for youth taking up alcohol drinking as a lifestyle.

3.2.7 Media impact

There has been tremendous increase in alcohol advertisement and promotion by the media in Kenya over the last few years. Some of these predominantly target the youth. Many advertisements convey skewed messages of exaggerated positive experiences. Further, the media highlights social joints where alcohol is consumed in large amounts. There are no corresponding educative messages on the harmful effects of excessive consumption of alcohol or on over-indulgence. The media has been put into focus over the issue of self-regulation as regards its activities and in particular the influence it has on the youth and underage access to alcohol. This policy seeks to ensure that no media activity in relation to alcohol shall target the youth, or in any way imply that drinking by young people is other than harmful at all times.

3.2.8 Alcohol accessibility and availability

Although alcohol consumption is legal in Kenya, its accessibility and availability have a direct negative impact on the social-economic well being of the people. The accessibility and availability of alcohol and related products has increased over time. This is notable in terms of the geographical location that has led to proliferation of alcohol selling outlets in the residential areas, selling of alcohol to minors or under age persons, non-adherence to alcohol selling hours by the alcohol-selling outlets, increase in road accident-related deaths due to drunk driving, and non-adherence to drinking hours as stipulated in the law. There is also emergence and increase of negative drinking patterns like binge drinking among the youth.

3.2.9 Milestones in the fight against alcohol problem in Kenya

The Government recognizes the negative impact that abuse of alcohol has on society. Several initiatives have been undertaken in the past to deal with the problem with insignificant results. For instance, as a result of increased road traffic accidents due to drunken driving and great loss to the insurance industry, a Commission of Inquiry of the Insurance Industry was set up in 1986 - 87 chaired by Justice Hancox and the late Dr. Oki Ooko Ombaka to look into the matter. In 1989 the Mental Health Act was enacted and the same recognized that alcohol abuse is a contributing factor in the increasing levels of mental health problems.

In 1994, the Government developed the Narcotic Drugs (and Psychotropic Substances) Control Act in which the problem of alcohol abuse was addressed. In 1996, a team of experts from Kenya was sponsored to go to South Africa to research the problems associated with alcohol misuse and road traffic crashes. In 1998, the Traffic Bill was drafted but it was neither debated nor passed by parliament.

Between 1998 and 2000, there was increased violence in secondary schools which was directly linked to alcohol abuse. For example in 1990, intoxicated boys invaded St. Kizito Girls' Secondary School in which 19 girls were killed and others raped. Further, several deaths occurred in Naivasha, Mai Mahiu, Machakos, Murang'a and Nairobi slums as a result of illicit brews (*kumi kumi*) consumption. A Commission of Inquiry was set up by the Kenya Government to look into the matter in 2000.

In the year 2001, the Government of Kenya formed the National Agency for the Campaign Against Drug Abuse (NACADA) and charged it with the task of initiating a public education campaign against drug abuse especially among the youth in schools and other learning institutions. In October 2006, NACADA initiated a key stakeholders' workshop and started the process of developing a comprehensive National Strategy on Drug and Substance Abuse. The strategy acknowledged the need to develop a policy to regulate alcoholic beverages. NACADA subsequently organized a stakeholders' consultative forum on the development of the National Alcohol Policy Framework on 13th March 2007. The current policy document is a product of this effort.

3.3 Policy Rationale

The rationale for alcohol policy is to have in place strategies that will ensure that harm caused by alcohol misuse is minimised, while the safe and moderate use of alcohol by those who wish to drink is unfettered. Most countries in the world, including Kenya, do not intend to prevent the use of alcohol but wish to halt the escalation of problems associated with alcohol abuse and most are concerned about the patterns of alcohol consumption, particularly binge drinking.

According to the World Health Organization, in 2000 alcohol-related death and disability accounted for 4.0% of the global burden of disease, ranking as the fifth most detrimental risk factor of 26 examined. Alcohol abuse accounts for about the same amount of disease as tobacco. In developed countries, alcohol was the third most detrimental risk factor, accounting for 9.2% of all burden of disease. In emerging economies such as China, alcohol was the most detrimental risk factor.

Overall, injuries accounted for the largest portion of alcohol-attributable disease burden, which ranged from close to zero among females in the predominantly Moslem Eastern Mediterranean regions to more than 20% for males in Eastern Europe. The volume of drinking is linked to most disease outcomes through specific dose–response relationships.

These relationships can at the individual level be linear (as in the case of breast cancer or suicide), accelerating (as in the case of liver cirrhosis or motor vehicle accidents) or *J*-shaped (as in the case of heart disease or all-cause mortality). Patterns of drinking also play an important role in the disease burden, being linked to coronary heart disease, motor vehicle accidents, and suicide and breast cancer. Moderate drinking has positive as well as negative effects.

It has been linked to an increased risk of cancer and other disease conditions. For coronary heart disease (CHD), studies indicate a cardio-protective effect of regular, light and moderate alcohol consumption at the level of the individual drinker. This effect applies mainly to the age group of 40 years and older, where the overwhelming majority of CHD occurs.

This effect explains the lower death rate of light drinkers relative to abstainers. However, aggregate-level studies suggest that there may be no net protective effect at the population level from an increase in the level of consumption, and even a detrimental effect in societies with heavy episodic drinking patterns.

Although public discussion has often concentrated on alcohol-related problems connected with disease and other medical conditions, alcohol is also linked to consequences in the social realm, which has been called 'the forgotten dimension'. Clearly, alcohol misuse is related to many social problems, especially violence (Babor *et al*, 2003), injuries and accidents, crime, disorder and anti-social behaviour.

As earlier mentioned, alcohol abuse has also been associated with risky behaviours including an increase in the transmission of HIV/AIDS. Overall, alcohol misuse accounts for a significant disease burden worldwide and is related to many negative social consequences. Most of the problems cited could be checked through the formulation of sound policies. Other reasons for developing a national alcohol policy include:

- In some situations, alcohol laws in Kenya appear to be backed up with insufficient executive authority, and are therefore not enforceable.
- The capacity to enforce the alcohol laws in Kenya need to be reviewed for effective implementation.
- There is need to clearly define illicit brews to distinguish them from other alcoholic beverages
- There is need for effective regulation of the drinking times and the drinking places.
- There has been an increase in the abuse of alcohol among teenagers.
- Individuals who abuse alcohol while taking anti-retroviral drugs for the treatment of the HIV virus face poorer treatment outcomes.

Despite the existence of enormous public health and socio-economic problems caused by alcohol, there has been no policy in place to regulate the consumption of alcohol and also to address alcohol-related demand side and supply side factors.

In an effort to address the issues raised, NACADA in collaboration with key stakeholders including those in the alcohol sector organized a series of workshops with a view to developing the National Alcohol Policy. Two meetings were organized by NACADA in Nairobi in 2006. The first meeting was a Stakeholders Consultative Forum on the Development of The National Alcohol Policy Framework, while the second meeting whose title was Alcohol Policy Media Consultative Group Meeting targeted media houses and institutions involved in advertising alcohol as well as manufactures and distillers of alcohol products. In both meetings there was emphasis on sector partnership approach.

The two initial meetings were followed by two workshops held in 2007. The first workshop was held in Nyeri from 21st to 23rd May 2007 and second validation workshop was held at Nakuru from 27th to 28th August 2007. The main objectives of the workshops were to:

- Clearly identify thematic priority areas and key strategies for intervention by all stakeholders including the Government, civil society, the youth and private sector.
- Empower civil society and private sector stakeholders to engage effectively in the national response and identification of existing gaps to enable efficient allocation of resources across the national grid in implementing the policy in line with National Strategy for Drug and Substance Abuse.

- Harmonise the over 15 Acts of Parliament that address issues related to alcohol use and abuse.

A key output of the two workshops was the development of the draft National Alcohol Policy.

Chapter 4: Evidence-Based Interventions in Preventing Alcohol-Related Harm

In an effort to guide the policy formulation process in Kenya, extensive literature review was done with a view to identifying evidence-based best practices that have been effective in reducing alcohol related harm in a number of countries. These best practices are grouped into six areas: Effects of high taxation and high alcohol prices, legislative measures; drink driving; safer drinking environment; and education and information.

A brief summary of the findings on evidence based effective interventions for preventing alcohol-related harm is provided for each of these areas. In the brief summaries, it is recognized that many of the arguments presented are complex - some technical and yet others not fully accepted in all jurisdictions. Others will apply in full or in part to Kenya, while others may be less relevant today, while in time, their relevance and importance could grow. It is further recognized that alone, none of the practices will achieve the desired goals but in combination, their effects can be significant.

4.1 Effects of Fiscal Measures

There is a consensus among researchers that higher alcohol prices and taxes result in a modest reduction in drinking and fewer alcohol-related problems (US Department of Health and Human Services, 2000; Raistrick D *et al*, 1999.) However, there is less consistent evidence on the effects of price on the heaviest drinkers (Plant M *et al* 1997). This implies that persons with heavy drinking problems require different strategies or intervention measures.

Empirical evidence has shown that the effectiveness of taxation and pricing depends on government oversight and control of alcohol production and distribution (Plant M *et al* 1997). With regard to the effect of high taxation on young people's drinking, there is some evidence that increases in taxes and prices of alcohol reduce young people's drinking (US Department of Health and Human Services, 2000); However, the severity of drink driving penalties appear to have a greater impact on college students' drinking and binge drinking than price increases (Babor T, *et al* 2003). The impact of this method is further complicated by the fact that in Kenya, only 45% of the alcohol consumed is in the taxable bracket. Until the greater proportion of the alcohol is brought into the formal sector, the impact of this measure though important may be limited by the effect of illicit trade in alcohol.

4.2 Legislative measures

There is strong evidence, based on 33 studies that minimum legal drinking age (MLDA) laws, particularly those set at age 21, are effective in preventing alcohol-related crashes and associated injuries (Shults R, *et al* 2001). In addition, studies that evaluated the effects of increasing the national minimum drinking age to 21 years showed significant decreases in traffic crashes and fatalities (Department of Health and Human Services in 2000, Zaza S, *et al* 2001).

Evidence from global studies shows that raising the minimum legal drinking age to 21 years leads to a decrease in the number of high school pupils who reported drinking in the previous

month and a reduction in binge drinking (Raistrick D *et al*, 1999). In bringing legislation on the minimum drinking age, the Government will remain conscious of the imperative to remain within the laws that define civil liberties, age of majority and other laws that may require amendment. Additionally, NACADAA will in advising Government to conduct comprehensive studies to establish the validity and relevance of studies carried out elsewhere, as well as establish the most appropriate minimum drinking age for Kenya, taking into account the country's demographic profile.

4.3 Drink driving control measures

Selective breath testing for drink driving: There is strong evidence that selective breath testing (SBT, where police must have reason to suspect a driver has been drinking) and random breath testing (RBT, where police can stop all drivers at checkpoints), are effective in preventing alcohol-impaired driving, alcohol-related crashes and associated fatal and non-fatal injuries **(**Shults R, *et al* 2001; Zaza S, *et al* 2001).

Random screening for drink driving: Random screening for drink driving reduces deaths and injuries from road traffic crashes. Most of the evidence is from the USA and Australia (Peek-Asa C. 1999).

Lowering legal blood alcohol concentration limits: There is strong evidence that the introduction of 0.08 blood alcohol concentration laws (BAC) (from 0.10%) in America have been effective in reducing alcohol-related motor vehicle fatalities **(**Shults R, *et al* 2001; Zaza S, *et al* 2001).

Lowering legal blood alcohol concentration limits among young drivers: Evidence from studies conducted in the USA and Australia (Zwerling C, *et al* 1999) show that laws to lower permitted blood alcohol concentration limits among young and/or inexperienced drivers reduce crashes and injury. Reductions ranged from 11% to 33%. The largest effects were in states with zero permitted blood alcohol.

Interventions for convicted drunk drivers: Rehabilitation programmes for those convicted of driving under the influence of alcohol have been shown to have a positive effect on reducing alcohol-related traffic incidents (Wells-Parker E, *et al* 1995). Interventions include education, psychotherapy, counselling, probation and pharmacological treatments. Combinations of methods were reported to be most effective.

Alcohol ignition interlock devices for convicted drunk drivers: Alcohol ignition interlock devices, which require the driver to provide a breath sample every time the car is started, have been tested in the USA. The results showed that the interlock devices were effective in reducing recidivism to driving while intoxicated during the period of intervention. Reductions were between 15% and 69% (Coben J, *et al* 1999).

Driving while intoxicated (DWI) law enforcement: Administrative license suspension, sobriety check points and mandatory jail sentences among other actions were the most effective interventions in reducing deaths, injuries and the prevalence of drink driving in the USA and other countries (Zobeck T, *et al* 1994).

4.4 Safer drinking environment

There is sufficient evidence, based on scientific studies, that intensive, high quality face-to-face server training, when accompanied by strong and active management support, is effective in reducing the level of intoxication among patrons of licensed drinking establishments **(**Shults R, *et al* 2001; Zaza S, *et al* 2001).

There is also sufficient evidence that responsible beverage service programmes can reduce alcohol intoxication (Plant M *et al* 1997). The enactment and enforcement of laws requiring refusal to sell more alcohol to intoxicated patrons is also important. Emphasis should be given to house policies and serving practices, backed up with management support and community commitment to the programme (Babor T, *et al* 2003).

4.5 Education and information

Peer led education programmes especially those that include group discussion are more effective in improving attitudes of young people involved in substance abuse (Bangert-Drowns R 1988). Studies have also shown that comprehensive and social influence programmes are most successful in preventing the onset of substance misuse among young people in schools (Hansen W 1992). In this study the interventions for the school based programmes were classified into the following groups: information/values clarification; affective education; social influence and comprehensive programmes.

In addition, social reinforcement and developmental behaviour modification interventions for adolescents seem to be more effective than traditional awareness programmes about the health risks of alcohol abuse. Similar studies have also shown that alcohol programmes increased knowledge on the risks of drinking alcohol (Rundall T, *et al* 1988).

4.6 Management of problem drinkers

The use of screening tools such as Alcohol Use Disorders Identification Test (AUDIT) screening tool to detect alcohol-related problems was found to be the most effective in identifying subjects with at-risk, hazardous or harmful drinking (Fiellin D, *et al* 2000). This tool was more effective than other screening tools or methods, including two question screening and quantity frequency questions.

Besides the use of screening tools, other measures such as brief interventions have been shown to be effective in reducing alcohol consumption. The measures mainly consist of giving advice to promote life style changes in primary care for patients who drink more than the recommended guidelines (Ashenden R, *et al* 1997). For instance, interventions by a physician were effective in reducing alcohol consumption by men by five to seven standard drinks per week and had a high public health potential (Kahan M, *et al* 1995).

Other treatment methods (for example, family therapy for treatment of alcoholism) are effective in motivating alcoholics to enter treatment **(**Edwards M, *et al* 1995). Studies among Alcoholics Anonymous (AA) in the USA have shown that people should not be coerced to join AA e.g. through court ordered attendance, as coercion seems to lead to significantly worse results than alternative treatment or no treatment at all. Altering the organization and practice procedures for clinicians, e.g. allowing for longer appointment times were more effective than single-method approaches (Hulscher M, *et al* 2003).

Chapter 5: Strategic Framework

5.1 Vision

A healthy and responsible Kenyan society free from alcohol abuse

5.2 Mission

To provide guidance for multi-sectoral interventions aimed at minimizing alcohol-related harm and abuse within the Kenyan society.

5.3 Goal

The goal of this policy is to contribute to the improvement of the overall health and socio-economic well-being of the Kenyan society through a significant reduction of the negative consequences caused by alcohol abuse.

5.4 Objectives

Overall objective:
The main objective of this policy is to minimize the incidence and prevalence of alcohol-related harm by addressing the underlying demand, supply and environmental factors.

Specific objectives:
The specific objectives of this policy are to:

a) Regulate access to and availability of alcohol especially to persons under the age of eighteen;

b) Reduce alcohol-related problems and harm that may occur in a variety of settings such as the home, workplace, community or drinking environment including fatalities, accidents, violence, child abuse and neglect, and family crises;

c) Develop and execute a coordinated public education campaign related to alcohol abuse

d) Support public health policies that address the prevention of harm that can be caused by alcohol abuse;

e) Regulate the advertising and promotion of alcohol beverages;

f) Provide greater protection from the pressures to drink for persons under the age of children, young people and those who choose not to drink alcohol;

g) Provide accessible and effective treatment and rehabilitation services for people with hazardous and harmful alcohol consumption and those with alcohol dependence.

h) To develop action plans with key stakeholders regarding the reduction of alcohol abuse

5.5 Policy Components and Interventions

The selection of the policy options and interventions outlined in this document are based on four major criteria: (i) evidence of effectiveness e.g. of measures to regulate availability and use of alcohol and drinking-driving; (ii) strength of research evidence; (iii) extent of implementation across diverse countries and cultures; and (iv) relative cost in terms of time, resources and money. Although the degree of effectiveness at individual and population levels for each of the strategies differs from high to low, given the broad reach of these strategies, and the relatively low expense of implementing them, the expected combined impact of these measures on public health is relatively high. Since no one alcohol policy can operate independently or in isolation from other policy measures, it is important to point out that complementary system strategies that seek to restructure the total drinking environment are more likely to be effective than single strategies. Therefore, it has been determined that full-spectrum interventions are needed to achieve the greatest population impact. Key policy areas and interventions are outlined below:

5.5.1 Fiscal measures

Consumers, including heavy drinkers and young people, are sensitive to changes in the price of drinks. Pricing policies can be used to reduce underage drinking, to halt progression towards drinking large volumes of alcohol and/or episodes of heavy drinking, and to influence consumers' preferences. A key factor for the success of price-related policies in reducing harmful use of alcohol is an effective and efficient system for taxation matched by adequate tax collection and enforcement.

Recommended policy interventions are as follows:

a) The government shall ensure that there shall be appropriate taxation on all alcoholic beverages both conventional and traditional products manufactured for commercial purposes. The level of taxation required to achieve the objectives of this policy shall be determined on a regular basis.

b) Have in place instruments, such as duty-paid stamps on alcohol products, to combat alcohol smuggling and ensure the implementation of effective price policies and the collection of all taxes.

c) Develop a taxation policy that ensures a high real price of alcohol, taxation based on alcohol volume (i.e. higher taxes on alcoholic beverages with a higher alcohol content), and the provision of non-alcoholic beverages at low prices.

d) Use alcohol levies and fees to fund alcohol abuse control activities, including health education, research into alcohol policy, and support to health services at both local and national levels.

5.5.2 Legislation to control accessibility to and availability of alcohol

The production and distribution of alcohol is controlled by the Kenya government licensing laws. There is widespread recognition that enforcement of the liquor licensing laws has been inconsistent within the retail sector, the hospitality industry, among patrons and the general public. In addition, there has been proliferation of alcohol selling outlets in the residential areas, selling of alcohol to minors or under age, non-adherence to alcohol selling hours by the

selling outlets, increase in road accident deaths due to drunk-driving and non-adherence to drinking hours stipulated in the Kenyan law. There has also been an increase in negative drinking patterns such as binge drinking among the youth.

In order to address these issues, the following policy interventions are recommended:

a) The minimum legal age for handling, purchasing, consuming and selling of alcohol shall be 18 years.

b) The size, packaging, packing and labeling of alcoholic products and beverages shall comply with existing legislation or as shall be prescribed from time to time.

c) Alcoholic products shall not be sold through vending machines.

d) There shall be no operating and licensing of alcohol selling outlets in residential areas as have been demarcated by.

e) Further, there shall be restrictions in relation to number of alcohol selling outlets allowed to operate in a given locality based on the population density in the area limiting the number of licenses and restricting hours.

f) There shall be no operation of any alcohol selling outlet in or near any learning institution of all levels including primary and secondary schools for persons under the age of eighteen.

g) Bars and other alcohol retail outlets shall not be licensed to operate within the same building as residential premises.

h) There shall be streamlining and harmonization of the required liquor licenses and their issuance thereof.

i) All alcohol retail outlets shall be expected to adhere to the operating hours and other conditions stipulated by the licenses and in this regard the government shall strictly enforce the law.

j) There shall be enhanced penalties for alcohol-related offences including offences related to licenses, production and sale of alcohol products. This will be done to reflect the current times and commensurate to the offences committed. The government will therefore review legal framework regarding licenses

k) There shall be no person below the age of eighteen minor and under age person allowed to access or enter any alcohol selling outlets whether alone or accompanied and there shall be prescribed penalty for such a breach. Such penalties shall include withdrawal of licenses, fines and jail terms for offending bar owners. Serving of alcohol at under-age leisure-time activities or sporting events shall be prohibited. Instead, a wide range of food and non-alcoholic beverages shall be provided

l) In order to protect persons under the age of eighteen from exposure in associating alcohol with sports and good social lifestyle, there shall not be any sale of alcohol or availing of alcohol at sporting and family oriented public events. In addition there shall be no sale of alcohol at public recreational facilities such as parks and beaches.

m) Where alcohol products are sold at supermarkets or other related outlets, there shall be designated alcohol selling points that should not be accessible to persons under the age of eighteen.

n) Ensure strict enforcement of existing licensing and drinking laws, mandatory training requirements and the placing of conditions on licenses which prohibit irresponsible trading practices within the drinking environment.

o) The government shall develop the necessary legislation for enactment in parliament to implement the policy direction contained in this part which shall include harmonization of liquor licensing and liquor licensing institutions.

5.5.3 Drink driving Control measures

Whether labeled as "drink driving", "drunken driving", "driving under the influence" (DUI), or "driving while intoxicated" (DWI), the consumption of alcohol is known to impair driving ability and the severity of the impairment relates of the amount consumed.

Policy interventions to minimize drink driving are recommended below as follows:

a) In order to reduce the number of road accidents associated to alcohol consumption, there shall be a prescribed maximum blood alcohol levels imposed for motor vehicle drivers, Motor cyclists, coxswains, pilots, operators of heavy machinery and any other related operators and the government shall establish an effective and efficient system or mechanism for testing the maximum blood alcohol levels.

b) There shall be legislation to regulate random breath tests where drivers may be stopped and given breath alcohol content (BAC) tests.

c) There shall be legislation to regulate and legalise selective breath tests (SBT) where the law enforcers must have reason to demand administration of breath tests at checkpoints-related to driving

d) Ensure high levels of enforcement of current drink driving legislation;

e) Encourage the provision of alternative transportation for drivers who have consumed alcohol. Manufacturers of legal alcohol beverages shall be required to publicize information on the safest practices for drivers, including where appropriate the encouragement of drivers not to drink at all.

f) Consider mandatory driver education and treatment programmes for habitual drink driving offenders.

g) Consider and where appropriate institute other measures such as use of *Alcohol ignition interlock devices for convicted drunk drivers*, which require the driver to provide a breath sample every time the car is started and enforcement of *Driving while intoxicated (DWI) law*. Measures such as administrative license suspension, sobriety check points and mandatory jail sentences among other actions shall be considered and applied.

5.5.4 Safer drinking environment

Well managed and responsible beverage service (training for personnel) programmes coupled with good in-house policies and management support by the owners and community commitment to the policies are effective in enhancing a Safe drinking environment among patrons of licensed drinking establishments. For example, the enactment and enforcement of laws requiring refusal of alcohol to intoxicated patrons is also important.

Policy interventions to encourage safer drinking environment with regard to alcohol consumption and consequences are recommended below as follows:

a) All licensed premises should conform to the prescribed OSHA regulations. Technical assistance shall also be provided to enhance compliance

b) The availability of alcohol at major public events where alcohol-related harm is likely to occur shall be controlled.

c) Foster awareness of personal, ethical and legal responsibility by providing training programmes for those serving alcoholic beverages;

d) Enact legislation so that those who serve alcohol in an irresponsible manner are held accountable by means of server liability, licence withdrawal or other mechanisms deemed appropriate by the authorities;

e) Ensuring strict enforcement of existing licensing and drinking laws, mandatory training requirements and the placing of conditions on licences which prohibit irresponsible trading practices within the drinking environment.

5.5.5 Controls on the advertisement and promotion of alcohol

Reducing the impact of marketing through advertisement and promotions, particularly on young people and adolescents, is an important consideration in reducing harmful use of alcohol. Alcohol is marketed through increasingly sophisticated advertising and promotion techniques, including linking alcohol brands to sports and cultural activities, sponsorships and product placements, and new marketing techniques such as e-mails, SMS and podcasting, social media and other communication techniques. The transmission of alcohol marketing messages across national borders and jurisdictions on channels such as satellite television and the Internet, and sponsorship of sports and cultural events is emerging as a serious concern in some countries.

It is very difficult to target young adult consumers without exposing cohorts of adolescents under the legal age to the same marketing. The exposure of children and young people to appealing marketing is of particular concern. Both the content of alcohol marketing and the amount of exposure of young people to that marketing are crucial issues. A precautionary approach to protecting young people against these marketing techniques should be considered Advertising and promotion of alcoholic drinks therefore must be done in a responsible manner that clearly does not impact on persons below the age of 18years and does not deceive consumers.

To ensure that the youth and underage are protected against negative influence as a result of alcohol advertisements, the government shall apply the following policy interventions:

a) The government shall initiate public awareness programmes that are geared towards encouraging the underage and the youth to abstain from alcohol use and harmful effects of alcohol abuse in order to enable them make informed choices.

b) There shall be no advertising to underage and youth and in this regard, there shall be regulation on advertisements of alcoholic beverages in both electronic and print media in relation to duration, timing and frequency in order to protect the underage and youth from the potential negative influence of alcohol beverage advertisements. In

this regard, the government shall put in place legislation to implement this policy direction.

c) The concept of product liability shall be extended to cover those who promote alcoholic beverages in an irresponsible and inappropriate way;
d) There shall be regulation on outdoor advertising of alcoholic beverages in relation to presentation and content. Proximity of such materials to underage youth, learning institutions and residential areas shall be controlled.

e) All alcoholic products for sale shall contain a label indicating the ingredients.

f) There shall be no promotion of alcoholic beverages by use of materials that are associated with the underage or youth and that have the potential to be misinterpreted or misunderstood by the underage and the youth hence misleading them.

g) There shall be no sponsorship or conducting of promotions in underage oriented events by any person or a manufacturer of alcoholic products.

h) Any advertisement of alcoholic products shall be expected to give factual information, not over-emphasize the strength or merit of alcohol, not cast abstinence from alcohol consumption in a negative way and shall not depict alcohol consumption as a lifestyle.

i) Advertisements shall not place emphasis on high alcoholic content as being a positive quality of the beverage. The promotion of low alcohol and non-alcoholic drinks within drinking establishments shall be encouraged including the provision of incentives for marketing and sales. In addition, low risk drinking information should be displayed within all licensed premises.

j) There shall be no music or any audio-visual programme that overemphasizes alcohol consumption in an electronic or print media

k) All alcoholic products' prize oriented promotions that encourage more alcohol consumption in order for one to win shall be banned.

l) There shall be no use of entertainment, sports, media models or celebrities in endorsing or advertising any alcoholic products. In addition, any person used in advertising or endorsing alcoholic products shall be above 30 years and further, there shall be no lifestyle advertising through any form of advertisement or promotion.

m) No communication should imply that the consumption of alcohol is acceptable before or whilst operating machinery, driving a vehicle or undertaking any other occupation that requires concentration in order to be carried out safely. Advertising and marketing activities should not imply that it is acceptable to consume alcohol before or while playing sports.

n) Communication will not suggest any association with violence or with any anti social behavior.

o) Alcohol beverage advertisements shall be sensitive to the variation in cultural sensitivities in Kenya. Advertisements shall not contain any images symbols or figures, which are likely to be considered offensive or demeaning to either gender or to any race, religion, and culture or tribe.

p) The government shall develop the necessary legislation for enactment in parliament to implement the policy direction contained in this part.

5.5.6 Information Education and Communication

The government in recognizing that there are inadequate intervention strategies proposes strategies on:

- Information, communication and education to the society on alcohol related health and social-economic problems.
- Documented evidence on alcohol related problems like accidents, homicides, dysfunctional families, disease burden and other socio-economic effects.
- Information system for monitoring and evaluating of alcohol use and abuse in the country as well as research on alcohol use and abuse trends, patterns and data in Kenya.
- Preventive education that is geared towards equipping persons below the age of eighteen and youth with life skills for informed decision making.
- Strategic alliances in communication and education between government, the private sector and the community.

In this regard, the government in collaboration with stakeholders will apply the following policy interventions:

a) Provide comprehensive information, education and communication programmes on health, socio-economic effects of alcohol to all persons to prevent alcohol abuse.

b) Develop appropriate education curriculum for use at all levels of educational institutions as the vehicle for imparting knowledge, skills, and attitude change on alcohol harm

c) Develop educational programmes designed to prevent alcohol abuse, especially among vulnerable groups like young people, prisoners and pregnant women in the country

d) Establish and strengthen community based resource centres with adequate and relevant information, education and communication materials on the risks of alcohol abuse, treatment and rehabilitation.

e) Develop media communication strategies for dissemination of information on dangers of alcohol abuse and to promote public support for existing or new policies to combat the harm that can be caused by alcohol.

f) Establish and support research programmes on national patterns, trends and effects of alcohol consumptions and effectively disseminate research findings

g) Review and develop the necessary legislation for enactment in parliament to implement the policy direction contained in this part.

5.5.7 Public Health Care

Alcohol abuse has a direct impact on the user, which includes in some serious cases of abuse, foetal alcohol syndrome, physical and psychological addiction, diseases such as alcohol induced diabetes, stomach ulcers, kidney and liver diseases, impotence, malnutrition, accidents and different mental disorders that may in complicated cases finally lead to death. Alcohol abuse has also been associated with the increase in transmission of HIV/AIDS through impaired judgment which can lead to risky behaviour. Alcohol also has indirect effects on the non-user which include domestic violence, child abuse and neglect, road traffic

accidents through drunk driving and other mishaps, psychological suffering and distress to the family.

In this regard, the following policy measures shall apply;

a) Recognizing that alcohol addiction is a preventable condition that should be treated and sufferers rehabilitated, the government shall make all necessary changes in the law and other policies to give effect to this.

b) The government shall ensure that all workplaces have put in place alcohol policy which will address issues such as education, prevention, early identification, treatment and rehabilitation of alcohol related effects. Institutional level managers shall ensure that the policy is integrated into workplace health programmes in both the public and private sectors. The said policy will also prescribe issues such as maximum blood alcohol levels allowable during working hours at every work place.

c) Health impact assessments, which evaluate the effect of the alcohol industry's social and economic policies and programmes on health, shall be carried out in order to ensure accountability.

d) Provide adequate facilities and information to counsel, treat, rehabilitate and integrate people affected by alcohol abuse

e) All people diagnosed with alcohol abuse disorders in recognized treatment centers will be covered by National Health Insurance Fund (NHIF). In this regard the government shall make the necessary legal changes to actualize this.

f) All medical, law enforcement, education and human resource personnel, community opinion leaders, policy makers, stakeholders in the country will be trained on alcohol abuse issues.

g) The government shall facilitate the establishment of residential and non residential community-based addiction rehabilitation services

h) The government shall facilitate the establishment of rehabilitation aftercare services ranging from sub-district to provincial hospitals.

i) There shall be adoption of the standards for rehabilitation centers as outlined in the National Drug Control Strategy.

j) Some of the levies and fees collected from all licensed persons in the alcohol industry and distributors will be used to subsidize the cost of rehabilitation services.

k) The government, and especially the criminal justice system, shall ensure that alcohol abusers convicted of offences shall be committed to mandatory treatment and rehabilitation while they serve their correction or probation period.

l) The government shall ensure that employers in the Public & Private sector identify alcoholism at the workplace as a problem and shall establish Employee Assistance Programmes for treatment of affected employees.

m) The government shall establish programmes in all health facilities, both for education and support to expectant women to avoid the dangers of drinking alcohol while pregnant.

n) The government together with stake holders in the alcohol industry shall establish comprehensive interventions for heavy drinkers covering aspects such as behavioural and pharmacological issues as well as clinic, hospital and residential services.

o) Provide education and training in alcohol policy for professionals in other sectors such as education, social welfare and the judiciary, in order to ensure an effective multi-sectoral approach. In addition, training of primary health care professionals in identification of, and brief interventions for, hazardous and harmful alcohol consumption should be provided

p) Support programmes that strengthen community mobilization, development and leadership for the prevention of alcohol-related problems;

q) Establish at least one coordinated and sustainable community demonstration project on the prevention of alcohol-related problems at district or municipal authority level where appropriate;

r) Ensure that treatment is evidence-based, effective and flexible enough to respond to developments in scientific knowledge and treatment technology

s) Ensure that treatment services cater for the complete range of problems and provide for detoxification, assessment, treatment matching, relapse prevention and after-care;

t) The government shall develop the necessary legislation for enactment in parliament to implement the policy direction contained in this part.

5.5.8 Alcohol products quality and standards

The government recognizes that alcohol product quality standards have been developed by Kenya Bureau of Standards (KEBS). For example the national alcohol manufacturing standard code is applicable to all manufacturing industries producing beers, spirits, wines and fortified wines. However, there are notable policy gaps and challenges that have warranted for government intervention such as continued existence of substandard alcohol products in the market due to adulteration, counterfeited products. These have led to many deaths, directly and indirectly.

There should be a capacity for continuous effective monitoring of alcohol production standards throughout the country.

In light of this, the government shall apply the following policy direction:

a) The government will revisit the repealed Traditional Liquor Act Cap 122 with the view of re-enacting the same for the better control, commercialization and consumption of traditional brews

b) The government shall ensure the continuous maintenance, adherence and conformity to stipulated alcohol manufacturing standards, by providing the necessary capacity building.

c) The government shall ensure availability and dissemination of alcoholic beverages' manufacturing and quality standards and information to law enforcement agencies, industry players and the members of the public.

d) The government shall ensure coordinated and harmonized standards enforcement and licensing by the relevant agencies.

e) The government shall build capacity, provide modern equipment and decentralize activities of the government chemist for the effective monitoring and maintenance of standards.

f) The government shall build the capacity of all stakeholders involved in addressing and implementing, enforcing all alcohol standards related issues.

g) The government shall strengthen community policing mechanisms to address issues like illegal production, adulteration, counterfeiting and mis-branding.

h) The government shall develop the necessary legislation for enactment in parliament to enhance the penalties for the alcohol standards related offences and implement the policy direction contained in this part.

i) The government shall develop the necessary legislation for enactment in parliament to.

j) The government shall, establish a standard procedure for the production of *chang'aa*, with a view of establishing quality *chang'aa* standards.

k) Ensure that regulations governing the alcohol content, packaging and marketing of alcoholic products lay down product safety standards, prohibit false claims and provide relevant warnings (e.g. in the form of unit labeling).

l) Labeling information on all spirits liquors and fortified wines shall include the need for dilution of product before consumption to minimize misuse.

m) There shall be public information to educate people on the effects of consuming highly concentrated alcoholic beverages without dilution and the benefits of dilution on consumers' health.

n) Ensure that the best available technology is used to develop high-quality alcohol products with low alcohol content at low cost.

5.5.9 Curbing Alcohol Access and Use among persons under the age of 18 years

Experiences with alcohol are relatively common among youths across cultures. However, the physiological and psychological transformations during adolescence coupled with the tendency to take risks, mixed with inexperience about drinking, make young, pre-adult individuals especially vulnerable to harm from certain drinking patterns and behaviors.

A Rapid Situation Assessment conducted by NACADAA on Drugs and Substance Abuse in Kenya covering the period 2006/2007 indicated that 9 percent of all young people aged 15 – 24 years are currently using alcohol and that the median age of first use of alcohol is 9 years. In addition, 27 percent of children aged 10 - 14 years, who have ever consumed alcohol have friends who take alcohol compared with only 5 percent of those whose friends did not take alcohol. These alarming figures compel the Government to take measures aimed at protecting the Kenyan youth population.

In order to limit youthful drinking, the following policy interventions are proposed:

a) Educational resources on reduction of harm caused by alcohol including brochures, pamphlets, and other resources should be distributed as widely as possible to parents, teachers and other caregivers.

b) Young people should be provided with the opportunity to experience skill-based learning through an integrated, holistic health education programme with a

commitment to a safe and health-enhancing social and physical environment free from alcohol.

c) Ensure that school-based alcohol education is integrated into the concept of health promotion at all levels.

d) Alcohol education to be included within the national curriculum from standard five onwards.

e) Support relevant non-governmental programmes and networks that have experience and competence in advocating policies at international and country levels to reduce the harm that can be caused by alcohol especially among the young people.

f) Include a compulsory element of the curriculum dealing with alcohol use and misuse for student doctors, nurses, midwives and health visitors.

g) Enhance fines and include jail terms for selling alcohol to underage persons.

5.5.10 Illicit Alcohol (Moonshine)

Over half of the beverage alcohol consumed in Kenya and around the world is "unrecorded." Often called "non-commercial alcohol" or "moonshine," these beverages are generally not taxed or regulated, and their sale and purchase cannot be easily monitored or quantified. "Moonshine" is an integral part of the drinking culture. While much non-commercially produced alcohol is of high quality, low quality, contaminated, or even toxic beverages can represent a serious public health problem.

Accordingly, the following policy interventions are proposed:

a) Enhance court fines or imprisonment term for the manufacturer, transporter or consumer in order to deter the manufacture supply, procession and consumption.

b) Make confiscation and destruction of seized of the illicit alcohol compulsory

c) Empower the District Alcoholic drinks Licensing committee board to issue occasional licenses regarding all forms of non commercial alcohol

d) Deploy additional customs and public health officers officers to try to reduce cross-border smuggling of illicit alcohol.

e) Sensitize and build capacity of the manufacturers on product standards and safety to prevent illicit production.

5.5.11 Controlling poor drinking habits and patterns

Patterns of drinking are reliable predictors of outcomes, whether positive or negative. One drinking pattern that has been associated with negative outcomes is the "binge", which has received much attention as a public health concern, in particular in relation to young people. Binge drinking is a reckless, harmful and potentially deadly pattern of drinking. A "binge" drinking and other negative patterns require special attention and a targeted approach through prevention.

On the other hand, drunkenness or drinking intoxication is not a drinking pattern but the outcome of certain patterns that involve the consumption of substantial amounts of alcohol in a brief period of time. Because it is associated with a broad range of social and health

problems, both acute and chronic, drunkenness represents a public health and public order issue. Harm reduction approaches around reducing drunkenness and its outcomes are important prevention and policy measures. Drunkenness is a behaviour found across cultures and geographic borders. Past policies have focused on chronic misuse and dependence on alcohol and yet drinking to intoxication or "binge drinking" is the pattern of drinking which is most highly correlated with death, injury and illness as well as potential years of life lost.

In order to deal with the twin problems of binge drinking and drunkenness, the following policy interventions are proposed:

a) Appropriate and targeted health education messages reach patrons before the onset of risky drinking behaviour and such messages continue to be targeted at young adults throughout the years where "poor drinking habits and patterns" has been shown to be a prevalent behaviour

b) Licensees including all persons who serve alcoholic drinks should undergo responsible server training programme that aims to reduce levels of intoxication among patrons of licensed premises. Examples include refusal to serve patrons who are already or deemed drunk.

c) The Government and the research community establish more evidence about the health risks of bad drinking habits including "binge drinking and disorder" and their patterns.

d) Information on host responsibility should be displayed prominently licensed premises.

5.5.12 Collaboration and Partnerships

The following agencies should be integrated in the implementation of this policy:

1. Ministry of State, Internal Security and Provincial Administration
2. Ministry of Health/Medical service
3. NACADA Authority
4. Ministry of Trade and Industrialization
5. Ministry of Finance
6. Ministry of Education
7. Ministry of Gender-Children's Department
8. Department Weights and Measures
9. Kenya Bureau of Standards (KEBS)
10. Kenya Revenue Authority (KRA)
11. Ministry of Planning
12. Ministry of Local Authority(County Government)
13. Police (Administration Police and Kenya Police)
14. Media
15. Industry players
16. Faith-Based Organization
17. Non-governmental Organization

5.5.13 Resources to support policy implementation

a) Given the public health importance of the National Alcohol Policy, the Kenya government, development partners and other stakeholders involved in the alcohol industry have an obligation to make sufficient resources available for purposes of implementing, regulating, monitoring and evaluating various aspects of the policy.

b) A legislation shall be enacted to establish an Alcoholic Drinks Control Fund to finance the implementation of this policy

c) Provide support for nongovernmental organizations and networks that have specific roles to play in informing and mobilizing civil society with respect to alcohol-related problems, lobbying for policy change and effective implementation of policy at government and society level.

d) Organizations and networks that have a role in providing care to persons whose conditions were inflicted or caused by alcohol e.g. associations of health care professionals, consumer organizations and health facilities should be supported by the government or any other lawful entity in terms of financial, material or technical support in order assist in increasing coverage of interventions to those in need.

e) Mainstream alcohol related harm reduction strategies in medical training colleges, hospitals, health centres, dispensaries and clinics in both urban and rural areas.

Chapter 6 – Management and coordination

6.1 Institutional Framework

In order to effectively administer alcohol related laws and regulations and implement this policy, NACADAA in collaboration with relevant departments shall be the responsible authority to oversee implementation and enforcing of all matters related to Alcohol which shall include and not limited to regulation of production, sale, licensing, consumption, advertising and promotion, research and public awareness.

The funding for NACADAA shall be drawn from the Exchequer. The funding will also cater for any other alcohol policy and law implementing agencies established by the government. NACADAA will work closely with other stake holders in the alcohol industry including those institutions that are responsible for carrying out regulatory activities on matters pertaining to the reduction of alcohol related-harm among others.

6.2 Implementation Framework

In order to give effect to this policy, various government departments shall be directly responsible for implementing this policy in collaboration with other players in the alcohol industry. NACADAA will take responsibility in coordinating the development of the policy implementation strategy in consultation with all relevant stakeholders in the alcohol industry. The implementation strategy of the National Alcohol Policy shall be reviewed after every five years in line with the policy priorities presented in this document.

6.3 Coordination of Stakeholders

The government recognizes the role different stakeholders such as civil society, religious institutions, players in the alcohol industry such as manufacturers, professional associations, the media etc could play in the alcohol industry to minimize alcohol related-harm. Therefore, the government shall seek to collaborate with these players in order to effectively and efficiently coordinate implementation activities. In order to make coordination efforts meaningful and efficient, appropriate periodic meetings or fora shall be held during which information on progress made, constraints experienced and planned activities with regard to the implementation of alcohol policy will be shared and discussed by the stakeholders.

Chapter 7 – Monitoring, Evaluation and Research

7.1 Policy Monitoring

The government recognizes the necessity of making this policy address the real needs of society and the emerging trends concerning all aspects of the beverage alcohol. Therefore, NACADAA will be charged with the responsibility of monitoring the implementation of this policy in relation to each policy directive herein and the benchmarks set by the implementation strategy of the National alcohol policy.

7.2 Policy Evaluation

NACADAA together with the relevant government ministries and departments shall be carrying out an evaluation of the alcohol policy after every 5 years in order to ensure that the policy is relevant and effective in achieving the policy goal and objectives set herein. An all inclusive and participatory action plan on reducing alcohol related-harm with clear targets and outputs as well as tracking indicators for progress will be developed.

7.3 Research Priorities

Research is a powerful strategy for providing evidence-based information for policy formulation and review, and for development of guidelines and standards. NACADAA together with all the key stakeholders in the alcohol industry will continue addressing alcohol-related problems on the basis of solid research evidence. This approach is likely to yield more benefits in informing policy making processes and evaluation of interventions as opposed to situations where unevaluated or ineffective strategies and interventions are implemented without any scientific basis at all. NACADAA will encourage other stakeholders to promote research and exchange of information between researchers and the end-users of research results with regard to various aspects of alcohol especially on issues of public health importance.

Key areas to be focused on will include:

(a) Developing standardized tools for gathering monitoring and evaluation information including a system for reporting on alcohol consumption and for monitoring and evaluating the implementation of alcohol policy and the harm that can be caused by alcohol.

(b) Giving consideration to improving theoretical models for assessing social, health and economic costs of alcohol which take proper account of the benefits of moderate use

(c) Conducting more research into the health effects of alcohol consumption

(d) Conduct more lifestyle research into the relationship between alcohol and crime which focuses on drinkers and drinking rather than crime and criminals

(e) Conduct further research into the effects of patterns of drinking on breast cancer risk.

(f) Conducting studies in the priority policy components and intervention areas outlined in section 5.5

(g) Conducting quantitative and qualitative studies on the lethal synergy between HIV and alcohol among different population subgroups besides other priority areas.

References

1) Acuda S. W. (1982). Drinking Patterns in a Rapidly Changing Culture. In Drug Problems in Socio-Cultural Context, the Basis of Policies and Programmes for Prevention Ed. Edwards .G. and Arif .A. Geneva 1982.

2) Acuda S. W. (1985). Alcohol and Alcohol Problems Research. International Review Series Number 1 (East Africa) British Journal of Addictions 80. 1985.

3) Acuda S. W. Mental Health Problems in Kenya Today. A Review of Research. East African Medical Journal Vol. 60. No. 1 Jan. 1983.

4) African Regional Workshop on Self Regulation. 15th – 17th October, 2006. Cape Town, South Africa.

5) Alcohol per capita consumption, patterns of drinking and abstention worldwide After 1995. Appendix 2 European Addition Research 2001, 7(3): 155-157.

6) Anne .M. Roche Drinking Behaviour: A multifaceted and Multiphasic Phenomenon in Learning About Drinking. (PP1-34). International Centre for Alcohol Policies. Brunner & Routledge 2001.

7) Ashenden R, Silagy C, Weller D. A systematic review of the effectiveness of promoting lifestyle change in general practice. Family Practice 1997;14:160-75.

8) Ayisi J. G. et al 2000. "Risk Factors for HIV infection among symptomatic Pregnant women attending an antenatal clinic in Western Kenya" International Journal of STDs & AIDS, 11: 789 – 797.

9) Babor *et al 2003: Alcohol: No Ordinary Commodity - Research and public policy.*

10) Babor T, Caetano R, Casswell S, Edwards G, Giesbrecht N, Graham K, et al. Alcohol: no ordinary commodity. Oxford: Oxford University Press, 2003.

11) Badia Peter (1985). Alcoholism among In-Patients at Mathari Mental Hospital Mmed Dissertation Thesis, Department of Psychiatry, University of Nairobi.

12) Bangert-Drowns R. The effects of school-based substance abuse education - a meta-analysis. Journal of Drug Education 1988;18:243-64.

13) Bien T, Miller W, Tonigan J. Brief interventions for alcohol problems: a review. Addiction 1993;88:315-336.

14) Brett Bivans. Comments on the Alcohol Draft Policy Document, 27th July, 2007 Nyeri Workshop, NACADAA May, 2007.

15) Bruun, K., Edwards, G., Lumio, M., K., M., Pan, L., Popham, R. E., Room, R., Schmidt, W., Skog, O. J., Sulkenen, P., & Osterberg, E. *Alcohol Control Policies in Public Health Perspective*. Helsinki: Finnish Foundation for Alcohol Studies, 1975.

16) Bryant K. J. 2006 "Expanding Research on the role of alcohol consumption and Related risks in the prevention and treatment of HIV/AIDS". Substance Use and Misuse 41: 1465 – 1507.

17) Coben J, Larkin G. Effectiveness of ignition interlock devices in reducing drunk driving recidivism. American Journal of Preventive Medicine 1999;16 (1S):81-7.

18) Current Research on Alcohol Policy and State Alcohol and other Drug (AOD) Systems Brief Prepared by National Association of State Alcohol and Drug Abuse Directors (NASADAD) August, 2006 USA.

19) Domestic Violence in Kenya: Report Baseline Survey among women in Kenya. FIDA, Kenya 2002.

20) Edwards et al.. *A Summary of Alcohol Policy and the Public Good. A Guide for Action.* Oxford, England: Oxford University Press and WHO Eurocare, December 1995.

21) Edwards M, Steinglass P. Family therapy treatment outcomes for alcoholism. Journal of Marital and Family Therapy 1995;21:475-509.

22) Eleni Houghton & Ann .M. Roche. Learning About Drinking, International Centre for Alcohol Policies, Brunner-Routledge 2001.

23) Fiellin D, Reid M, O'Connor P. Screening for Alcohol Problems in Primary Care. A systematic review. Archives of Internal Medicine 2000;160:1977-1989.

24) Giesbrecht, Norman. *Proposed Privatization of Retail Alcohol Sales in Ontario: Health, Social, Economic and Safety Implications.* Toronto: Addiction Research Foundation, 1995.

25) Global Status Report Alcohol Policy. World Health Organization, Geneva 2006.

26) Hansen W. School-based substance abuse prevention: a review of the state of the art in curriculum, 1980-1990. Health Education Research 1992;7:403-30.

27) Haworth A. & Acuda Wilson (1998) Sub-Saharan Africa. In M. Grant (Ed). Alcohol and Emerging Markets: Patterns, problems and responses (pp. 19-90) Philadelphia: Brunner / Mazel.

28) Hulscher M, Wensing M, van der Weijden T, Grol R. Interventions to implement prevention in primary care (Cochrane Review). In: The Cochrane Library, Issue 2 2003. Oxford: Update Software. 2003.

29) ICAP, International Center for Alcohol Policies, 2003. http://www.icap.org/.

30) Jernigan, H. *Global Status Report: Alcohol and Young People*. Geneva: World Health Organization, 2001.

31) Kahan M, Wilson C, Becker L. Effectiveness of physician-based interventions with problem drinkers: a review. Canadian Medical Association Journal 1995;152:851-9.

32) Kenya Police Statistics: Categories of Crimes Dangerous Drugs & Traffic Offenses 2004, 2005 and 2006.

33) Kenya Prisons Statistics Youth and Prison 2000, 2004, 2006.

34) Lower Alcohol Beverages International Centre for Alcohol Policies (ICAP Reports April 2007.)

35) Marcus Grant & J. Litrak (1997) Drinking Patterns and their consequences. Washington DC Taylor & Francis

36) Marcus Grant, Alcohol and Emerging Markets: Patterns, Problems and Responses. International Centre For Alcohol Policies. Philadelphia Brunner & Mazel 1998.

37) Ministry of Youth Affairs Statistics, http://www.youthaffairs.go.ke.

38) Mosher, J. F. & Rose, M. Works. *Confronting Sacramento. State Preemption, Community Control and Alcohol-Outlet Blight in Two Inner City Communities.* San Rafael, California: Marin Institute for the Prevention of Alcohol and Other Drug Problems, December, 1994.

39) Mulindi Sobbie & Paul Saoke. Report of the Workshop Launch of the Geneva Partnership on Alcohol and Workshop on Alcohol Policy in Kenya, May 2001 Nairobi.

40) National Forum on Health. (1996). What Determines Health? Summaries of a series of Papers on the Determinants of Health Commissioned by the National Forum on Health. Available:

41) National Health Service (2002): National Alcohol Harm Reduction Strategy, a response from the PORTMAN GROUP to the Consultation Document published by The Strategy Unit and Department Of Health December 2002

42) NHS Health Scotland: Public Health Policy on Alcohol – An International Perspective, March 2005.

43) Odero .W. Alcohol-related road traffic injuries in Eldoret, Kenya. East African Medical Journal 1998, 75(12) 708-711.

44) Odero W., Zwi A.B. Drinking and driving in an urban setting in Kenya. East African Medical Journal 1997, 74(11) 675-679.

45) Othieno C. J., Kathuku D. M., Ndetei D. M. Substance abuse in outpatients Attending rural and urban health centres in Kenya. East African Medical Journal 2000, 77(11): 592-595.

46) Othieno C. J., Obondo A.A., Kathuku D. M., Patterns of substance use among Kenyan Street Children. Southern African Journal of Child and Adolescent Mental Health 2000, 12(2) 145 – 150.

47) Peek-Asa C. The effect of random alcohol screening in reducing motor vehicle crash injuries. American Journal of Preventive Medicine 1999;16 (1S):57-67.

48) Pernanen, K. & Brochu, S. *Attributable Fractions for Alcohol and Other Drugs in Relation to Crimes in Canada Literature Search and Outlines of Data Banks.* Ottawa: Canadian Centre on Substance Abuse, 1998. Available [http://www.ccsa.ca/docs/kairap1.htm].

49) Plant M, Single E, Stockwell T. Alcohol: Minimising the harm. What works? London: Free Association Books, 1997.

50) Raistrick D, Hodgson R, Ritson B. Tackling Alcohol Together. The Evidence Base for a UK Alcohol Policy. London: Free Association Books, 1999.

51) Responsible Drinks Marketing: Shared Rights and Responsibilities. Report of ICAP Expert Committee. Internal Center for Alcohol Policies.

52) Ross, H.E., "DSM-IIIR Alcohol Abuse and Dependence and Psychiatric Co-morbidity in Ontario: Results from the Mental Health Supplement to the Ontario Health Survey." *Drug and Alcohol Dependence*, Vol. 39 (1995): 111-128.

53) Rubel .W. Chang'aa: distilled alcohol in Kenya (http://williamrubel.com/alcohol/changaa.html).

54) Rundall T, Bruvold W. A meta-analysis of school-based smoking and alcohol use prevention programs. Health Education Quarterly 1988;15:317-34.

55) Shaffer. SN, R. Njeri, AC Justice, et al 2004. "Alcohol abuse among patients with And without HIV infection attending public clinics in Western Kenya". East African Medical Journal 81: 594 – 598.

56) Sharing Best Practice in Self-Regulation: An International Workshop. London United Kingdom 28 & 29 October 2004 Meeting Report International Centre for Alcohol Policies www.ICAP.org.

57) Shults R, Elder R, Sleet D, Nichols JL, Alao M, Carande-Kulis V, et al. Reviews of Evidence Regarding Interventions to Reduce Alcohol-Impaired Driving. Am J Prev Med 2001;21:66-88.

58) Single, E. et al.. *Alcohol and Drug Use: Results from the General Social Survey, 1993*. Ottawa: Health Promotion Directorate, Health Canada, 1994.

59) Single, E., MacLennan, A., MacNeil, P. *Horizons 1994: Alcohol and Other Drug Use in Canada.* Ottawa: Health Canada and the Canadian Centre on Substance Abuse, 1994.

60) Single, E., Robson, L., Xie, X. & Rehm, J. *The Costs of Substance Abuse in Canada, Highlights of a Major Study of the Health, Social and Economic Costs Associated with the Use of Alcohol, Tobacco and Illicit Drugs.* Ottawa: CCSA, 1996.

61) Smart R, Goodstadt M. Effects of reducing the legal alcohol-purchasing age on drinking and drinking problems: a review of empirical studies. Journal of Studies on Alcohol 1977;38:1313-23.

62) Some E. S. Misuse of drugs: perceptions of household heads in Kisumu District Kenya. East African Medical Journal 1994, 71(2) 93-97.

63) The Geneva Partnership on Alcohol Toward a Global Charter 2000. International Center for Alcohol Policies. Geneva.

64) The Kenya Beer Industry 2005 Report Export Processing Zones Authority Report. www.epza Kenya.com.

65) The Structure of the Beverage Alcohol Industry, March 2006, International Centre For Alcohol Policies Reports 17.

66) US Department of Health and Human Services. 10th Special Report to the US Congress on Alcohol and Health. Washington DC: US Department of Health and Human Services, 2000. http://www.niaaa.nih.gov/publications/10report/intro.pdf

67) US General Accounting Office. Drinking-Age Laws: an evaluation synthesis of their impact on highway safety. Washington, DC: US GAO, 1987. http://161.203.16.4/d2t4/132530.pdf

68) USAID Research Update 2007 Horizons should Voluntary Counselling and Testing Counsellors Address Alcohol Use with Clients. Findings from An Operations Research Study in Kenya.

69) Wagenaar, A.C. & Holder, H.D. "Changes in Alcohol Consumption Resulting from the Elimination of Retail Wine Monopolies: Results from Five U.S. States," *Journal of Studies on Alcohol,* Vol. 56, No. 5, (Sept. 1995): 566 - 572.

70) Wells-Parker E, Bangert-Drowns R, McMillen M, Williams M. Final results from a meta-analysis of remedial interventions with drink-drive offenders. Addiction 1995;90:907-26.

71) West, P., Giesbrecht, N., & Pius, B. *Alcohol Policy, Consumption Patterns, Access to Alcohol, and Harmful Effects of Drinking. Preliminary Report: Based on the 1995 Ontario Alcohol and Other Drugs Opinion Survey*. Toronto: Addiction Research Foundation, 1995.

72) WHO Summary Report (2003): *Addiction,**98**, 1343-1350,* published by 2003 Society for the Study of Addiction to Alcohol and Other Drugs.

73) WHO. Health 21. The health for all policy framework for the WHO European Region. Copenhagen: WHO, 1999.

74) Zaza S, Carande-Kulis V, Sleet D, Sosin D, Elder R, Shults R, et al. Methods for Conducting Systematic Reviews of the Evidence of Effectiveness and Economic Efficiency of Interventions to Reduce Injuries to Motor Vehicle Occupants. Am J Prev Med 2001;21:23-30.

75) Zwerling C, Jones M. Evaluation of the effectiveness of low blood alcohol concentration laws for younger drivers. American Journal of Preventive Medicine 1999;16(1S):76-80.

Appendices

Appendix I: List of Participants at the Product Quality, Standards, Administration and Enforcement Workshop at Green Hills Hotel, Nyeri

NO	Name	Organization	TEL NO
1.	Tobias Angela Ololo	Kenya Bureau of Standard	0722 - 734921
2	Daniel O. Bolo	O. O. P	0722 - 619677
3	Kiragu Wachira	International Trade Advisory Services	0722 - 218233
4	Fred Nabea	PARAGON	0722 - 523717
5	Kiarie Waweru Kiarie	Judiciary	0722 - 600124
6	Kennedy Mwangome	Prov. Administration	0723 - 287704
7	K.C. Kabetu	NACADAA	0722 - 499830
8	Elija M. Nayaribo	K.R.A Nyeri	0724 - 275671
9	Joseph Yano	MOH /PPB	0722 - 331995
10	Julie Moraa	Provincial Administration	0726 - 660885
11	J. Kibuthi	G. Chemist	0721 - 839351
12	Bernard M. Mbogoh	MOH- HQs	0722 - 310105
13	Redemta Koki	TSC	0721 - 726622
14	Moses Waweru	SCAD	0720 - 563217
15	Caren Wakoli	NYC	0733 - 223205
16	David Ogot	Going Home Dotcom	0733 - 989083
17	David O Kebati	NACADAA	0720 - 755804
18	Burugu J.N.	M.O.Y.A	0722 - 852195
19	Miriti Mangu	Kenya Scouts Association	0723 - 982871
20	Simiyu Sosio	NACADAA	0722 - 324566
21	Odillia Mwani	Teacher	0721 - 646771
22	Owiti F.R (Dr)	Consultant	0733 - 610978
23	Sobbie A.Z Mulindi	Consultant	0723 - 455115
24	Maua Susan	Psychologist	0722 - 609276
25	George Murimi	NACADAA	0723 - 349731
26	Hassan Wafula	Prisons	0723 - 919637
27	Lucy Ndayara	NACADAA	0724 - 102285
28	Dr. Kisivuli A. Jackson	Mathari Hospital	0722 - 829757
29	Bernard Mwangi K.	Asumbi	0721 - 916582
30	Susan Gitau	Mathari Hospital	0724 - 730117
31	Charity W. Giteru	K.R.A	0721 - 76594
32	James Mwenda	Solicitor General	0721 - 273279
33	Agnes Lempaa	M.O.Y.A	0722 – 231092
34	Dr. Peter M. Gaku	MASAA	0722 - 877617
35	Prof. Gershom N. Amayo	ICPA KENYA UEB	0733 - 638887

Appendix II: List of Participants (Nakuru Workshop)

NO	NAME	ORGANIZATION	TEL	EMAIL
1	Alice Opee	PERAK/ENTER.	0722-990329	prime_stuff@yahoo.com
2	Muthui Kariuki	PRMASTERS	0722-518692	Mkariuki@prmaster.co.ke
3	Kiruri Kamau	CONSULTANT	0722-808578	kirurikamau@yahoo.com
4	John K. Kibathi	MOH – GC	0721-839351	gchemist@yahoo.com
5	Kiarie W. Kiarie	JUDICIARY	0722-600129	kiariewawerukiarie@yahoo.com
6	Caren Wakoli	GCAP/EFW	0733-222205	cwakoli@yahoo.com
7	Seneiya Kamotho	EMPIRIS	0726-609290	empiris101@gmail.com
8	James Mwenda	A.G CHAMBERS	0721-273279	mwenda_james@yahoo.com
9	Fred Nabea	PARAGOR	0721-523717	flenabea@yahoo.com
10	Julius P.G. Ndungo	GGHHT	0722-769426	jgndungo@yahoo.co.uk
11	Dr. Sobbie Mulindi	UON/KNH	0723-455115	drmulindi@yahoo.com
12	Gerald Masila	NABAK / KWAL	0722-516250	gmasila@kwal.co.ke
13	Dr. P. M. Mbugua	UON	0722-702694	pmungai@uonbi.ac.ke
14	Agnes S. Lempaa	MOYA	0722-231092	agnes@yahoo.com
15	Sam Ikwaye	PERAK/KAHC	0722-942054	peraucoast@yahoo.com
16	Joseph Mindo	NACADAA	020-2074953	propapoa@yahoo.com
17	Itumbi Patrick	NAIROBI	0723-763679	pitumbi@domc.or.ke
18	Miriti A. J. Mangu	KENYA SCOUTS	0723-982871	alfredmiriti@yahoo.com
19	B. Y. Tuikong	MOIC	0723-376589	
20	Dr. R. M. Gakunju	MASAA	0722-714978	drrgakunju@gmail.org
21	Bernard M. Mbogo	MOH (DEH)	0722-310105	mbogotibernard@yahoo.com
22	Kiragu Wachira	CONSULTANT	0721218231	kiraguwachira@yahoo.com
23	Dr. Fred Owiti	CONSULTANT	0733-610978	fowiti@usiu.ac.ke
24	A. S. Biko	PDES REP.	0721-994631	
25	Dr. Violet Okech	KNH	0721-704716	aviookech@yahoo.com
26	Dr. Ndege P.K.	NACADAA	0722-642744	pkndege@yahoo.com
27	L. R. Ochieng	KUPPET	0723-315955	leonardochieng2006@yahoo.com
28	Hassan F.M. Wafula	PRISONS	0722-919637	hassanstima@yahoo.com
29	Dr. Yano Joseph	PPB	0722-331995	josephyamo@yahoo.com
30	Tom Chariga	KUPPET	0722-520975	tomchariga@yahoo.com
31	Francis W. Maliti	MOTI	0720430798	fmaliti@tradeandindustry.go.ke

Appendix III: List of Participants in Alcohol Policy Stakeholders' Meeting Held at Serena Hotel, Nairobi

	Name	Title	Organisation	Telephone	Email
1	Dr. Keith Evans	Senior Consultant	Australian Govt		evansk@internode.on.net
2	Mitch Ramsay	Consultant	Inter Centre for Alcohol Policies		evansk@internode.on.net
3	Nicholas Etyang	Dep Commandant	Admin Police	020-823216	
4	David K. Birech	Superintendent of Police	C.I.D.	0722-245610	birechdavid@yahoo.com
5	Dr. C.E. Ekuttan	Epidemiologist	Dept. of Defence	0724-224320	acekuttan@yahoo.com
6	Ken N. Kariuki	Director of Corporate Affairs	EABL	020-886213	kenkeea@yahoo.com
7	Damon Ansell	Corporate Affairs	Diageo	0734-167589	Damon.ansell@gmail.com
8	Justine Ombuti	Journalist	Parallel media	0722-370949	justineombati@yahoo.com
9	James Mwenda	Counsel	Attorney General's Office	0721-273279	mwendajames@yahoo.com
10	Kirunya Limbitu	SSP	Police Headquarters	0721-815927	
11	David Ogot	Prog Coordinator	Going Home Dot Com		goinghomedotcom@yahoo.com
12	Jane Waikenda	Under Secretary	Immigration Dept	020-222022	jwaikenda@yahoo.com
13	Daniel Bolo	A.O.D.	NACADAA	0722-619677	dnbolo@yahoo.com
14	Connie Kivuti	Director	Emerging Leadership	0723-886313	Braved-heart@hotmail.com
15	Nancy Linet Mahihu	Consultant	NACADAA	0722-361578	Linnet2003@lycos.com
16	Mary Onyango	TV Manager	KBC	020-341173	marygonyango@yahoo.com
17	Fr. John Karimi	Counsellor	SAPTA Centre	0723-716091	Karimindari2003@yaho.com
18	Steve Kihingya	Ass. Comm	KRA	0722-844085	Stephen.kihingya@kra.go.ke
19	Newton K. Musau	Ass Comm	KRA	0722-617523	umagu@kra.go.ke
20	Dr. Sobbie Mulindi	Consultant	UON/KNH	0723-455715	drmilindi@yahoo.com
21	Dr. D.M. Kiima	Director – Mental Health	MOH	0722-845735	kiima@wananchi.com
22	W. Muchiri	CEO	NCBDA	020-219412	dmh@health.go.ke
23	Sanjay Mahajan	Manager	London Distillers Ltd	020-531007	info@londondistillers.com
24	Katana Ngowa	DS	OVP – Ministry of Home Affairs	0721-463945	Katanangowa05@yahoo.com
25	Dr. F.R. Owiti	Psychiatrist	CLMC	0733-361078	fowiti@usiu.ac.ke
26	Miriti Mangu	NEC	Kenya Scouts Association	0723-982871	kenyascouts@yahoo.com
27	J. Muia	Admin Assist	NCBDA	020-219412	ncbda@africaonline.com.ke

28	Kevina Chemsto	Media	Waumini Radio	0727-440728	kcchemsto@yahoo.com
29	Steve Mbogo	Media	B. Dowly	0722-214261	stevembogo@gmail.com
30	Lucianne Limo	Media	Standard Group	0722-818946	
31	Moses Koech	Reporter	Kenya Times	0722-507700	moseskoech417@yahoo.com
32	Wanjiru Waithaka	Reporter	Business Daily	0722-247838	wwaithaka@nation.co.ke
33	Moses Kofa	Reporter	Biblia Husema	0720-411959	bhbnews@yahoo.com
34	Washington Sekub	Reporter	Kenyan Spectator	0720-287624	newskenya@gmail.com
35	Ken Andiema	Reporter	Citizen TV	0723-416691	betkip@yahoo.com
36	Carlos Cheluget	Reporter	KASS FM	0720-775677	Carloskim2002@yahoo.com
37	Esther Kangethe	Reporter	Citizen Radio	0720-942029	essremoyo@yahoo.com
38	Valerie Aseto	Reporter	Times Newspaper	0720-875260	valaseto@yahoo.com
39	Okama Ademita	Marketing Executive	KBC	0722-305692	ademitam@yahoo.com
	Name	**Title**	**Organisation**	**Telephone**	**Email**
40	James Kumeiya	Director	Baffin Ent.	0723-960646	jakigi@yahoo.com
41	Simiyu Sosio	Prog Officer	NACADAA	0722-324506	sosiosteve@yahoo.com
42	George Murimi	Counselor	NACADAA	0723-349731	murimikariuki@yahoo.com
43	Frank Omari	Coordinator	ECBO	0724-414041	omarfrankj@yahoo.com
44	Violet Onyangi	Advocate	Njugi BG Advocates	0733-781374	voyangi@yahoo.com
45	Chelangat Mutai	Advocate	Njugi BG Advocates	0720-293790	muttzig@yahoo.com
46	Edwin Wachira	Org. Secretary	CHAN	0721-932037	ewachiraw@yahoo.com
47	Bernard Onyarim		Ess-Green	0725-689753	Onyanda1973@yahoo.com
48	John Litunda	DC	GOK	044-20889	
49	Jamlick Baruga	DC	GOK	057-2125814	
50	David Awori		NYS	020-8560224	
51	Caleb Angira	Coordinator	Asumbi TTC	0733-901657	asumbitc@yahoo.com
52	Daniel Obam	Communication Expert	MOIC	020-27119953	Daniel_obam@yahoo.com
53	Katherine Muoki	Economist	GOK	020-25229	kmuoki2002@yahoo.com
54	Dr. Elizabeth Ogaja	Dep Chief Pharmacist	MOH	0722221774	lizogaja@health.go.ke
55	Rev. Tom Otieno	Pastor	ACK	0722-786499	christchildrench@kenyaweb.com
56	Isaac B. Naderia	Counselor	Prisons Dept	0721-973056	naderiaisaac@yahoo.com
57	Elizabeth Taka	Marketing Dept	Keroche Industries	0722-357243	nanyingi@yahoo.com

58	Gerald Kimeu	Prog Officer	CFYD	0727-598393	kimeuge@yahoo.com
59	Hanna Kiarie	Industrial Dev. Officer	MOT/GOK	020-315001	hkiarie@tradeandindustry.go.ke
60	Muhia N Michael	Chief Principal	Upper Hill High School	020-3003858	
61	Kimutai Simon	Chairman	MOA/POWAK	0722-522275	mwakenya2003@yahoo.com
62	Rymer Sikobe	Head, Lupots Promotions	GOK/NMOA	0734-463580	sikobery@yahoo.com
63	Agnes Lempaa	CYO	Ministry of Youth	0722-231092	
64	Kiriro wa Ngugi	CEO	Lobbying Associates	0722-558780	kiriro@lobbyingassociates.com
65	Moses Waweru	CEO	SATP	0720-563217	Moses.waweru@yahoo.com
66	Kiragu Wachira	Chief Executive	Int. Trade Law Advisory Services	0721-218231	kiraguwachira@yahoo.com
67	Masudi Ngeywo	Revenue Officer	KRA	020-2813044	masudic@yahoo.com
68	Dr. Kibosia J.	Director	Prisons Health	020-2010909	jkibosia@yahoo.com
69	Dickson Mbugua	Chairman	POWAK (PSV)	0722-670996	matatuwelfare@gmail.com
70	Bernard Mbolwa	PHO	MOH	0722-310705	lemambogo@yahoo.com
71	Onyango Ondeng	Prog Officer	NACC	0721-295355	ondengke@yahoo.com
72	Franklin Magaju	DS	OOP	0721-243728	
73	J. Wangocho	Marketing Officer	Agro-Chemical & Food	0722-657672	acfcnbi@africaonline.co.ke
74	G. Ogunya	Marketing Manager	Agro-Chemical & Food	0722-657672	marketing@acfc.co.ke
75	Damaris Wachira	Reporter	People Daily	0721-647416	damagivens@yahoo.com
76	Abute C.	Reporter	People Daily	0721-973623	
77	Jane W. Mwangi	Ass Director	Probation Dept	0722-703558	Mwangi.jane@yahoo.com
78	Phoebe Okall	Photojournalist	Kenya Times	0723-543285	okalph@yahoo.com
79	Agnes Odawa Kinyanyi	Ass Director	MOE	0720-458186	kodawa4@yahoo.com

Appendix IV: List of Participants in Alcohol Policy Media Consultative Group Meeting Held at Serena Hotel, Nairobi

	Name	Organisation & E-mail contact	Other contact
1.	Lucy Kuserwa (representing Mr. Gerald Masila – MD KWAL)	Kenya Wines Agencies Ltd (KWAL) masila@kwal.co.ke	Box 40550, 00100 Nairobi
2.	Sanjay Mahajan Marketing Manager	London Distillers Kenya Limited sales@londondistillers.com	Box 57387, 00200 Nairobi
3.	Richard Mukoma Vice Chairman – APA	APA rmukoma@ogilvy.co.ke	Box 30280, Nairobi
4.	Ken Kariuki Director of Corporate Affairs	East Africa Breweries Ltd (EABL) kenkariuki@eabl.com	Box 30161, Ruaraka (NBI)
5.	Sheila Amdany Radio Simba	Advertising Standards Committee / Media Owners Association samadny@radiosimba.co.ke	
6.	Prof. Solly Rataemane	University of Limpopo, South Africa sratama@mweb.co.za	Box 164, Medunsa 0204, South Africa
7.	Mary Onyango (representing MD – KBC)	Kenya Broadcasting Corporation	Box 30456, Nairobi
8.	Isaac M. Nkari	Kenya Broadcasting Corporation	Box 30456, Nairobi
9.	Rev. Tom Otieno	Anglican Church of Kenya / NACADAA Advisory Board christchildack@kenyaweb.com	Tel: 0722-499786
10.	Patricia Ithau	East Africa Breweries Ltd (EABL) patricia.ithau@eabl.com	Box 30161, Ruaraka (NBI)
11.	Joanne Mwangi	Advertising Standards Committee joanne@pms.co.ke	
12.	Tom Sitati	Marketing Society of Kenya sitati@brandscope.co.ke	
13.	Franklin Magaju	OOP/Provincial Administration & Internal Security	
14.	Dr. Sobbie Mulindi	University of Nairobi / Kenyatta National Hospital drmulindi@yahoo.com	Tel: 0723-455115
15.	Kiriro wa Ngugi	Lobbying Associates Kiriro@lobbyingassociates.com	
16.	Connie Kivuti	Emerging Young Leaders info@eylafrica.com	

Published by: Office of the President
Department of Internal Security and Provincial Administration
National Campaign Against Drug Abuse Authority
NSSF Building, Block 'A' Eastern Wing
Bishops Road
P.O. Box 10774, GPO 00100
Nairobi, Kenya
Email: nacada@mail2world.com
Website : www.nacada.go.ke