Barriers and Facilitators to Treatment for Alcohol Use Among Fathers in Kenya:

A Qualitative Study

by

Puja Patel

Duke Global Health Institute
Duke University

Date:_____

Approved:

_____
Eve Puffer, Supervisor

_____
Christina Meade

_____
Bronwyn Kaiser

Thesis submitted in partial fulfillment of
the requirements for the degree of
Master of Science in the Duke Global Health Institute
in the Graduate School of Duke University

2018

ABSTRACT

Barriers and Facilitators to Treatment for Alcohol Use Among Fathers in Kenya:

A Qualitative Study

by

Puja Patel

Duke Global Health Institute
Duke University

Date:_____

Approved:

_____
Eve Puffer, Supervisor

_____
Christina Meade

_____
Bronwyn Kaiser

An abstract of a thesis submitted in partial
fulfillment of the requirements for the degree
of Master of Science in the Duke Global Health Institute
in the Graduate School of Duke University

2018

Abstract

Introduction: Substance use disorders account for 9.6% of Disability-Adjusted Life Years worldwide. In Kenya, close to 3 million individuals are reported to abuse alcohol, but a notable treatment gap persists. This problem is especially pronounced among men, leading to negative consequences at individual and family levels. This study examines the perceptions of problem-drinking fathers in Kenya regarding previous experiences with receiving help related to alcohol use. The experiences and dynamics of the family as they pertain to help-related experiences are also explored. **Methods:** In Eldoret, Kenya, semi-structured qualitative interviews were conducted with 11 families, which consisted of the male exhibiting problem drinking, their spouse, and one child. Thematic content analysis was used to examine themes related to barriers and facilitators to treatment. **Results:** Participants only reported informal help delivered by family and community members; they exhibited very little awareness of available formal treatments. Families were deeply affected by the alcohol use and actively involved in seeking help. Results elucidated barriers and facilitators of fathers' acceptance of help. Three main barriers to help acceptance included: fathers perceiving help strategies as negative or harsh; negative peer influence; and ambivalence about quitting. Four facilitators to help acceptance were identified: fathers perceiving help to be positive and well-intentioned; financial motivation; perceived social-support for

behavior change; and fathers' motivation to decrease external stigma. Cultural factors, including religiosity and gender identities, emerged as strong influences on experiences of help. Overall, most help efforts were short-term and reported only to lead to very short-term behavior change. **Conclusion and Implications:** Families and communities are active in help provision for men in Kenya, though results confirm ongoing need for effective interventions. Future interventions could benefit from recognizing the role of the family in engaging men in treatment and attending to the identified barriers and facilitators in designing treatment strategies.

Contents

List of Tables

List of Figures

Acknowledgements

I would like to thank my advisor, Dr. Eve Puffer, in being instrumental in my success in the MSc program. I would like to thank my committee members, Dr. Christina Meade and Dr. Bonnie Kaiser, without whose guidance this thesis would not have been possible. I would also like to thank Ali Giusto and Elsa Healy for their continued support and encouragement. Not to forget my Team in Kenya: Wilter, Mercy, Eunice, Nancy, and Nathan, I thank them for their hard work and cooperation throughout my time in the field and after. Also, special thanks to Dr. Ayuku for guiding as well, for guiding and advising us throughout our journey. Additionally, I am would like to thank DGHI staff and faculty for always having the student's best interest in mind. I am also thankful for the love and support of my parents, friends, and mentors. I wouldn't be half the researcher I am without your unconditional and unwavering faith in me.

1. Introduction

Substance use disorder accounts for 9.6% of Disability-Adjusted Life Years (DALYs) worldwide (Whiteford et al., 2013), and approximately 5.9% of all deaths across the world are due to harmful alcohol use (World Health Organization [WHO], 2014). Currently, close to 3 million individuals are reported to abuse alcohol and over 2 million individuals are reported to be dependent on alcohol in Kenya (National Authority for the Campaign Against Alcohol and Drug Abuse [NACADA], 2012). Cross-culturally, studies have found that men consume higher rates of alcohol and are disproportionately impacted by harmful consumption compared to women (Wilsnack, Vogeltanz, Wilsnack, & Harris, 2000). Disparities between male and female alcohol consumption might be exacerbated due to cultural influences, such as strict gender roles and/or patriarchal social structure (WHO, 2005). In a study in Kenya, socially constructed gender roles were found to be associated with higher alcohol consumption among young men (Mugisha, Arinaitwe-Mugisha, & Hagembe, 2003).

Systematic reviews on harmful alcohol consumption have shown negative impacts on physical and mental health on an individual and familial level (Steel et. al., 2014; Rehm et. al., 2010). On the individual level men suffer from liver damage, certain cancers, and heart failure; on a psychological level, they suffer from issues such as depression and anxiety (Bofetta P & Hasibe M, 2006; Laonigro, Correale, Di Biase, & Altomare, 2009). On a familial level, high paternal alcohol use is associated with

domestic violence and early onset of substance abuse for the offspring (Lenord & Eiden, 2007).

1.1 Barriers and Facilitators to Treatment

Current literature on barriers and facilitators to alcohol treatment, as perceived by the patient, is heavily based on data from high-income countries (HICs). Studies in HICs have identified multiple common barriers to treatment as summarized in Figure 1. These include stigma, service accessibility (high cost, distance, and efficacy), culture, religion, perceived need, mental health, finances, and family related factors, such as family functioning, relationship between the couple, as well as child and father. (Saunders, Zygowicz, & D'Angelo, 2006; Meade et al., 2015; Benegal, Chand, & Obot, 2009). A community based study done on help-seeking barriers faced by untreated alcohol dependent persons found issues of cost and privacy also, individuals perceived their alcohol use to be an issue but it could be solved by themselves, and not problematic enough to seek treatment (Tucker, Vuchinich, & Rippins, 2004). In a systematic review done on stigma in relation to treatment for alcohol disorders, Keyes et. al. (2011) found individuals with alcohol disorders who perceived stigma in the community were less likely to utilize mental health services; but closeness among family members predicted lower perceptions of stigma. In a mix methods study done by Meade et. al. (2015), individuals reported denial, fear of stigma, cost, and control over addition as barriers to substance abuse treatment in Cape Town, South Africa. There is currently

little to no literature on person-related barriers and facilitators in low and middle income countries (LMICs) but some indicators surface through qualitative research on alcohol consumption, such as fear of stigma compelling individuals to refrain from consuming alcohol, and lack of efficacious facilities (clinics being too far or too expensive) (NACADA, 2010).

1.2 Treatments in LMICs

Treatments are scarce in LMICs and the available treatments are often out of reach for rural populations (Myers, Louw, & Pasche, 2010). A review, done by Benegal et. al. (2009), of treatment efficacy and intervention delivery in LMICs found alcohol treatment facilities were mainly private clinics located in urban areas and usually have high fee structures; For some countries, there are government-funded clinics or counseling centers but the general efficacy is extremely low. Consequently, the median gap in treatment, between individuals who receive treatment and individuals who do not, for Alcohol Use Disorders (AUDs) in LMICs is an estimated 78.1% (Benegal et.al, 2009). In efforts to mitigate the increasing number of untreated population, the Mental Health Gap Action Programme (mhGAP, 2016) has published an intervention protocol for mental, neurological, and substance use disorders. The mhGAP protocol lists motivational interviewing, family & problem-solving counseling, and pharmacological therapy as a recommended treatment for alcohol use disorder with proven acceptability and feasibility in a few regions of South Africa (Myers et.al., 2012). A randomized

controlled trial done in India trained lay counselors using mhGAP guidelines on motivational interviewing methods to provide counseling for harmful alcohol use; participants who received the counselling in addition to primary care were more likely to report significantly low consumption and higher remission rates compared to their counterparts (Nadkarni, et. al., 2017).

In the past two decades, there also has been an increase in implementation of non-medical treatment interventions in LMICs. A review of available treatment for substance use disorders in developing countries showed a majority of available treatment venues to be Non-Governmental Organization (NGO) operated; these facilities have several non-medical social activists, often from Christian ministries (Salwan & Katz, 2014). Alcoholics Anonymous (AA), also known as the Minnesota Model is another non-medical treatment method that relies on spirituality and interpersonal relationships to promote behavior change (Galanter, 2016); it has been implemented in several LMICs, such as Brazil, Antigua, Trinidad and Tobago, and China (Salwan & Katz, 2014). There is a scarcity of information on church-based treatment interventions in low resource settings but data from HICs suggest church-based treatment interventions, which incorporate church communities for culturally relevant group activities, and offered personal mentoring by church volunteers, saw higher retention and better outcomes at 6-month follow up for substance abusing individuals (Stahler, Kirby, & Kerwin, 2007).

Kenya currently has a few counseling and rehabilitation centers located in urban areas; most of these locations provide inpatient and outpatient services for individuals suffering from mental health and/or addiction problems (NACADA, 2017). The National Authority for the Campaign Against Alcohol and Drug Abuse (NACADA) in Kenya has also established a hotline for alcohol and drug users, which provides free counseling over the phone with referrals to alcoholics anonymous/narcotics anonymous, and there are a few rehabilitation facilities located in urban areas and yet the percent of population seeking treatment remains low (NACADA, 2010).

1.3 Familial Effects of Paternal Problem Alcohol Use

Findings from HICs have shown that history of paternal alcohol abuse is a direct predictor of child mental disorders and early onset of substance use in adolescents (Jääskeläinen, Holmila, Notkola, & Raitasalo, 2016; Obot, Wagner, & Anthony, 2001). Alcohol abuse is linked with child maltreatment, harsh parenting, and lack of stimulation at home (Keller et.al., 2009; Meinck et. al., 2015; Neger et.al., 2015). Also, parental alcohol use and parenting stress were associated with approximately 50% increased odds of child neglect (Lee et. al., 2013). Studies from several LMICs reveal that an increase in alcohol consumption by the husband brought an increased risk of intimate partner violence, poor co-parenting, poor communication, and marital conflict (Jeyaseelan et. al., 2004; Changalwa et. al., 2012).

Also, family can affect treatment seeking behavior in positive or negative ways.

They may act as social support (Hser, Maglione, mpp, Polinsky, & Anglin, 1998), meaning that the familial factors like a stable marital relationship or open communication within the family can be seen as supportive for the father seeking treatment. On the other hand, desire to repair poor family relationships was reported to be the primary motivation for substance use cession in methamphetamine users in Cape Town, South Africa (Meade et. al., 2015). According to the NACADA (2010) report, approximately 62% of alcohol using individuals sought informal counseling from a family member. In 30.8% of cases, parental restrictions proved to be effective in reducing alcohol use among adolescents and parent-dependent individuals; (NACADA, 2010). To our knowledge, there is no literature to our knowledge available on how children impact the parent's treatment seeking behavior, which is one construct explored in this study. Together, the evidence suggests that families can affect and be affected by father's treatment or lack thereof.

1.4 The Current Study

The objective of this study was to examine the perceptions of fathers engaged in problem drinking and their families about previous experiences with seeking or receiving help related to alcohol use. We explored both formal and informal sources of help, barriers and facilitators to accepting help, and perceptions of effectiveness. Further, a unique aspect of this study is the examination of the dynamics of the family as they pertain to these help-related experiences. We aimed to understand how the family is

involved and affected by these processes.

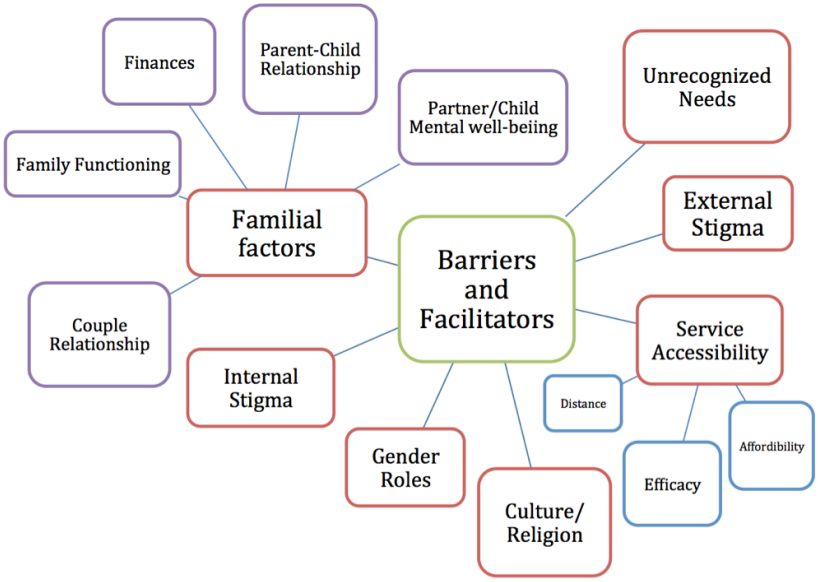

Figure 1: Barriers and Facilitators to Treatment for Alcohol Use

2. Methods

2.1 Setting

This study was conducted in Kenya in collaboration with AMPATH and Moi Teaching and Referral Hospital. Participants were recruited from Eldoret Town and several peri-urban communities outside of Eldoret in Uasin Gishu County.

2.2 Participants and Procedures

This study was conducted as part of a pilot intervention trial that aimed to develop a culturally anchored intervention to reduce problem drinking and increase positive family interactions for alcohol abusing fathers in Kenya. The study included assessments of the fathers participating in the intervention, their spouses, and one of their children. To be included in the study, men needed to be responsible for the care of a child between the ages of 8 and 17 years and to sleep majority of the nights per week with the family (i.e., not be separated from spouse or have employment in a different location). The father also needed to engage in problem drinking as measured by the Alcohol Use Disorder Identification Test (AUDIT) (Bush et. al., 1998). The spouse was eligible if over age 18. Exclusion criteria included reporting extreme violence in the home that could lead to imminent danger, as assessed with critical items on the Conflict Tactics Scale (Straus, 1999). Families brewing alcohol in their home also were excluded from the study due to the environmental constraints present if alcohol is being brewed in the home, which may require additional intensive strategies that were beyond the

scope of this intervention. Also, in this context, brewing is typically done by women, so families in which the female partners reported brewing alcohol were excluded (Pappas et. al., 2010). Male caregivers who scored above the cut-off on the AUDIT scale were excluded as well, as this indicated the presence of dependence and a level of severity too high for participation in a first pilot study of an intervention.

2.3 Data Collection

Primary recruitment for eligible fathers and their families was done by local pastors and leaders in the community. Semi-structured interviews were conducted between August and November 2017. The interview guides included open-ended questions targeting broadly occurring themes and specific probes based on constructs relevant to barriers and facilitators based on the literature (see Figure 1).

The guide was translated into Kiswahili and reviewed by Kenyan research assistants. It was then further refined during pilot testing that was conducted as part of interviewer training as described below. Four bilingual Kenyan research assistants, 2 males and 2 females, were trained to do the interviews over the span of 4 days; they also received a refresher training mid-study, they were trained in both general interviewing techniques and specific interview content. As a part of the training, the research assistants each conducted practice interviews with community members. After each interview, the interviewers asked for participant feedback on the understandability and cultural appropriateness of the questions; this led to further refinement of the interview

guide.

Interviews took place individually in a private room at the participant's home. Each interview lasted between 20 to 100 minutes and was audio recorded. Each participant received non-monetary compensation worth 100 Kenyan Shillings (Ksh) (~ 1 USD), such as small amounts of food (e.g., bag of rice), mobile phone airtime, or pencils for children.

2.4 Analysis

All interviews were transcribed and translated by a Kenyan team member at the field site. After each interview the interviewers wrote structured memos about their personal reflections, including non-verbal and environmental observations from the interview. The research team conducted weekly meetings to provide ongoing supervision focused on continual improvement of interviewing techniques and conduct ongoing analysis with local input from the team. Interviewer memos were used to inform the addition of themes that were not previously emphasized or not included in the guide but observed by the team, these were taken into consideration and were focused on in subsequent interviews. For example, drinking patterns related to occupation, and perceptions of God and church emerged as specific topics to explore further. Thematic content analysis was used to analyze the salient themes in the data. The transcripts were reviewed and memos were written related to each one. Memos were written in narrative form to summarize and organize the data and to identify

patterns. Based on the observed patterns, initial codes were generated by collapsing the data into labels. An analysis software (NVivo 11) was used to complete inter-rater reliability (IRR) between the researcher and another member of the team who was not familiar with the data. A kappa score of .72 for the IRR was achieved. All transcripts were then coded by the researcher.. Based on the code review, "thick" descriptions were written for each theme to concisely explain the data. Descriptions of the themes were then discussed with the field team to assure accuracy in interpretation and articulation.

3. Results

A total of 31 individuals took part in the semi-structured interviews. The sample included men (n=11), women (n=11), and children (n=9). The average age was 38 years for fathers, 32 for mothers, and 12 for children. All but one of the children were enrolled in primary school. The majority of the adults in the sample were married, casual workers, and belonging to the Kalenjin tribe. Households reported an average income of 1,905 Ksh (~19 USD) per week with a range of 500 Ksh (~5 USD) to 7,200 Ksh (~72 USD). Almost all of the participants reported fathers mostly consuming locally brewed alcohol (i.e. Changaa and Busaa).

3.1 Experiences of Drinking

3.1.1 Individual

Almost all fathers reported negative experiences related to alcohol consumption, and therefore desired to quit, but it was often described as a necessary tool to cope with mental and physical stress. Despite these perceived benefits of drinking, most fathers reported being unable to control the amount of alcohol they consumed and therefore faced negative consequences. One father reported, *"Usually by [the end of the work day] I have a lot of money, this triggers me to decide and go to drink in hiding, for I wouldn't like my wife to know about it. Once I have gone [to the alcohol den], I will not be able to control the amount of alcohol consumption; I will definitely overdo it"* (Father). Due to this lack of control, most fathers reported spending their daily earnings on alcohol. In many cases,

the fathers reported spending all their money on alcohol or, if they didn't have any money, that their friends usually offered to buy alcohol for them. Apart from the financial strains on the family, excessive drinking also led the fathers to being robbed, unable to reach home, and to sleep on the streets. Several fathers also reported frequently getting into fights when drunk. Such behaviors lead to community members and neighbors avoiding contact with the father or his family. Fathers and wives reported that fathers were intentionally excluded from community or village meetings, and two fathers reported being unable to trust the community or church members due to the fear of gossip or ill intent. Most fathers reported a lapse in attending church or religious activities during the period of time of active alcohol use. Several fathers reported evading church members who visited the father to bring him back to church.

3.1.2 Family

Most families reported having financial, emotional, and functional difficulties due to the father's drinking. Wives reported a lack of basic needs such as food and clothing as a result of her husband spending earnings on alcohol. They also reported having to find casual work, usually manual labor, to earn enough money to feed the children. One mother reported, *"I was digging at a very tedious job because I knew that my children needed to eat and bathe. You just assume that you are a single mother. When he comes back home, he eats and worries about nothing as long as he is full. He goes get drunk then come back home."* (Wife). Related, several wives reported not trusting the father with money;

one father was reported to steal money from the wife's savings to drink alcohol. Children were often sent home from school due to lack of school fees. In some cases, the wives described talking to the school teachers and request for extra time or asking for financial favors from extended family members. Even when children were able to attend school, they reported lack of school related materials due to lack of money.

Wives further reported facing difficulty in communicating about the family's needs with the father and described overall negative effects of the drinking on family relationships. Fathers were reported to come home drunk and quarrel with the wife, with one wife reporting severe physical abuse if the father was angered when drunk. Children reported having very limited contact with the father, but when the father was at home, they feared him when he was drunk. Fear of the father often lead to the child being unable to communicate his/her needs to the father, and a few children reported being beaten when they tried. One child reported, *"[The reason I can't talk to my father] is because whenever I tell him something, he says that I am speaking lies...Like I can tell him that my school exercise book is filled up and he would in return tell me that I must have tore it up; then he beats me."* - (Child, Female, Age 17). A few wives and children also reported facing stigma from peers and community members due to the father's alcohol use. Wives reported feeling ashamed walking with the father in the community, and one child reported being laughed at in school because his father is a "drunkard." Some wives reported people not visiting their home and neighborhood children not being

allowed to go to their home due to how the community perceived their household. One wife reported that their home was known as the "alcohol house."

3.2 Types of Help

When asked about experiences with treatment, all participants reported various types of informal help received by the father and none reported awareness of formal treatment services in the area. Only two fathers reported having heard of someone they knew who had received formal treatment at a rehabilitation facility that was far away; one of those two fathers reported being skeptical of the price and efficacy of the treatment. The help received by the fathers included help from family (nuclear and extended), community members or neighbors, church members, and friends. As seen in Table 2, participants most frequently reported the wife as one of help givers; followed by the father's parents, siblings, community/neighbors, friends, church, children, and in-laws. A few fathers also reported having successfully reduced or quit alcohol for a period of time through helping themselves. They reported reducing contact with friends, keeping themselves busy, and praying as beneficial methods. Related, three fathers reported believing that quitting or reducing alcohol use can only be done when the person decides on their own and not by the help of others. There were no reports of fathers engaging in any active help-seeking behaviors. Rather, the help givers (i.e. family, church, community, etc.) approached the father, visiting him at his home.

Most often the wife was the first line of help. The wives usually began by

advising the fathers to quit drinking so they can provide for their family and accomplish family goals, such as saving money to buy cattle or completing house repairs. Most wives did not use a harsh tone when giving help to the father; rather they described calm or pleading tones with the aim to gently convince. One father reported, *"Sometimes I come home when I am drunk, and [my wife] doesn't want to chase me away, she welcomes me home and tells me that 'Baba so and so,' 'do this so that your life may change.' She has been wishing me well, while I have been drinking."* -(Father). The term 'baba' (which means father) is used in an endearing manner to appeal to the father to reduce or quit alcohol. There were two exceptions, in which the wives threatened to take the children and return to her parent's home. A few wives reported waiting for the father to sober up before giving help so they could ensure that the father is understanding their advice and the conversation doesn't turn into a quarrel.

Most wives reported reaching out to extended family and community members to offer help to the father in addition to their own efforts to talk with him. Among extended family, fathers and wives described the father's parents and siblings as most helpful. One wife reported, *"I said to him that it was high time he stopped abusing alcohol; otherwise his home will get destroyed. He listened and calmed down but after like a span of one to two weeks he went back to it again...So I went to his mother and reported him, and the mother talked to him"* - (Wife). The extended family was reported to use a harsher tone in their help than the wife. Often they threatened to relocate the wife and children away from

the father or attempt to scare the father by telling him that he would "leave his family behind," meaning his alcohol consumption could prove to be fatal. In some of cases, the extended family asked the father to just reduce his consumption if he didn't want to quit completely.

Community members, specifically those affiliated with the church, also gave advice to the father on quitting alcohol. Help from the community members and neighbors consisted of asking the father to stop drinking excessively so that he can return home instead of sleeping in the streets, avoid physical altercations, and maintain peace within the household and the community. In the case of church members, they often visited the father upon the request of the mother and/or when the father stopped attending church. Most often the church members advise the father to go back to church and change his lifestyle. They attempt to help the father by praying for him and visiting him when possible.

In the situations described above, participants reported that fathers received vague statements of guidance or warning rather than specific advice related to ways to change their behaviors. There were a few notable exceptions, however. In two cases, behavioral advice was given from individuals from the community or family who had successfully quit drinking alcohol in the past. One father reported, *"[The neighbor's] words came to me clearly. He told me that he took alcohol for 25 years, but he later had to quit. He told me that there is no place alcohol takes people... He told me that you can't stop once, you just*

proceed gradually until you stop." - (Father). Another father reported being advised by his father-in-law who had successfully abstained from alcohol for many years. The father-in-law advised him to 'start by leaving his friends and that alcohol would not come following him.' Interestingly, wives seemed to have ideas about specific behavioral changes that may be helpful, such as the father getting a job or finding new activities that could occupy his attention; however, they did not explicitly report talking to the father about these ideas.

Table 1: Frequency of Types of Help Reported by Fathers and Wives

Types of Help	Reporting Frequency
Wife	15 (68%)
Father's Parents	10 (45%)
Father's Siblings	9 (41%)
Children	3 (14%)
Community members/Neighbors	8 (36%)
Friends	8 (36%)
Church	8 (36%)
In-laws	2 (9%)

3.3 Barriers to Help Acceptance

Three types of barriers were salient throughout the data: negative perceptions of help, social influence, and ambivalence about quitting.

3.3.1 Negative Perceptions of Help

When receiving non-behavioral help, some fathers reported feeling anger or apathy towards individuals attempting to help. Often this was related to the tone being used. For instance, there were situations in which the harsher tones used by extended family members left the father feeling shame, guilt, or overwhelmed; this led them to resist the help. Many times, this resistance took the form of fathers listening apathetically while feeling judged. One father described, *"I was happy that he came [to the hospital], but when he began talking to me about alcohol, I became angry at him. I just showed interest to please him but I had not taken any keen interest in the actual sense...I felt like he was looking down upon me, and I was not happy about it."* - (Father). Similar reports were made by wives who observed the father's response upon receiving help from herself or extended family members.

Most fathers reported that someone had advised them to go to church to be helped; only two fathers reported attending and only during the period of time that they had reduced or quit alcohol. Most fathers reported agreeing to attend church but left home or become unavailable at the last minute. Even though most fathers were not attending church, they did not object on family members continuing to attend or children going to Sunday school. Only one wife reported that during the time the father was drinking, he did not allow her to go to church or even the church members to visit their home. Two fathers explicitly reported not wanting to go to church due to reasons such as discomfort, mistrust, and lack of time. One father reported, *"The issue of asking*

me to go to church, that was so much of a bother to me. They were wasting my time...even just going to sit in church, that is wasting time.... it was just out of my comfort zone." - (Father).

3.3.2 Social Influence

Almost all fathers, wives, and children reported social influences such as friends and festivals to be a barrier to help acceptance. Almost all fathers reported understanding that the influence of peers was one of the reasons they were unable to quit or reduce their drinking, but only a few of fathers were successful in resisting. Most fathers reported their attempts to quit alcohol, with the help of the wife or extended family members, were ruined by the friends offering to buy alcohol for them, asking them to accompany to the alcohol den, or by tricking them into drinking. One father reported, *"Everybody is in hot pursuit of the other. In that even when they come and find you working in your garden they keep enticing you to follow them to the center to go and drink. They are never tired; they keep nagging you even when you have refused. They sweet talk and say to me that they have 20/- for buying a cup of tea for me."* - (Father). A few fathers reported having informed the friends of their intention to reduce or quit drinking, but the friends either responded by not believing him, saying that he will be back to drinking soon or by asking him just to accompany them to the alcohol den for tea. One father reported that his friends, unbeknownst to him, mixed alcohol in his tea, which lead him to drink more since his resolution had already been broken

3.3.2.1 Occupation

Fathers and wives reported most fathers in the study were casual workers. Casual workers get paid daily based on the tasks of the day, in contrast to job holders who get paid once a month. Casual work is typically manual labor and often is in less than desirable circumstances. Most fathers reported the need to drink alcohol after a day of casual work to "rejuvenate the body" or deal with family related stress. One father reported, *"So, you might find yourself going for one glass and say, 'Just a warm up to deal with any burn outs… to rejuvenate and relax the body from hard work'; it is sometimes necessary. But you will find that one may end up overdoing it."* - (Father). A cyclical consumption pattern appeared from the data, which indicated that the nature of casual work and being paid daily often lead fathers to drink alcohol regularly, usually with coworkers and friends. Fathers and wives reported that fathers almost always spent all of their earnings on alcohol. Fathers then sought more casual work to get quick cash to provide for the basic needs of the family. However, once the money was procured, the father was tempted to consume alcohol before returning home with the money; this led to continual strain on the family. A few fathers reported that, over time, some individuals look for casual work purely to pay for their alcohol needs. Upon being asked how he would feel if all men in the community received help, one father reported, *"You mean if they can all recover from drinking?! Where will people get casual laborers? (Loud laughter). Because these people look for work so that they can get money to spend on alcohol."* - (Father).

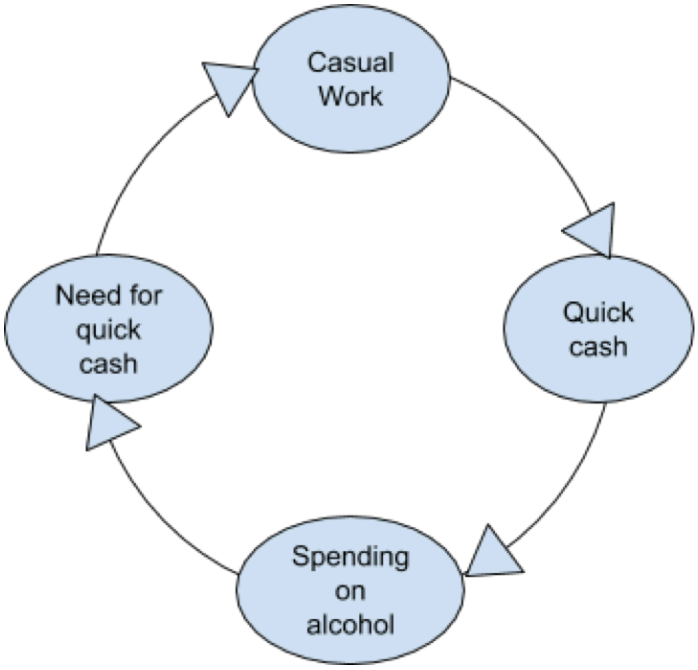

Figure 2: Cyclical Behavior Pattern in Relation to Father's Occupation

3.3.3 Ambiguity about Quitting

Only two of the eleven fathers reported the desire to continue drinking. The reasons mainly revolved around the need to recover from the hardships of casual work and to have a means to relax. One father reported, *"You know I hardly get free [time]. Therefore, when it is Sunday, I like going out for leisure because the children are at home. That's what I can say is the problem because I too need time to go out and you can see that means an opportunity to drink alcohol because most of my friends are alcoholics"* -(Father). Two fathers reported finding enjoyment in being around friends, which usually also incorporated visiting alcohol dens and drinking locally brewed alcohol.

3.4 Facilitators to Help Acceptance

Four types of facilitators acceptance were salient throughout the data: Positive perceptions of help, Financial motivation, Perceived social-support, and External stigma.

3.4.1 Positive Perceptions of Help

Almost all fathers reported perceiving help as a way to attain peace and improve conditions for their families. Two fathers reported that it was difficult to leave the habit of alcohol without help and therefore all help is good for individuals who desire to quit. Fathers were most willing to accept help when it was offered by wives or extended family members but, as mentioned earlier, the tone of help was an important factor. Help given using a calmer approach was perceived to be positive and therefore accepted by the father. For example, a wife may choose not to quarrel with the father when he returns home drunk, but rather wait to talk until the next morning. Fathers perceived this type of approach to be a sign of caring. Upon being asked how he felt about receiving help from his mother, one father reported, *"I felt like my parent still love me and I was happy. I realized that even if you can be a drunkard, your parent is still a friend and is close to you. I saw it wise that if my parent could still loves me like this, I should change"* - (Father). In two cases, in which men received specific behavioral advice, they perceived it as valuable, especially since it came from individuals who had successfully quit alcohol in the past. Additionally, even though most fathers reported not attending church/mosque during the time they were consuming alcohol, many fathers reported turning to God or prayer for help. Fathers perceived praying, and being prayed for, as positive sources of

help and were willing to pray with family members. A few fathers explicitly reported having faith in God to help them reduce drinking and progress in life.

3.4.2 Financial Motivation to Stop Drinking

Most fathers reported financial strains as motivation to reduce or quit alcohol consumption. A few fathers reported disappointment at their financial situation since they were not able to save any amount of money from their casual work. Two of the eleven fathers reported previously owning businesses, which allowed them to provide for basic needs of the family and accumulate savings for emergencies. However, since they started drinking alcohol, their businesses have failed and they have found themselves without any money to take home at the end of the day.

Most fathers recognized that the lack of money caused strains on the family. Fathers reported that witnessing these strains on the family motivated them to accept help so that they could be better providers for their family. One father reported, *"I told [my daughter], let me stop drinking so that I can provide her with everything that is needed in school and anything that she might ask from me."* - (Father).

Wives were reported to play a vital role in opening the father's eyes to the financial situation of the household. Not having basic needs and not being able to accomplish family goals, such as building a new home or financial savings, were reported as the main motivators for the wives to initiate help. Children reported that they prayed for their fathers to stop drinking so they could afford school fees.

3.4.3 Perceived Social Support

Some fathers reported receiving emotional and financial support from members of the family and community. Several fathers also reported their wives and/or their extended family members having faith in their ability to quit drinking. During their attempts to reduce or quit drinking, some also reported receiving encouragement from family, community, and church members; often fathers received compliments or encouragements such as "you are now looking well" or "you are doing a good thing." In some cases, wives and extended family members were reported to broaden the support circles around the father. One mother reported, *"I usually even consult some of my women friends. When they find him sober they usually congratulate him and say to him, 'It is good you continue thus'"*. - (Mother).

Several fathers also described that others helped with paying children's school fees, buying materials for a new house, or covering medical fees. The fathers perceived this as an act of trust in the fact that they will reduce or quit drinking. One father reported his brother instilled hope in him by helping the father look for jobs. In contrast to the above, some fathers also reported being motivated by negative social responses, such as the family or community members not believing the father is capable of reducing or quitting alcohol. Fathers reported that this lack of faith led to their becoming determined to change; one father reported that he has to "give his family time" and "show his people that he can change," meaning he has to be patient with his family

because his family will only believe him if he is able to continue to abstain without relapsing

3.4.4 External Stigma

As described earlier, high daily alcohol consumption can lead to the father facing issues of stigma. Fathers reported being excluded from family and community gatherings, as well as from family decisions. This led the fathers to feel rejected and often disrespected, but the negative feelings also motivated the fathers to reduce or quit drinking in order to be a better head of the household. A few fathers reported experiencing stigma from family and community members that acted as a facilitator. One father reported, *"I sympathized for my family; I said that if people could talk about me like this, then what about my family? So I said that is better I fight for my family..."* - (Father).

4. Discussion

In this qualitative study, we explored the barriers and facilitators to receiving help for problem drinking among fathers in Kenya. This was a sample of men who had been unsuccessful in reducing their alcohol use in the past who, at the time of this study, were enrolling in an intervention for problem drinking delivered by lay counselors from their communities. Understanding the perspectives of these men, their spouses, and their children provides a unique contribution to the scarce literature on the treatment gap for substance use in Kenya and other low-resource settings.

The current study found informal help to be most prevalent in the region alongside a remarkable lack of awareness of any available formal services; almost none of the study participants reported knowing about the available rehabilitation or mental health services in the area. The vast lack of awareness is consistent with the findings from the NACADA (2012) population-based survey in Kenya stating that 82% of the respondents reported little to no awareness of available formal services. Currently, there are three rehabilitation facilities to our knowledge in a 30 kilometers radius of Eldoret town, each offering a three-month inpatient program with cost ranging from 50,000 Kenyan Shillings (Ksh) (~ 500 USD) to 90,000 Ksh (~900 USD); two of these report having outpatient counseling services as well. These costs are high, confirming concerns raised in the broader literature on rehabilitation and mental health services in LMICs that, even if awareness were higher, services are very expensive and often hard to reach by basic

means of transportation (Patel et. al., 2007).

In describing the types of informal help provided and received, the important role of family and community in this context was apparent across all interviews. This is consistent with literature on the perception of family in sub-saharan Africa, where family is said to be the nexus of social life (Ekane, 2013). Some writers have even noted that individuals are perceived as "incomplete" until they have started a family (Nijue, Rombo, & Ngige, 2007). Further, the concept of family extends beyond the nuclear family to include siblings, grandparents, cousins, and even members of the community such as neighbors (Wilson & Ngige, 2006). Village or town communities also tend to be close-knit and often have regular structured interactions through events such as village meetings. Community elders and chiefs, along with others who are perceived as role models, are often consulted by the families for advice or guidance for familial issues (Kariuki, 2015).

The prominence of families and community members in response to drinking found in this study is clearly different from their roles in high-resource settings with more accessible evidence-based treatments in formal settings. This said, families and others are sometimes active in the help-seeking processes and treatment in these settings as well. One example of family involvement in promoting treatment engagement is the Community Reinforcement and Family Training (CRAFT), which aims to train concerned family members to reinforce abstinence, and assist substance-related behavior

change in day to day activities (Meyers, Miller, Hill, & Tonigan, 1998). Another example is Alcohol focused behavioral couples therapy (ABCT), an intervention that involves partner and family members in treatment, providing skills to better support the drinker's efforts to change (Epstein & McCrady, 2002). These intervention methods use continual engagement and targeted support from the family to facilitate change. This is clearly unlike the unstructured, general guidance families provided to the fathers in our study. However, since the above mentioned literature on family interventions provide persuasive evidence of how positive family involvement can promote successful treatment outcomes, these practices could be useful in settings like Kenya where families are clearly already involved.

Findings also provide information about barriers and facilitators to help acceptance and effectiveness that point towards considerations for interventions. First, the men's receptiveness to help appeared somewhat dependent on the tone and attitude taken by the help giver. Fathers were not responsive to, or were angered by, harsher tones or threatening language, but reported having a positive perception of help provided with calmer tones and supportive actions. This is analogous in some ways to findings related to how clients' perceptions of counselors influence outcomes. A review on the role of therapeutic alliance in substance misuse treatment revealed that a close relationship between the client and counselor was a strong predictor of subsequent change in drug use during treatment (Meier, Borrowclough, & Donmall, 2005). A

prospective longitudinal study conducted by Kasarabada, Hser, Boles, and Huang (2002) also linked perceptions of the counselor with better treatment outcomes for substance using clients. Similar to fathers in the present study, participants who had favorable perceptions of their counselor's attitude (i.e. empathy, nurterence, and openness) showed higher treatment retention and lower alcohol use over time.

The role of positive social support as a facilitator to help acceptance is consistent across settings (Kelly et. al., 2010), and we found the same in this study. Surprisingly, however, our results also suggested that negative aspects of social support, such as fathers learning that their families had lost "faith" in their ability to stop drinking, actually served as a facilitator, motivating men to accept treatment in order to become a better husband, father, and provider. Likewise, experiences of external stigma, such as being excluded from family and community meetings or being avoided by others, also emerged as a motivator for fathers to change in order to become "role models." While these are negative experiences that could certainly have other negative effects on the emotional well-being of men, it is interesting that they found these experiences motivating.

Negative influence of peers who also drink alcohol was observed as one of the greatest barriers to accepting help; oftentimes friends were reported as the reason for relapse after abstaining for a period of time. Consistent with this, a review on social networks and alcohol use disorders showed peer influence in HICs as a risk factor to

positive treatment outcomes and for high relapse rates (Mccrady, 2004). A longitudinal study in the US done by Mohr, Averna, Kenny, and Del Boca (2001) also provides evidence that changing social networks, such as decreasing friendships with regular drinkers, can lead to lower levels of drinking over time. No fathers in this study described any efforts to change social networks during periods of abstinence or reduced drinking, but this could be a potential avenue for intervention.

The association between alcohol use and poverty was clear in this study and is an association that also has been documented in the broader literature. Pre-existing poverty has been identified as a risk factor for problem drinking or alcohol dependence (Karriker-Jaffe, 2011), and alcohol abuse has been found to perpetuate poverty by causing consistent financial burden due to excessive spending on alcohol, especially in LMICs (Matto, Nebhinani, Kumar, Basu, & Kulhara, 2013; Tudawe, 2001). Results from this study mirrored these findings as fathers reported casual work (manual labor) as their main source of income and often found the daily income, combined with peer influence, to be pathways to immoderate alcohol use. The spending on alcohol left little to nothing for basic household needs, perpetuating a cycle of financial deficit leading to the family suffering chronic economic burdens.

Two factors that were culturally-grounded in their influence on fathers' experiences of help were religion and gender identity. Related to religion, fathers were urged to attend church during periods of active drinking as a way to receive help, but

most fathers reported not doing so, even though most of them had attended church before they began drinking. Despite not wanting to attend church, however, fathers reported acceptance of other religiously-oriented sources of help, including being prayed for by others or being encouraged to have faith in God. This points towards a more complicated role of faith in these men's lives as it relates to drinking; it cannot be categorized as a positive or negative influence. Religion plays an important role in Kenya; Approximately 83% of the population self-identifies as Christian, and approximately 11% identifies as Muslim (Central Intelligence Agency [CIA], 2009). Religion in the context of treatment is important to understand, and the the salience of religion throughout the data is not surprising since religious institutions, such as churches and mosques, are incredibly influential in many communities (Kaplan, 1986; Nandwa, 2016). More broadly, a systematic review on the relationship between alcohol and religion shows evidence of religion playing a protective role from alcohol abuse (Chitwood, Weiss, & Leukefeld, 2008). However, empirical research on the effectiveness of interventions for alcohol or substance use that incorporate spiritual or religious content is sparse (Neff & MacMaster, 2005). Religion and spirituality are often used as tools to engage substance users in treatment or to maintain abstinence, rather than using actual spiritual principles as a part of treatment. (Pardini, Plante, Sherman, & Stump, 2000) One method that does integrate spirituality explicitly is AA, in which treatment combines spirituality, but there is inconclusive evidence on the effectiveness of such

twelve step facilitation methods (Kaskutas, 2009).

Related to gender identity, the strongly gendered expectations of fathers to be providers and leaders, or "heads" of households (Kato-Wallace, Barker, Eads, & Levtov, 2014; Schafer & Koiyet, 2018), may have lead a father to perceive dire conditions of the family, such as lack of money for food, as a dereliction of his duties as a man. A mixed method study conducted in Kenya sampled men and women of diverse backgrounds from the six main provinces of Kenya to understand perceptions of masculinity; the data showed men increasingly clinging to the roles of protector and provider when they were faced with a threat of losing this part of their identity (Corria, Amuyunzu-Nyamongo & Francis, 2006). This is reminiscent of fathers in this study who became motivated to accept help after having the realization that they were not recognized as the provider or head of the household anymore. On the other hand, a cross-cultural study in 8 different countries, including South Africa and Zambia, found that heavy alcohol use was associated with both masculinity and freedom, carrying a positive connotation (WHO, 2005). The fathers in the present study did not endorse notions of freedom or masculinity associated with drinking but there may be a subtle interplay between these two conflicting perspectives that should be explored in future work.

4.1 Limitations and Future Implications

There are several limitations to this study that should be considered. First, the sample represents only men who have not yet received effective help for problem

drinking. That is, it does not include men who may have successfully stopped drinking after receiving either informal or formal help. The sample also excluded men with alcohol dependence who may have unique perspectives on the issues explored here. Therefore, as with all qualitative inquiries, the findings are bound to the participants and context in which the study was conducted. In this case, findings are most informative forthe important population of men and families affected by persistent alcohol use who are very unlikely to access formal intervention services. Future research will be important for understanding perceptions of the broader population of individuals abusing substances.

One of the strengths of this study is the insight results provide into the vastly unexplored network of informal help received by problem drinking individuals in Kenya. As this study focuses on individuals who continue to engage in problem drinking, studies that investigate help patterns that have been successful in aiding individuals quit or reduce consumption will be immensely valuable; identifying strengths in the existing social networks (i.e. nuclear and extended family and community members) will inform future community-based interventions.

5. Conclusion

In conclusion, our findings revealed person-related barriers and facilitators to help seeking and receiving among Kenyan fathers who engage in problem drinking from the perspectives of the fathers and the family. Understanding the pre-existing help patterns will help future interventions in providing more contextually relevant treatment and aid in closing the persisting treatment gap in the region

References

Adamson, T. A., & Akindele, M. O. (1994). Experience with an in-patient treatment model for alcohol and drug dependence in Nigeria. *West African Journal of Medicine*, *13*(2), 105–108.

Alcohol Use and Sexual Risk Behaviour: A Cross-cultural Study in Eight Countries. (2005). World Health Organization.

Atwoli, L., Mungla, P. A., Ndung'u, M. N., Kinoti, K. C., & Ogot, E. M. (2011). Prevalence of substance use among college students in Eldoret, western Kenya. *BMC Psychiatry*, *11*, 34. https://doi.org/10.1186/1471-244X-11-34

Barnett, M. L., Lau, A. S., & Miranda, J. (2018). Lay Health Worker Involvement in Evidence-Based Treatment Delivery: A Conceptual Model to Address Disparities in Care. *Annual Review of Clinical Psychology*. https://doi.org/10.1146/annurev-clinpsy-050817-084825

Benegal, V., Chand, P. K., & Obot, I. S. (2009). Packages of Care for Alcohol Use Disorders in Low- And Middle-Income Countries. *PLOS Medicine*, *6*(10), e1000170. https://doi.org/10.1371/journal.pmed.1000170

Boffetta, P., & Hashibe, M. (2006). Alcohol and cancer. *The Lancet Oncology*, *7*(2), 149–156. https://doi.org/10.1016/S1470-2045(06)70577-0

Bush, K., Kivlahan, D. R., McDonell, M. B., Fihn, S. D., & Bradley, K. A. (1998). The AUDIT Alcohol Consumption Questions (AUDIT-C): An Effective Brief Screening Test for Problem Drinking. *Archives of Internal Medicine*, *158*(16), 1789–1795. https://doi.org/10.1001/archinte.158.16.1789

Chitwood, D. D., Weiss, M. L., & Leukefeld, C. G. (2008). A Systematic Review of Recent Literature on Religiosity and Substance Use. *Journal of Drug Issues*, *38*(3), 653–688. https://doi.org/10.1177/002204260803800302

Copello, A. G., Copello, A. G., Velleman, R. D. B., & Templeton, L. J. (2005). Family interventions in the treatment of alcohol and drug problems. *Drug and Alcohol Review*, *24*(4), 369–385. https://doi.org/10.1080/09595230500302356

Correia, M. C. B., Ian. (2006). *The Other Half of Gender*. The World Bank. https://doi.org/10.1596/978-0-8213-6505-2

Do patients' perceptions of their counselors influence outcomes of drug treatment? (2002). *Journal of Substance Abuse Treatment*, *23*(4), 327–334. https://doi.org/10.1016/S0740-5472(02)00276-3

Dobkin, P. L., Civita, M. D., Paraherakis, A., & Gill, K. (2002). The role of functional social support in treatment retention and outcomes among outpatient adult substance abusers. *Addiction*, *97*(3), 347–356. https://doi.org/10.1046/j.1360-0443.2002.00083.x

Epstein, E. E., & McCrady, B. S. (2002). Couple therapy in the treatment of alcohol problems.

Galanter, M. (2016). *What Is Alcoholics Anonymous?: A Path from Addiction to Recovery*. Oxford University Press.

Galanter, M., & Post, S. G. (2014). Alcoholics Anonymous: New Directions in Research on Spirituality and Recovery. *Alcoholism Treatment Quarterly*, *32*(2–3), 108–110. https://doi.org/10.1080/07347324.2014.907021

GENACIS, & Abuse, W. H. O. D. of M. H. and S. (2005). Alcohol, gender and drinking problems in low and middle income countries. Retrieved from http://www.who.int/iris/handle/10665/43299

Hser, Y.-I., Maglione, M., mpp, Polinsky, M. L., & Anglin, M. D. (1998). Predicting Drug Treatment Entry Among Treatment-Seeking Individuals. *Journal of Substance Abuse Treatment*, *15*(3), 213–220. https://doi.org/10.1016/S0740-5472(97)00190-6

Ingoldsby, B. B., & Smith, S. D. (2006). *Families in Global and Multicultural Perspective*. SAGE.

Is, O., Fa, W., & Jc, A. (2001). Early onset and recent drug use among children of parents with alcohol problems: data from a national epidemiologic survey. *Drug Alcohol Depend*, *65*(1), 1–8.

Jääskeläinen, M., Holmila, M., Notkola, I.-L., & Raitasalo, K. (2016). Mental disorders and harmful substance use in children of substance abusing parents: A longitudinal register-based study on a complete birth cohort born in 1991. *Drug and Alcohol Review*, *35*(6), 728–740. https://doi.org/10.1111/dar.12417

Jeyaseelan, L., Sadowski, L. S., Kumar, S., Hassan, F., Ramiro, L., & Vizcarra, B. (2004). World studies of abuse in the family environment - risk factors for physical intimate partner violence. *Injury Control & Safety Promotion*, *11*(2), 117–124. https://doi.org/10.1080/15660970412331292342

Kariuki, F. (2015). Conflict resolution by elders in Africa: Successes, challenges and opportunities. *Alternative Dispute Resolution*, *3*(2), 30–53.

Karriker-Jaffe, K. J. (2011). Areas of disadvantage: A systematic review of effects of area-level socioeconomic status on substance use outcomes. *Drug & Alcohol Review*, *30*(1), 84–95.

Kasarabada, N. D., Hser, Y.-I., Boles, S. M., & Huang, Y. C. (2002). Do patients' perceptions of their counselors influence outcomes of drug treatment? *Journal of Substance Abuse Treatment*, *23*(4), 327–334.

Kato-Wallace, J., Barker, G., Eads, M., & Levtov, R. (2014). Global pathways to men's caregiving: Mixed methods findings from the International Men and Gender Equality Survey and the Men Who Care study. *Global Public Health*, *9*(6), 706–722. https://doi.org/10.1080/17441692.2014.921829

Keller, P. S., El-Sheikh, M., Keiley, M., & Liao, P.-J. (2009). Longitudinal relations between marital aggression and alcohol problems. *Psychology of Addictive Behaviors*, *23*(1), 2–13. https://doi.org/10.1037/a0013459

Kelly, S. M., O'Grady, K. E., Schwartz, R. P., Peterson, J. A., Wilson, D. M. E., & Brown, B. S. (2010). The relationship of social support to treatment entry and engagement: The Community Assessment Inventory. *Substance Abuse : Official Publication of the Association for Medical Education and Research in Substance Abuse*, *31*(1), 43. https://doi.org/10.1080/08897070903442640

Keyes, K. M., Hatzenbuehler, M. L., McLaughlin, K. A., Link, B., Olfson, M., Grant, B. F., & Hasin, D. (2010a). Stigma and Treatment for Alcohol Disorders in the United States. *American Journal of Epidemiology*, *172*(12), 1364–1372. https://doi.org/10.1093/aje/kwq304

Keyes, K. M., Hatzenbuehler, M. L., McLaughlin, K. A., Link, B., Olfson, M., Grant, B. F., & Hasin, D. (2010b). Stigma and Treatment for Alcohol Disorders in the United States. *American Journal of Epidemiology*, *172*(12), 1364–1372. https://doi.org/10.1093/aje/kwq304

Laonigro, I., Correale, M., Di Biase, M., & Altomare, E. (2009). Alcohol abuse and heart failure. *European Journal of Heart Failure*, *11*(5), 453–462. https://doi.org/10.1093/eurjhf/hfp037

Lee, A. K. (2009). Alcoholics Anonymous Effectiveness: Faith Meets Science. *Journal of Addictive Diseases*, *28*(2), 145–157. https://doi.org/10.1080/10550880902772464

Lee, S. J. (2013). Paternal and Household Characteristics Associated With Child Neglect and Child Protective Services Involvement. *Journal of Social Service Research*, *39*(2), 171–187. https://doi.org/10.1080/01488376.2012.744618

Leonard, K. E., & Eiden, R. D. (2007). Marital and Family Processes in the Context of Alcohol Use and Alcohol Disorders. *Annual Review of Clinical Psychology*, *3*(1), 285–310. https://doi.org/10.1146/annurev.clinpsy.3.022806.091424

Lund, C., Breen, A., Flisher, A. J., Kakuma, R., Corrigall, J., Joska, J. A., … Patel, V. (2010). Poverty and common mental disorders in low and middle income countries: A systematic review. *Social Science & Medicine (1982)*, *71*(3), 517–528. https://doi.org/10.1016/j.socscimed.2010.04.027

Mattoo, S. K., Nebhinani, N., Kumar, B. N. A., Basu, D., & Kulhara, P. (2013). Family burden with substance dependence: a study from India. *The Indian Journal of Medical Research*, *137*(4), 704–711.

McCrady, B. S. (2004). To have but one true friend: implications for practice of research on alcohol use disorders and social network. *Psychology of Addictive Behaviors: Journal of the Society of Psychologists in Addictive Behaviors*, *18*(2), 113–121. https://doi.org/10.1037/0893-164X.18.2.113

Meade, C. S., Towe, S. L., Watt, M. H., Lion, R. R., Myers, B., Skinner, D., … Pieterse, D. (2015). Addiction and treatment experiences among active methamphetamine users recruited from a township community in Cape Town, South Africa: A mixed-methods study. *Drug & Alcohol Dependence*, *152*, 79–86. https://doi.org/10.1016/j.drugalcdep.2015.04.016

Meier, P. S., Barrowclough, C., & Donmall, M. C. (2005). The role of the therapeutic alliance in the treatment of substance misuse: a critical review of the literature. *Addiction*, *100*(3), 304–316. https://doi.org/10.1111/j.1360-0443.2004.00935.x

Meinck, F., Cluver, L. D., Boyes, M. E., & Mhlongo, E. L. (2015). Risk and Protective Factors for Physical and Sexual Abuse of Children and Adolescents in Africa: A Review and Implications for Practice. *Trauma, Violence, & Abuse*, *16*(1), 81–107. https://doi.org/10.1177/1524838014523336

Meyers, R. J., Miller, W. R., Hill, D. E., & Tonigan, J. S. (1998). Community reinforcement and family training (CRAFT): engaging unmotivated drug users in treatment. *Journal of Substance Abuse*, *10*(3), 291–308.

mhGAP Intervention Guide for Mental, Neurological and Substance Use Disorders in Non-Specialized Health Settings: Mental Health Gap Action Programme (mhGAP): Version 2.0. (2016). Geneva: World Health Organization. Retrieved from http://www.ncbi.nlm.nih.gov/books/NBK390828/

Mohr, C. D., Averna, S., Kenny, D. A., & Del Boca, F. K. (2001). "Getting by (or getting high) with a little help from my friends": an examination of adult alcoholics' friendships. *Journal of Studies on Alcohol*, *62*(5), 637–645.

Moyer, A., Finney, J. W., Swearingen, C. E., & Vergun, P. (2002). Brief interventions for alcohol problems: a meta-analytic review of controlled investigations in treatment-seeking and non-treatment-seeking populations. *Addiction*, *97*(3), 279–292. https://doi.org/10.1046/j.1360-0443.2002.00018.x

Mugisha, F., Arinaitwe-Mugisha, J., & Hagembe, B. O. N. (2003). Alcohol, substance and drug use among urban slum adolescents in Nairobi, Kenya. *Cities*, *20*(4), 231–240. https://doi.org/10.1016/S0264-2751(03)00034-9

Myers, B. J., Louw, J., & Pasche, S. C. (2010). Inequitable access to substance abuse treatment services in Cape Town, South Africa. *Substance Abuse Treatment, Prevention, and Policy*, *5*, 28. https://doi.org/10.1186/1747-597X-5-28

NACADA | Surveys & Results. (n.d.). Retrieved March 22, 2018, from http://nacada.go.ke/?page_id=387

Nadkarni, A., Weobong, B., Weiss, H. A., McCambridge, J., Bhat, B., Katti, B., … Patel, V. (2017). Counselling for Alcohol Problems (CAP), a lay counsellor-delivered brief psychological treatment for harmful drinking in men, in primary care in India: a randomised controlled trial. *The Lancet*, *10065*(389), 186–195. https://doi.org/10.1016/S0140-6736(16)31590-2

Neff, J. A., & MacMaster, S. A. (2005). Applying Behavior Change Models to Understand Spiritual Mechanisms Underlying Change in Substance Abuse Treatment. *The American Journal of Drug and Alcohol Abuse*, *31*(4), 669–684. https://doi.org/10.1081/ADA-200068459

Neger, E. N., & Prinz, R. J. (2015). Interventions to address parenting and parental substance abuse: Conceptual and methodological considerations. *Clinical Psychology Review*, *39*, 71–82. https://doi.org/10.1016/j.cpr.2015.04.004

Ngige, L. W., Njue, J. R., & Rombo, D. O. (2007). Family Strengths and Challenges in Kenya. Retrieved from http://ir-library.ku.ac.ke/handle/123456789/8387

Obot, I. S., Wagner, F. A., & Anthony, J. C. (2001). Early onset and recent drug use among children of parents with alcohol problems: data from a national epidemiologic survey. *Drug and Alcohol Dependence*, *65*(1), 1–8. https://doi.org/10.1016/S0376-8716(00)00239-8

Organization, W. H. (2014). *Global Status Report on Alcohol and Health, 2014*. World Health Organization.

Papas, R. K., Sidle, J. E., Wamalwa, E. S., Okumu, T. O., Bryant, K. L., Goulet, J. L., … Justice, A. C. (2010). Estimating Alcohol Content of Traditional Brew in Western Kenya Using Culturally Relevant Methods: The Case for Cost Over Volume. *AIDS and Behavior*, *14*(4), 836–844. https://doi.org/10.1007/s10461-008-9492-z

Pardini, D. A., Plante, T. G., Sherman, A., & Stump, J. E. (2000). Religious faith and spirituality in substance abuse recovery: Determining the mental health benefits. *Journal of Substance Abuse Treatment*, *19*(4), 347–354. https://doi.org/10.1016/S0740-5472(00)00125-2

Patel, V., Araya, R., Chatterjee, S., Chisholm, D., Cohen, A., De Silva, M., … van Ommeren, M. (2007). Treatment and prevention of mental disorders in low-income and middle-income countries. *Lancet (London, England)*, *370*(9591), 991–1005. https://doi.org/10.1016/S0140-6736(07)61240-9

Patel, V., & Thornicroft, G. (2009). Packages of Care for Mental, Neurological, and Substance Use Disorders in Low- and Middle-Income Countries: PLoS Medicine Series. *PLOS Medicine*, *6*(10), e1000160. https://doi.org/10.1371/journal.pmed.1000160

Rehm, J., Baliunas, D., Borges, G. L. G., Graham, K., Irving, H., Kehoe, T., … Taylor, B. (2010). The relation between different dimensions of alcohol consumption and burden of disease: an overview. *Addiction*, *105*(5), 817–843. https://doi.org/10.1111/j.1360-0443.2010.02899.x

Salwan, J., & Katz, C. L. (2014). A Review of Substance Use Disorder Treatment in Developing World Communities. *Annals of Global Health*, *80*(2), 115–121. https://doi.org/10.1016/j.aogh.2014.04.010

Saunders, S. M., Zygowicz, K. M., & D'Angelo, B. R. (2006). Person-related and treatment-related barriers to alcohol treatment. *Journal of Substance Abuse Treatment*, *30*(3), 261–270. https://doi.org/10.1016/j.jsat.2006.01.003

Schafer, A., & Koyiet, P. (2018). Exploring links between common mental health problems, alcohol/substance use and perpetration of intimate partner violence: A rapid ethnographic assessment with men in urban Kenya. *Global Mental Health*, *5*. https://doi.org/10.1017/gmh.2017.25

Sheikh, W. A., Paul, R., Banda, H., Agath, K., & Luty, J. (2017). Impact of brief relapse prevention intervention in patients with alcohol dependence in Zambia. *Journal of Substance Use*, *22*(1), 113–117. https://doi.org/10.3109/14659891.2015.1090494

Stahler, G., Kirby, K., & Kerwin, M. (2007). A faith-based intervention for cocaine-dependent Black women. *Journal of Psychoactive Drugs*, *39*(2), 183–190.

Steel, Z., Marnane, C., Iranpour, C., Chey, T., Jackson, J. W., Patel, V., & Silove, D. (2014). The global prevalence of common mental disorders: a systematic review and meta-analysis 1980–2013. *International Journal of Epidemiology*, *43*(2), 476–493. https://doi.org/10.1093/ije/dyu038

Straus, M. (2018). CHILD.REPORT. ADULT.RECALL. AND SIBLING VERSIONS OF THE REVISED CONFLICT TACTICS SCALES.

The Relationship between Parenting Styles and Alcohol Abuse among College Students in Kenya - Semantic Scholar. (n.d.). Retrieved March 29, 2018, from /paper/The-Relationship-between-Parenting-Styles-and-Abuse-Changalwa-Ndurumo/635fe62af25d41740a3729740dced01c6297584f

Tsuei, S. H.-T., Clair, V., Mutiso, V., Musau, A., Tele, A., Frank, E., & Ndetei, D. (2017). Factors Influencing Lay and Professional Health Workers' Self-efficacy in Identification and Intervention for Alcohol, Tobacco, and Other Substance Use Disorders in Kenya. *International Journal of Mental Health and Addiction*, *15*(4), 766–781. https://doi.org/10.1007/s11469-017-9775-6

Tucker, J. A., Vuchinich, R. E., & Rippens, P. D. (2004). A factor analytic study of influences on patterns of help-seeking among treated and untreated alcohol dependent persons. *Journal of Substance Abuse Treatment*, *26*(3), 237–242. https://doi.org/10.1016/S0740-5472(03)00209-5

Tudawe, I. (2001). *Chronic Poverty and Development Policy in Sri Lanka: Overview Study* (SSRN Scholarly Paper No. ID 1754524). Rochester, NY: Social Science Research Network. Retrieved from https://papers.ssrn.com/abstract=1754524

Weisner, C., Delucchi, K., Matzger, H., & Schmidt, L. (2003). The role of community services and informal support on five-year drinking trajectories of alcohol dependent and problem drinkers. *Journal of Studies on Alcohol*, *64*(6), 862–873. https://doi.org/10.15288/jsa.2003.64.862

Whiteford, H. A., Degenhardt, L., Rehm, J., Baxter, A. J., Ferrari, A. J., Erskine, H. E., … Vos, T. (2013). Global burden of disease attributable to mental and substance use disorders: findings from the Global Burden of Disease Study 2010. *The Lancet*, *382*(9904), 1575–1586. https://doi.org/10.1016/S0140-6736(13)61611-6

Wilsnack, R. W., Vogeltanz, N. D., Wilsnack, S. C., & Harris, T. R. (2000). Gender differences in alcohol consumption and adverse drinking consequences: cross-cultural patterns. *Addiction*, *95*(2), 251–265. https://doi.org/10.1046/j.1360-0443.2000.95225112.x

Wolff, B., Busza, J., Bufumbo, L., & Whitworth, J. (2006). Women who fall by the roadside: gender, sexual risk and alcohol in rural Uganda. *Addiction*, *101*(9), 1277–1284. https://doi.org/10.1111/j.1360-0443.2006.01516.x