PSYCHOSOCIAL FACTORS ASSOCIATED WITH ALCOHOL USE IN SCHOOL GOING CHILDREN IN A PUBLIC PRIMARY SCHOOL IN WESTLANDS SUB-COUNTY, NAIROBI.

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DECLARATIONN AND APPROVAL

Declaration

This research project is being submitted as my original work and has not been presented to any other higher institution of learning for the purpose of advancing knowledge and award of Masters of Medicine in Psychiatry.

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DEDICATION

I dedicate this research project to my lovely mother Joyce Ndinda Ongero and my two children Trudy and Tanya Khasenye, who were very supportive in the entire period of my Research Project.

Thank you all.

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I would like to sincerely thank my supervisors Dr.Anne Mbwayo and Dr. Judy Kamau for their guidance throughout this research project work. I would like to appreciate the participants in the area where my research project was conducted. I would like to thank my mother and my children for their love and endless support

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ABSTRACT

NACADA's filed report for 2017 indicates that alcohol consumption in the age gap of 10-19 years in Nairobi city is close to 13.7%. Other research has connected teen drinking to peer pressure, bad parenting, drug availability, lack of parental involvement, and lack of monitoring and therapy. The Westland region's children's studies did not explore psychosocial components like self-esteem or parenting traits like parental control. This study sought to examine the psychological elements of alcohol use among primary school children in West Lands Sub-County. Cross-sectional research was used in the study, which included 220 students aged 11 to 15 years from a public primary school in Nairobi County, Kenya, who were enrolled in the study. Parents and/or guardians were consulted to get their permission. The children gave verbal permission. For this study, researchers used a variety of questionnaires, including their own, a WHO global health survey on alcohol intake, the Rosenberg self-esteem scale, and the Parental Authority Questionnaire. In order to evaluate the data, SPSS version 22.0s was used. Narratives, tables, and figures were used to display the descriptive data. An inferential statistical approach was utilized to illustrate any statistically significant connections found in both univariate and multivariate analyses. Findings The study recruited 220 participants. The prevalence of alcohol use was found to be 12.7 %The Rosenberg self-esteem scale showed that majority of the respondents had low self-esteem scores of below, <15, the family setup, employment, were significantly associated with alcohol use at a, $p= <0.023$, $p=<0.0027$, respectively. The study concludes that Psychosocial factors family set-up and economic status of the home are perceived to influence alcohol use in pupils in public primary schools. In addition, some family setups are not usually concerned about their children thus, prompting the children to continuously engage in drinking behavior.

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LIST OF ACRONYMS AND ABBREVIATIONS

AIDS	Acquired Immunodeficiency Syndrome
CDC	Centers for Disease Control
HIV	Human Immune Virus
NACADA	National Authority for the Campaign against Alcohol and Drug Abuse
PCT	Peer Cluster Theory
SPSS	Statistical Package for the Social Sciences
UNDCP	United Nations Drug Control Program
UNODC	United Nations Office on Drugs and Crimes
US	United States
W.H.O	World Health Organization

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OPERATIONAL DEFINITION OF TERMS

Psychosocial

A psychological and social component that affects mental health is referred to be psychosocial. People's socioeconomic level, cultural background, parental influence, peer pressure, religious background, and interrelationships all have a role in molding an individual's personality and psychological makeup.

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CHAPTER ONE

1.0 INTRODUCTION

According to a study of 17 Kenyan counties, the frequency of drug and alcohol addiction and consumption among school-aged children is high (NACADA 2017). The type of parental child-rearing practices directly contributes to the behavioral traits of children. They are determinants of self-esteem and self-control among children and therefore determining a child's decision to engage in drug abuse and alcohol consumption (FN Glozah - 2014). Alcohol is the most commonly misused substance in Kenya, accounting for 13.3% of the population, followed by tobacco (9.1%), cannabis (1.0%), and heroin (0.1%). (Nacada 2017). According to a 2017 research by Nacada, 30 percent of Kenyans between the ages of 15 and 65 have tried alcohol at some point in their lives.

Traditional brews like Chang'aa, which are commonly accessible in rural regions, pose a greater danger to rural children than their urban counterparts (Atwoliet al., 2011). In October of that year, according to The Star 2015, 230 students were detected drinking in a downtown Nairobi club called Jerry City Discotheque. Owner of the Discotheque was among those charged in the case. If the parents showed up in court, they would face a fine for permitting their children to enter an unsupervised establishment, while the juveniles would be prosecuted as youngsters in need of care (The Star, 2015). Alcohol abuse is influenced by parental absence. Regional studies show that teenage alcohol usage is influenced by psychosocial variables.

According to the findings, peer influence was a major factor in exposing people to alcohol usage. The desire to match the peer-set standards in alcohol usage leads to more consumption. The study also showed that alcohol users had multiple problems related to drug and substance use. Alcohol consumption and usage are influenced by one's social group. Locally, it was noted that in today's modern culture, young people seldom get guidance from their parents and instead spend time socializing with their friends, who have a significant impact on their conduct (Mwenesi 1996). Lack of parental participation, peer influence, and bad parenting are all linked to alcohol consumption, according to research done in Kenya.

Alcohol consumption, self-esteem, and parental control in children are not well-studied.

The prevalence and psychosocial variables related with alcohol use among elementary school kids in Nairobi County, Kenya, will be the focus of this research study. Among the

psychosocial elements studied were peer pressure, parental control, and self-esteem. A study by Kamenderi et al. (2020) intended to assess the effect of the environment and parenting approaches on the alcohol consumption of Kenyan primary school kids. With an 82.7 percent response rate, 3,307 students from 177 public elementary schools throughout the country were questioned. According to the research, 51.8% of students were male and 48.2% were female. A research indicated that the average lifetime alcohol intake of primary school children is 7.2%.

1.1 Problem Statement

Admitting that alcohol abuse among school-aged children is a social issue is difficult for some people. The problem is that it seems to be a long-standing practice. Younger elementary school students need to be studied in terms of alcohol use risk factors. Many studies have focused on teenagers aged 14 and older, although we know that the age at which alcohol addiction begins is much younger. The rising trend of young people in the nation abusing alcohol and other illegal drugs is leading to incidences of irresponsible conduct and dangerous sex (Mwenesi 2015). Addiction to drugs, reckless conduct, and immoral sexual behavior are just a few of the behaviors that may be influenced by peer pressure (Eneh & Starnley, 2004). Low self-esteem, being around individuals who drink, and having a family member with a history of alcoholism all seem to be risk factors for young people abusing alcohol (Donovan 2004). There is currently a lack of information on the subject. Parental permissiveness has an impact on adolescent drinking (Donovan J. E, 2004). He mentions several risk factors for alcohol use in the Adolescent Health Journal, including age of onset, alcohol availability, parental permissiveness and monitoring, parental perception of monitoring, peer involvement in alcohol use, and alcohol availability.

These risk variables, according to Donovan J.E. (2004), are psychological and impact alcohol consumption. To add insult to injury, there is no epidemiological research to illustrate just how big the issue has become. Alcohol intake among young people is difficult to measure in order to assess the present and future risks associated with it, according to current research. Peer pressure, living with an alcoholic family member, society's perceived easiness, and low self-esteem are all risk factors for alcoholism. It's common to dismiss children's stories of drinking as exaggerated. Protective characteristics include proactive parenting, strong family management, and family connection. All adolescents, regardless of color or ethnicity, have the potential for alcohol misuse issues. Lack of data on alcohol use and its relationship to self-esteem, peer pressure, and parental control are all problems in the Westlands sub-county.

1.2 Justification of the Study

Studying the psychological and social variables that influence alcohol use in a low-risk population was the goal of this study. Adolescents of this age group 11-14 are considered a low risk group thus they are not many studies that had been done in the country. In recent years, incidents of drug, alcohol, and other anti-social conduct have risen sharply among young people, making it one of the most pressing issues confronting the nation. The broad topic of alcohol use has been well researched by the government and non-governmental bodies. Alcohol use among students has been studied in more depth (NACADA 2017) and the risk factors linked with alcohol use, however there are few research in this age group. Furthermore, there are very few studies that show how peer support self-esteem and parental control are affected by alcohol use. The study found that parental influence on their children's drug use (tobacco, alcohol, and marijuana) was adversely connected with substance use, whereas peer support was favorably correlated as a suppression effect.

Alcohol usage among primary school-aged children and its ties to peer influence, parental control, adolescent self-esteem have been mostly unexplored. As a result of this lack of information, administrators and planners in the education sector were unable to come up with proper policies regarding alcohol use in schools.

Alcohol's availability to minors is concerning, even if some businesses are flouting the law by selling it to individuals under the age of 18. Stringent restrictions are needed to protect youngsters from exposure to alcohol and other substances. School excursions and competitions, as well as on the way home and at the weekend when students are free to socialize with each other, are sites when students are most likely to consume drugs (Mwirigi, 2015).

In cities, parents work long hours and don't have time with their kids to discover problems, leading to a rise in young people using drugs and alcohol (Mwirigi, 2015). The presence or lack of parental supervision may influence an individual's alcohol use. In Naivasha, Kenya, fourteen students were found having sex, smoking bhang, and drinking alcohol in risky conditions in September 2016. Among those seized were elementary school girls in a situation that appalled the parents and teachers of those involved, officials searched a property the youngsters had rented.

In order to get parental permission to be left alone, children informed their parents and guardians that they were going to church (Murage, 2016).

The researcher's goal was to gather data on the psychosocial variables that influence the usage of alcohol by students in Kenya's Nairobi County. The study demonstrated how self-esteem, parental control, and peer support might influence alcohol usage. The ultimate objective is to have an impact on the alcohol policies of all public primary schools and to investigate the inclusion of an alcohol screening tool in guidance and counseling departments of these establishments. Also, it helped to develop school-based alcohol intervention programs. School-based treatments are most effective when implemented as a primary prevention program, with the largest impacts reported in kids who had not previously experimented with alcohol (Perry et al., 1996). The knowledge obtained from the study was informed caregivers to come up with appropriate care and prevention plans. This will enable interventions that affect the children in their social setup which is both at school, in the community and at home.

1.3 General Objective

To ascertain the prevalence of alcohol consumption and the psychosocial variables that impact it among primary school students in a Westland Sub-County public school.

1.3.1 Specific Objectives

I. Determine the prevalence of alcohol abuse among students.

II. To evaluate the level of self-esteem of pupils who use alcohol.

III. To find out whether there is a connection between students' alcohol use and their psychological well-being (peer pressure, parental supervision, and self-esteem).

1.4 Research Question

To what extent do psychosocial characteristics (peer pressure, parental supervision, and self-esteem) affect the prevalence of alcohol use among primary school students?

1.5 Significance of the study

The field of early childhood studies will benefit from this investigation. It will assist teachers and parents identify protective factors that can deter underage drinking. This works importance is to establish active guidance and counseling departments in schools and enable child psychologists, counselors and psychiatrist identify risk factors in children that are associated with alcohol use.

CHAPTER TWO

2.0 LITERATURE REVIEW

2.1 Lifetime Prevalence of Alcohol Use among School Children

It has been shown that students' risk of acquiring alcoholism is influenced by socioeconomic and cultural factors. There has been a rise in alcoholism in Kenya, which has sparked worries about the likely causes of this troubling development. According to Lukoye et al., the percentage of Kenyan college students who have been intoxicated is 51%. The frequency of drunkenness among Nairobi's street children is substantially greater than previously reported research, which found a 14 percent prevalence rate (Obonyo et al., 2018). An further concern is the decreasing age at which most youngsters first try alcohol.

Studies have also shown that the onset of alcoholism is strongly linked to the age at which a person begins drinking, with younger people more likely to develop alcoholism as adults. A person's efforts at alcohol-free living are made possible by modifying the environmental circumstances or signals associated with alcohol use. The statistics for alcohol use and drug abuse among school-going children are astonishing. Specifically, 12.6% of teenagers are active consumers of tobacco, 6.6% drink alcohol among 6 African states (Rhew, David D. Hawkins & Oesterle, 2011). There are many consequences of substance use, such as school absences, loneliness, sleep issues, melancholy, suicidal thoughts and plans and poverty, which are all linked to substance use. Furthermore, the inclusion of alcohol and drug awareness lectures and the lack of action by both the school administration and parents in addressing emergent behavioral issues were shown to enhance the continuation of deviant behavioral changes. In another study, the prevalence rates for alcohol consumption, smoking, and the abuse of other drug substances among teenagers in Pietersburg area in Northern Province was 39.1% (Madu SN & Matla NQ 2003).

Alcohol abuse is a problem that affects students throughout the world, according to international studies. There is a rising issue of underage drinking in England, and the National Foundation for Educational Research has recommended a wide range of solutions that may reverse the trend. According to a 2012 research, 43 percent of kids between the ages of 11 and 15 were found to have engaged in the vice. The research found that 12 percent of 11-year-olds were inebriated on a regular basis, compared to 74 percent of 15-year-olds, indicating that frequent intoxication increases with age.

Individuals' proclivity for confessing to being intoxicated differed greatly as well. According to research, females were more likely to confess to being inebriated than their male counterparts. Simultaneously, kids who drank often were more likely to acknowledge to their drinking habit. In Wales, comparable drinking patterns are seen, with over 250,000 children aged 11 to 16 declaring having had alcohol twice or more in 2010. Girls' proclivity to report drinking incidents was similarly much greater than boys' in the Walsh setting.

2.2 Age of onset

Research by Embleton, Atwoli & Braitstein (2013) found that children who begin drinking alcohol at a young age are more prone to develop drug addiction issues that may lead to the usage of harsher substances like Heroine and Bhang if they don't seek treatment. Obonyo and Lukoye observed that several minors began drinking before their 12th birthdays in their research. This is when the majority of students begin drinking for the first time, and it occurs throughout this time period, which is when puberty begins. This suggests that peer pressure and influence may play a role in influencing Kenyan children's alcohol use.

Several variables explain alcohol consumption patterns for people, including the age at which individuals start drinking alcohol. It is generally established that males engage in alcohol use earlier in life compared to their female counterparts. (Okwumabua, Duryea, & Okwumabua, 1987). Adolescent drug usage seems to peak in the first year of high school, according to a recent South African study. People who had tried drugs or alcohol were found to have started using far earlier than their peers their own age, with alcohol and cigarette use being the most common culprits by far (Van Heerden et al., 2009) Youth alcohol use and fatality rates are particularly high in the United States, with the country accounting for a large majority (thousands) of these tragedies each year (IAS, 2016). The country had 4300 deaths in 2010, with steps to combat the escalating trend expected to cost $24 billion. In the United States, the legal drinking age is 21. However, data indicates that underage drinking consumes 11% of all alcoholic beverages consumed in the nation (IAS, 2016).

Binge drinking is a common way for minors to consume alcohol. According to research comparing the drinking habits of American adults and teenagers, the latter are more prone to partake in binge drinking. According to CDC surveys from 2010, about 189,000 people aged 12 to 20 are likely to engage in binge or controlled use of alcohol in some way in the previous year.

2.3 Psychosocial Factors

Cognitive and behavioral research is the best way to get a handle on alcohol usage. People's drug-taking habits may be shaped with the help of learning and conditioning principles. Studies show that views learnt through role models in family, society, and media can have an impact on how much alcohol people drink and how much they misuse it. Alcohol abuse is linked to a number of risk factors. This causal relationship helps to identify the groups which bear a greater risk of falling into alcohol consumption (Helzer, 1987). At the same time, it is not all the risk factors that directly lead to alcohol usage trends (Helzer, 1987).

Children who are more prone to become alcoholics have particular characteristics, according to studies. It has been shown that the majority of students that developed alcoholism in high school either lived with their grandparents or were Christian and attended boy's schools, according to Francis et al. (2014). Parents' inclination to give their children substantial quantities of pocket money was a factor in the rise in alcohol use among the students, and another risk factor was the positive effect of peers who adopted alcoholic practices. Alcohol misuse may be exacerbated by low self-esteem. According to Patock Peckham and Morgan-Lopez (2008), parenting styles have a direct influence on children's self-esteem, self-control, and alcohol use attitudes. Overprotection during the early stages of development directly contributed to poor decision-making abilities during teenage life and these predisposed children to engaging in alcohol and substance abuse. The problem of low-self-esteem was prevalent among male children compared to girls. Overprotection directly contributes to active alcohol consumption patterns as children get tempted to try their curiosity on some things while hiding from parents.

Family structures and setup had been found fundamental in the prediction of alcohol consumption behaviors among children. EG Broke et al. (1990) and Kandal & Andrews (1987) established that poor bonding among family members, poor child upbringing practices directly contributed to early alcohol consumption. Godwin found that children of alcoholics were more prone to start drinking at an early age (1985). A combination of such attitudes makes it possible for teenage initiation into alcohol use and substance abuse.Even though there is evidence to show that these attitudes are family-based as well as the environment in which a child is brought up, the relationship has remained unexplored to comprehend how children are initiated to alcohol usage.

Peer pressure has a major impact on group behavior since people are perceived to have relationships in their social networks and the effect of group behavior is greatly influenced by social networks (Duan et al., 2009; Berdnt 1992). A society that makes it simple to get alcohol and

other narcotics encourages people to use them in line with their social context and established norms. The study's findings revealed a negative correlation between parental control and drug and alcohol usage. Peer pressure, on the other hand, is directly linked to drug misuse because of the suppressing effect (Wasis TA, Resko AJA, Ainnete MJ & Mendoza d June 2004). A poll found that 10% of children who had drank alcohol had friends who had also done so, compared to 5% of children who had not. That many youngsters who feel that drugs are easily accessible at school may have used alcohol is a strong indication.

2.3.1 Parental Control

Parents and guardians, particularly those who are responsible for raising children, have a huge influence in creating social and behavioral disorders in their children. Health and conduct among youngsters were influenced greatly by parental guidance (Loke & Mak, 2013). At various levels, parents are perceived as first role models that mold behavior and character among children. As a result, they should advocate for good conduct, use the right techniques to reward good character, and remove any impediments to the formation of good behavior in children. Children whose parents are drug abusers have a greater chance of developing the habit themselves (Messina, Calhoun, Conner & Miller, 2015). There is evidence to show that the parent-child patterns had a key role to play in influencing teenage alcohol use behaviors (Baumrind, 1991).

Authoritative parenting has been identified to have a negative effect on alcohol consumption patterns among teenagers. Frankling (2014) found that children raised by domineering parents are more prone to participate in alcoholism in the early stages of their lives because of their poor self-esteem. Parental engagement in drug and substance abuse is influenced by a lack of support from parents, monitoring, communication, and parental contact, according to a study by NACADA. Another factor that leads to youngsters finding consolation elsewhere is a lack of consistency in punishing, antagonism, or rejection from their parents. According to the report, 18.5% of parents admitted to accompanying kids to alcohol establishments. This psychologically influences the children to engage in alcohol consumption at an early age. 28.3% of the interviewed parents reported to had adults in homes who were actively consuming alcohol. The study further revealed that 19.6% of the parents were taking alcohol from their homes, which is a serious risk for children. However, the majority (77.3 percent) admitted to drinking alcohol only when they were away from their houses and no minors were present. This question was ignored by 3.1 percent of respondents.Sixty-five percent of parents surveyed were unaware of their

children's social circles (Nacada 2010 survey Role of parents in prevention). Family conflict is more prevalent among parents of alcoholic children.

Without their awareness, kids may have friends that are harmful to their well-being (In Nairobi, 2010: Parents' Role in Preventing and Controlling Alcohol and Drug Abuse in Their Children).

2.3.2 Peer Influence

Adolescents are often influenced by their peers, and many of them take up the habit from their role models, who are often their best friends. Identifying friends with similar interests and attitudes may lead youngsters to explore and emulate each other's behavior; if other family members are also users, there is a greater risk of alcohol use. The family history of alcohol misuse is the most significant risk factor for children. Although hereditary predisposition may play a role in alcoholism, it's unclear how much of such vulnerability is a result of the family's environment (Kaitlin Bountress and Laurie Chasin Am J Orthopsychiatry. 2015 May).

A person's susceptibility to alcoholism may be influenced by hereditary factors. According to local surveys, kids in rural and urban areas consume a wide range of alcoholic beverages. Canned alcohol is more popular in metropolitan areas than in rural areas, where people consume illegal brews like Chang'aa and Busaa more often (Francis, Grosskurth, Changalucha, Kapiga, & Weiss, 2014).

Family and cultural variables have a significant role in determining a person's likelihood of abusing drugs (Glints &Pickens 1992). Kenyan studies show that more than one-fifth of elementary school pupils (22.7%), and more than two-thirds of university students (68%) consume alcohol. From elementary school through university, children across the board are exposed both to alcohol and illegal narcotics (Atwoli et al., 2011). A poll found that 22% of secondary school pupils were using drugs, with men more likely to use khat and inhalants, followed by alcohol, miraa, cigarettes, and bhang (Siringi, 2003). It was more dangerous to live with a group of your peers, then your siblings, and finally to remain in a town. It's also important to consider how bad things are where you live when assessing the scope of the issue. Kids raised in areas where drugs are easily accessible. There are a large number of residents who use drugs, and those who live in areas where drug use is common are more inclined to follow in the footsteps of their peers and participate in undesirable actions (Glantz and Pickens 1992).

Peer pressure may lead adolescents to engage in risky conduct. Children under the age of 12 are included in one out of every three worldwide polls. Students in grades 8 through 12 participate in the Monitoring the Future study. Students in grades 10 through 12 were more likely to have drank alcohol within a month of each other in 1999, according to a survey (Johnston et al., 1999). According to the CDC, grades 9-12 are covered in the annual Youth Risk Behavior Survey.

The NIDA requires annual household drug abuse survey Current research has revealed a number of factors that encourage teenage substance use, including a parent's alcoholism and a close friendship with classmates who use drugs (Chassin et al. 1996). Another substantial risk factor for teenage alcohol intake is having companions who are drunkards or actively use drugs, in addition to delinquent conduct (National Institute of Drug Abuse October 2003 publication).

2.3.3 Self-esteem

Self-esteem is the conviction in one's own physical, emotional, and intellectual potential. It is personal respect which determines the attitude that individuals have towards different subjects in addition to how they interact with other members of the society. Having unstable self-esteem is a key predictor of both internal and external troubles (Ostergeel et al. 2001). Addiction to alcohol may cause physical and emotional harm. When someone begins drug usage, their self-esteem almost invariably decreases. Individuals with poor self-esteem, for example, have emotions of inadequacy; they are unable to escape self-destructive sentiments of unworthiness and are readily sidetracked by environmental contacts when pursuing personal objectives. Fernandez (1995) claims that teenagers with poor self-esteem are more prone to drug use. Adolescents with poor self-esteem use substances to deal with bad emotions and to escape from stressful situations (Ryan, 1995).

According to Rosenberg (1965), adolescent self-esteem is a major factor in determining one's psychological well-being. Self-esteem was examined in a research of young people. Barstch, King and Vidoureck (2017) observed that adolescents with poor self-esteem were more likely to binge drink. Parish and Parish (1991) found that those with poor self-esteem are considerably more prone to drink alcohol as a means of gaining some kind of support and acceptance from their peers. It has also been shown that children who are raised in an authoritarian environment have poor self-esteem. Both of these concerns work together to encourage young people to drink and abuse drugs at an early age (Franklin Glotzer Ghana 2014). Self-esteem in teenagers was strongly linked to

parental conduct (Mwihaki, 2013). Most alcoholics use alcohol to cover up their undesirable personality traits.

2.4 Theoretical Framework

Scientific research relies on theories to give direction and guidance, and theories serve as a foundation for understanding public health issues and developing effective solutions. In my study we investigated how psychosocial factors affect alcohol use. The psychosocial factors being studied include peer influence, self-esteem and parental control. One theory in itself cannot explain how all factors can affect alcohol use in children. Since self-esteem and parental control impact children's peer group alcohol consumption, I used the cognitive social learning model. An important component of drug use is predicted by the theory of social learning, which holds that people's attitudes about substances and expectations about their effects both play an important role.

a. Social Learning Theory

The Theory of Planned Behavior is unique in that it separates self-efficacy from SCT. Self-efficacy is impacted by an individual's talents, personal variables, and the environment in which they are living. (Bandura 1997). Because parents are the major socializers and role models for their children, their drinking habits have a disproportionately large impact on their offspring. Parenting activities in general and alcohol-specific practices specifically are strongly linked to their children's alcohol consumption to the degree that parents serve as both models and agents of socialization (Jackson et al, 1999). Several pathways for the transfer of dangers from parents to children have been discovered via study.

b. Social Cognitive Theory

According to Social Cognitive Theory, behaviour is a function of inherent internal processes of an individual, which include self-awareness, beliefs, and spatial perceptions. The theory outlines the relationship that has been established between stress, socialization, and the methods of coping with the stress. All of these factors directly influence one’s self-esteem. Bandura postulates that the interaction between internal and external processes shapes one’s behavior. In addition, the self-esteem model suggests that expectations are a product of cognitive influences. Thus, a person's long-term conduct is influenced by their self-esteem, which interacts with external variables including a dysfunctional family, peer influence, and accomplishment aspirations. Application of the social cognitive theory in understanding drug and substance abuse among teenagers shows that it is an activity that starts with observation and desire. Attractive

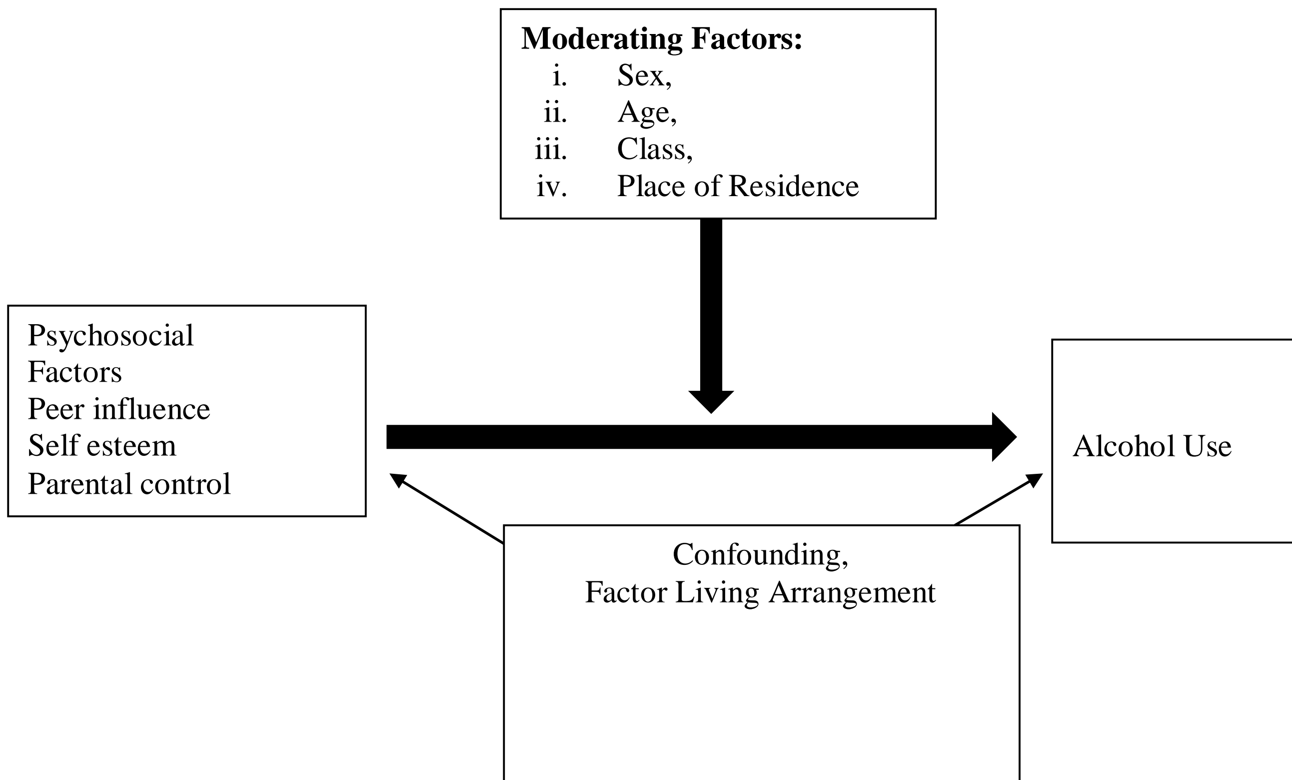
expectancies towards the use of drugs and alcohol lead to early initiation in the use of the substances. Self-esteem has an important influence in goal-directed conduct, for example (Patterson, 1986). According to the theory of social learning, attitudes toward drugs and expectations about their results play a significant role in their usage. Teenage alcoholism may be caused by low self-esteem and lack of parental supervision.

2.5 CONCEPTUAL FRAMEWORK

Psychosocial factors i.e. self-esteem peer influence and parental control are independent variables they are the factors that can affect the dependent variable which is alcohol use. Moderating factors in this study are sex age class and place of residence this can affect by either strengthening or diminishing alcohol use in children

Confounding factors are like living arrangements it can affect both the association between dependent and independent variables and affect my result. This was be reduced in my study because of random selection of student. **Conceptual Framework**

Dependent Variable **Independent Variable**



CHAPTER THREE

3.0 METHODOLOGY

Cross-sectional analysis of the Dagoretti North Constituency in Westland's sub-county primary school students in Nairobi was the focus of this research. It was the goal of this research to examine the psychosocial influences on alcohol usage. The study focuses on one public primary school located in Westlands in Nairobi County. Westlands sub county has 25 public primary schools whose population is approximately 28,000 pupils. Due to budgetary constraints the study only sampled one school.

3.1 Study Site Description

The study was conducted at Kilimani Primary School in Westlands Sub County, which serves both poor and middle-class families. The school was b conveniently sampled due to the fact that it is public primary schools and children enrolled in the school are from diverse backgrounds. A new curriculum is now being introduced at the school, however the 8-4-4 curricula is still in place. It is situated on Argwings Kodhek Road in Nairobi County, Kenya, and was established as a public elementary school in 1955. There are now 1311 students enrolled in grades 5 through 8 at the school, which is located in the Kilimani area of Nairobi. Students come from a wide range of religious traditions.

3.2 Inclusion Criteria

- Pupils enrolled at the elementary school.
- Between the ages of 11 and 14
- Class 6 to 8 students.
- Permission from a parent or guardian to participate in the study
- A consent form must be filled out by children who desire to participate in the study.

3.3 Exclusion Criteria

- A parent or guardian's inability to provide informed consent
- Children under the age of eleven
- Children who are not interested in participating in the research.
- • Students who skip a crucial day of school.
- • Students unable to participate due to sickness on the study day.

3.4 Sample Size

According to the school's data, there are around 1311 students enrolled. $N=Z^2pq/d^2$ as employed by Cochran was used to get the sample size, which is the usual formula.

n = the minimum sample size (if the target population is greater than 1,000)

Z = standard normal deviation at 95% confidence level 1.96

p = the proportion of the target population estimated to have characteristics being

Measured. 30 percent of the population was studied in this research (NACADA, 2007).

q = the remaining population after removing p from 1 (1-p)

d = 0.05 statistical significance level or degree of freedom

The sample size was determined using the following parameters: 95% confidence, 1.96 standard deviation, and 0.05 minimal error:

Sample size desired = 1.96^2x 0.3x 0.7/ 0.0025

n= 322.69 = 323

3.5 Sampling Procedure

West lands sub-county in Nairobi County was be conveniently sampled. The schools were conveniently sampled due to the fact that it is a public primary school and children enrolled in the school are from diverse backgrounds. Children were selected by random sampling. The questionnaires were sent to all students in the three streams that were chosen for the study: sixth, seventh, and eighth graders. A researcher expects some children and their parents and guardians to reject to participate in the study because of its sensitive nature.

3.6 Participant Selection, Recruiting and Consenting Procedures

The investigator was in constant communication with the school's head teacher. A primary school visit was arranged, as was a meeting with the head teacher to discuss the study's details. After that, the principal worked with the school's parents and teachers' organization and the individual instructors in charge of the various classrooms. It was made clear to the parents and teachers association, as well as to the instructors and the principal investigator, that the research was taking place. Each classroom was visited by the researcher, who explained the goal of the study, as well as the ethical problems involved with it, to each participant. Attendees who couldn't make it signed informed consent papers to have their parents or guardians sign them in their place. The lead researcher requested that the youngsters provide him with the contact information for their parents or guardians.

One week later, the principal investigator met with eight research assistants who were her coworkers. At 4 p.m. on the study day, the research assistants went to their various courses and did the research. Teachers were instructed to leave the classroom to emphasize the need of privacy. The questionnaires were distributed. Next, a socio-demographic questionnaire was filled out, which contained questions about age, sex, class, domicile, family structure, and religion. The Rosenberg self-esteem scale and a parental authority questionnaire were used to examine students' drinking habits The Rosenberg self-esteem scale and a parental authority questionnaire were used to examine students' drinking habits. As soon as classes ended at 4 pm, this had to be done in the children's classroom.

The questionnaires were labeled with unique identifiers, and pupils were asked not to complete them with their names. In the classroom, each child was given a questionnaire to complete. Any child who had not been informed or given informed consent forms was asked to leave the class; this caused no inconvenience, as this was their 4pm break. After the remainder of the children completed the questionnaires, they were placed in a box outside the classroom. Research assistants gave out questionnaires to the lead investigator after explaining alcohol usage to all of the kids. Forms were produced and correctly labeled and saved by the lead investigator. They will be used in the future.

3.7 Data collection instruments

a) Socio-demographic questionnaire (researcher designed)- Appendix 4
b) Pupils alcohol usage as measured by a modified global school-based health questionnaire- Appendix 5
c) Rosenberg self-esteem scale –Appendix 6
d) Parental authority questionnaire – Appendix 7

3.8 The social demographic data questionnaire

All individuals completed the socio-demographic survey. The survey was utilized by researchers to learn more about the children. Data on socio demographic characteristics such as age, sex, education and religion, and family structure are gathered through this survey questionnaire. There are also inquiries on one's drinking habits. Children who drank with this were initially tested for peer influence.

3.9 Global School-Based Health Questionnaire

Health-related behaviors such as alcohol consumption and protectiveness were examined by the WHO and CDC in cooperation on a short, structured questionnaire for students aged 12 to 17 years old. It was given in the classroom and has been used in several epidemiological investigations. Researchers conducted tests to ensure the GSBHQ's validity and reliability and found it to be acceptable. While other instruments might take longer to administer, this one can be used by any researcher following a short training session. Studies in the general population of our nation have employed this approach effectively before. A modified WHO questionnaire to evaluate alcohol consumption among students and a minimal subset of items that concentrate on gathering data on children's alcohol use are included in this survey. Measurement of alcohol consumption in children under the age of 10 has been done using the WHO Questionnaire, which has been modified.

3.10 Rosenberg Self Esteem Scale

Swagger is a test that Rosenberg devised.

The Rosenberg Scale may be used to gauge one's self-esteem. (RSES 14).

Five good and five bad items are rated from one to four on a scale of one to four, with the highest possible rating of strong agreement to strong dissent (0). The greater the score, the more self-assured the individual is. In general, I feel good about myself, but there have been times when I've felt awful about it. From 0.85 to 0.88, internal consistency reliability was discovered. It has also been discovered that the reliability is 0.88.

Scores on the Rosenberg self-esteem scale is:

Scores are calculated as follows; *For items 1, 2, 4, 6,* and *7: strongly agreed=3, Agreed=2* Disagree d= 1strongly disagreed is 0 *For items 3, 5, 8, 9,* and *10* (which are reversed in valence): Strongly agree d= 0 Agreed = 1 Disagreed = 2 strongly disagreed =3. The scale ranges from 0-30. Scores between 15 and 25 are within normal range; scores below 15 suggest low self-esteem.

3.11 Parental Authority Questionnaire

Description: The PAQ is used to determine parental authority, or disciplinary practices, in relation to the child (of any age). The PAQ is split into three subscales: permissive (P) (items 1, 6, 10, 13, 14, 17, 19, 21, 24 and 28), authoritarian (A) (items 2, 3, 7, 9, 12, 16, 18, 25, 26 and 29), and authoritative/flexible (A) (items 2, 3, 7, 9, 12, 16, 18, 25, 26 and 29). (A: items 2, 3, 7, 9, 12, 16, 18, 25, 26 and 29). (4), (5), (8), 11, 15, 20, 22, 23, 27, and 30. The only difference between the

mother's and father's portions of the evaluation is the mention of gender. On a 5-point scale, students mark the number that most accurately depicts how the kid feels about his or her mother or father, with 1 indicating strong disagreement and 5 indicating strong agreement.

Scoring: In order to assess the PAQ, one just has to total each individual question's score in order to acquire the Subscale scores. In each subscale, there is a maximum possible score of 50. Taking the Parental Authority Questionnaire. The PAQ was used to examine parenting behavior. The PAQ was designed as a self-report instrument for teenagers to answer questions on their parents' relationship with them in order to measure this relationship. On a five-point scale, the PAQ has 30 questions, 10 for each of the three primary parenting styles, with higher scores indicating more dominance of one type over the others. Throughout my youth, my parents never allowed me to question their judgments, and they constantly told me exactly what they wanted me to accomplish and how to do it. During a two-week period, the PAQ's dependability ranged from α=0.77% to 0.92%. α=0.78, 0.86, and 0.74 for the authoritarian, authoritative, and permissive patterns in this sample, respectively, are the PAQ reliability scores.

3.12 Data Collection

For the sake of accuracy, quality control steps were conducted before data collecting began. This involved the creation of SOPs and a data collecting manual to assist in the gathering of data. All data put into MS Access databases was overseen by the researcher (2007). The questionnaire architecture was used to build the databases, and the data was encoded numerically to minimize data entry errors. Access databases were converted to SPSS version 22 for analytical purposes. In order to clean and analyze information. The SPSS algorithm for summarizing variables was used to evaluate the database for inconsistencies and erroneous entries. Using the unique identifier supplied in each questionnaire, researchers may go back to the questionnaire and fix any data entry errors.

Data Analysis

Rudimentary statistics were used to analyze the data. Completeness, correctness, and consistency of information were evaluated on the questionnaires. The surveys were verified for mistakes and omissions, as well as for appropriate information, readability, and relevant replies. SPSS was used to analyze the data. Tables displaying frequency and percentage data were created from the programmed data and shown.

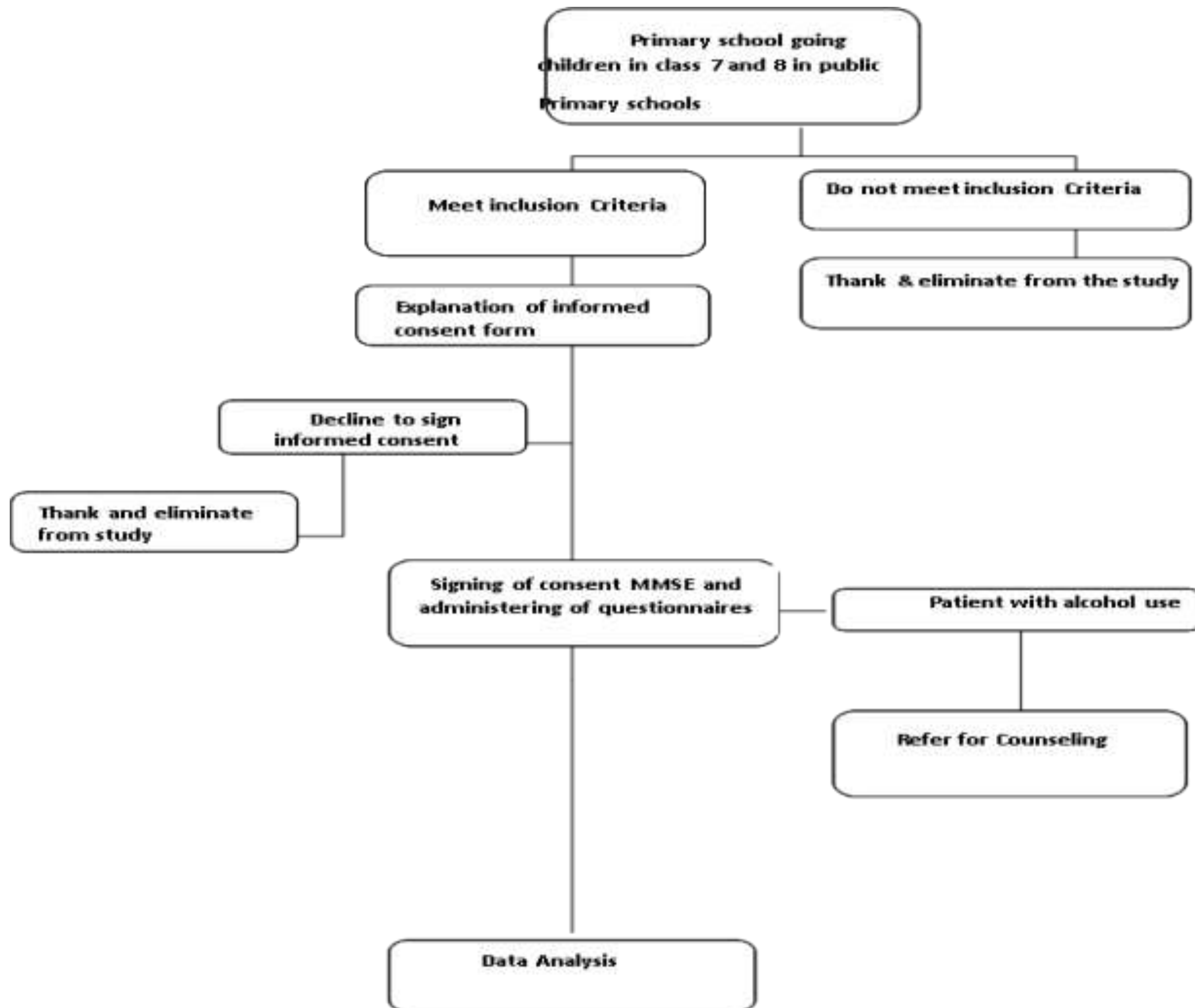
3.13 Data Collection Procedure

Throughout the study period, the researcher questioned students who met the requirements. In the first semester, there was time for studying. The researchers used an easy sampling strategy to enroll volunteers. When the informed permission of the parents was obtained, the participants were exposed to a socio-demographic questionnaire devised by the researchers and a modified version of the GSBHQ questionnaire to quantify their alcohol usage. The self-esteem measure developed by Rosenberg with the questionnaire on parental control. As a consequence, participants were not compelled to provide their identities on the surveys they completed. According to ethics, children cannot be sampled individually; this is because children are considered as vulnerable and require protection; this is why the data collecting was done in groups of pupils. For this study, the research assistants received instruction on how to complete the necessary forms and gather the necessary data in a systematic manner. Researchers' questions were promptly answered by the principal investigator.

3.14 Data Management and Analysis

Confidential responses to the questionnaires were stored in a safe place. To input, cleanse, and analyze the completed surveys' data, the researcher utilized SPSS version 22.0, which required a password to access. Data analysis using descriptive statistics was done, and data was presented in narratives, tables, and figures.

Figure 2: Data Management and Analysis.



3.16

Study Limitations

1. Only one location was used for this investigation. Note that this research focuses on students in elementary school. Children who were not in school were expelled.
2. Students with significant intellectual and developmental disabilities were not included in the research because they may not be able to appropriately answer questions. All students who had not been given informed permission by their parents or guardians were also exempted from the study.
3. Children are not picked individually, but rather as a group, and this means that they may not be able to gain individualized information since the questions were wide and the responses received were broad.
4. The teachers assisted in distribution of the questionnaires to the children this caused a bias that was considered. This hindered anonymity bearing the sensitive nature of the study.
5. The informed consent was sent in needy cases to the email of the recipients, in this case recipients were the parents. This may have encouraged survey fraud.
6. Not all parents had access to the internet and modern technology.

3.17 Ethical Consideration

3.17.1 Institutional Review Bodies

The study's ethical and research committees at the University of Nairobi (UON) and the Ministry of Education both gave their approval to its execution. NACOST written authorization was acquired from the administration and school officials at Kilimani primary school to conduct study.

3.17.2 Recruitment Strategy

Information gathered during this survey was utilized only for research purposes, participants were notified of this prior to their participation. Participants had the freedom to leave the experiment at any time they choose. At each point, a verbal renegotiation of permission was used to ensure that the children's interest remained high enough to continue their participation in the study. That made it possible for the youngsters to step away from the study as necessary.

3.17.3 Consenting Process

Written informed permission was obtained from the children's gatekeepers, their parents or the school officials, after the study's aim, benefits, and dangers were properly explained to them.

3.17.4 Confidentiality

The client's privacy was a top priority throughout the planning stages of this investigation. Professional behavior and discipline (the Declaration of Helsinki on human experimentation and structural legislation and the 1949 medical ethics) were followed in this study. Serial numbers rather than names were utilized to identify participants. There were strict privacy policies in place for all information gathered, and all data was stored in a locker.

3.17.5 Covid-19 precautions

Conduct a Covid-19 test before to beginning the research. Prior to the trial, each research assistant underwent a Covid-19 test. At all times both research assistants and I were put on protective head gear to prevent infection. We also maintained adequate social distance of about one meter at all times. The research questionnaires were stored for 14 days in a safe environment before the researcher started to analyze the data. The teachers administered the questionnaires to the children this caused a bias that was considered. The questionnaires were also where need be sent to the email of the recipients, in this case recipients were the parents. In addition, telephone consent was be sought from the parents instead of verbal consent.

3.18 Financial benefits

Participation in this research came with no monetary compensation. Participants with alcoholism disorders, on the other hand, were directed for further treatment and counseling as necessary. The findings of this research will help doctors treat patients in similar circumstances in the future.

3.19 Risks and Protection against Risks

Discussion of sensitive themes posed a risk. In the event that an alcohol use disorder diagnosis was made, those individuals were directed to the appropriate treatment facility or facility.

3.20 Potential Benefits to Participants

A M.Med. thesis will be published with the study's partners (KNH/UON, Kilimani Primary School).

3.21 Study Outcome

Reports on alcohol use should prompt the development of effective treatments, laws, and preventative measures, as well as a determined effort to combat the vice.

CHAPTER FOUR

RESULTS

4.0 Introduction

According to the general and particular goals of the investigation this chapter focuses on the presentation, interpretation and analysis of results of the study.

4.1 Response Rate

The target demographic was comprised of 220 students. The surveys were returned at a rate of 96%. Eight surveys were omitted from the analysis due to incomplete responses. This research had a response rate that was greater than the norm for academic surveys suggested by experts (1999, Daniel).

4.2 Interpretation of Demographic Information

Two hundred and twenty questionnaires were sent to responders. The respondents' ages were dispersed according to the distribution presented in Table 4.1. The economic status and other demographic information of the pupils' parents are distributed as show in the table below.

Variable		Frequency	Percentage (%)
	Age		
	12	26	12
	13	112	53
	14	55	26
	15	17	8
	Missing	2	1
	Gender		
	Male	51	24
	Female	161	76
	Class Enrolled		
	6	45	21
	7	168	79
	Religion		
	Christian	8	4
	Catholic	51	24
	Muslim	38	18
	Protestant	106	50
	Others	8	4
	Family Setup		
	Both Parents	148	70
	Single Mum	28	13
	Single Father	8	4
	Others	28	13
	Occupation of Parent		
	Unemployed	20	9
	Formal employment	65	31
	Informal employment	14	6.6
	Self-employment	97	46
	Missing	16	8

Table 4.1: demographic information

This table shows that most people surveyed were between ages 13 and 14, with 79% being from the seventh grade and the majority of them being females. Eight respondents come from Christian home, 51 are catholic and 18% are Muslim. Most of the respondents 70% come from homes with both parents, while 4% live with single fathers. A large percentage of the parents (31%) are employed in the formal employment sector while 9% are unemployed.

4.2 Determine Prevalence and Psychosocial factor that influence Alcohol use

The primary objective of this research was to examine the prevalence and psychosocial variables that influence the use of alcohol. This section focuses on identifying psychosocial variables and assessing whether they impact alcohol usage. First, the students were asked whether they had ever consumed alcohol, and their replies are reported below.

Have you ever drunk alcohol		Frequency	Percentage (%)
	yes	27	12.7
	no	185	87.3
	Total	**212**	**100.**0

Table 4.2: Alcohol Use

Findings in table 4.2 show that 87.3% of the respondents have never abused alcohol and the remaining percentage having ever drunk alcohol at 12.7%.

4.2.0 Gender * Have you ever drunk alcohol cross tabulation

The table below shows which gender uses alcohol. A cross-tabulation was performed to illustrate the link between alcohol usage and gender.

		have you ever drunk alcohol		Total
		yes	no	
gender	Male	22	29	51
	Female	5	156	161
Total		**27**	**185**	**212**

Table 4.2.1 How gender influences alcohol use

The table above shows that majority of the pupils who have ever drunk alcohol are boys. When boys reach adolescence, they tend to feel like they have become more masculine and can experiment whatever they feel like and only two girls have ever drunk alcohol.

4.2.1 Peer Influence

This section determines which company influences the use of alcohol. The pupils were asked who they were with when they first drunk alcohol and their responses are summarized as follows:

Who were you with when you first drunk alcohol	Frequency	Percentage (%)
My peers	16	7.5
My family	8	3.8
Someone else	3	1.4
Non- drinkers	185	87.3
Total	212	100.0

Table 4.3: First time drinking with whom

When the respondents were asked, who were they with when they first tested alcohol? Most of those who had tasted alcohol tasted it while in the company of their peers.

Students were further asked if in the past days, they had drunk alcohol and how did they get access to the alcohol. Their responses are summarized below.

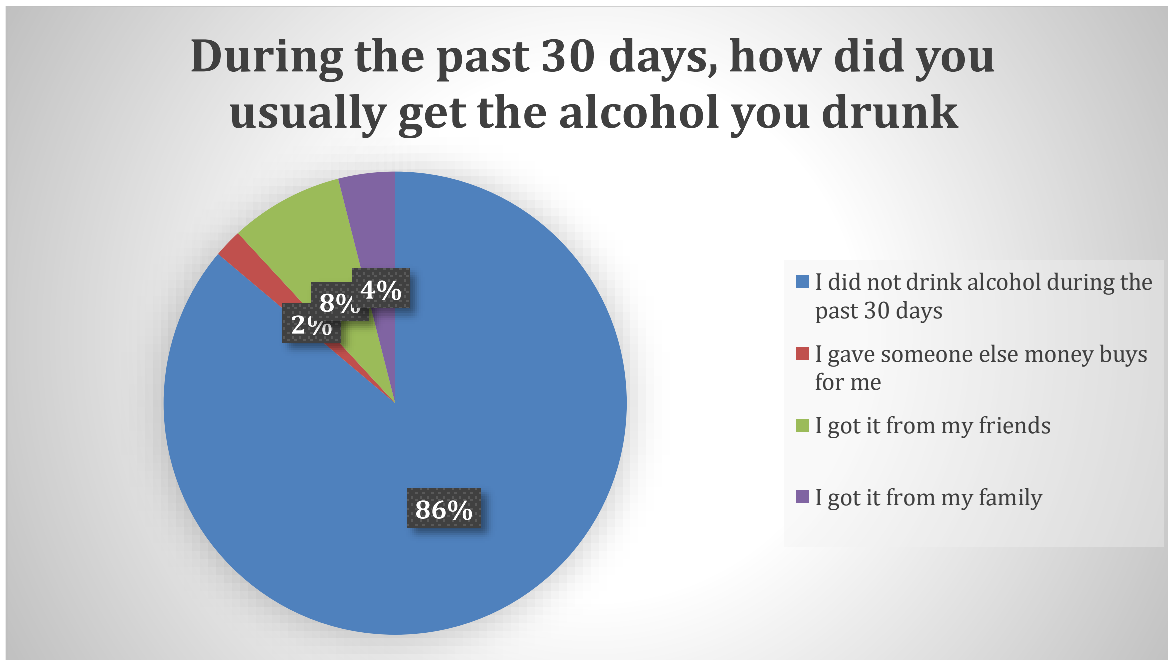


Figure 4.2 How students get access to alcohol

Findings from figure 4.1 show the association between who they were with when they first drunk alcohol and how they usually get the alcohol they drink. The table above shows that most pupils get their alcohol from friends.

Table 4.4 Global school research questionnaire

Table 4.4 gives a summary of the responses on the global research questionnaire as shown below.

Questions on alcohol drinking		Frequency	Percentage (%)
How old were you when you had your first drink, or rather a few sips, of alcohol?	Never drunk	185	87.2
	<7	4	1.9
	8-9	7	3.3
	10-11	11	5.3
	12-13	5	2.3
During the past 30days, how many days did you drink at least have a drink containing alcohol?	0	185	87.2
	1 to 2	8	3.8
	3 to 5	4	1.9
	6 to 9	15	7.1
	10 to 19	0	0
	20 to 29	0	0
	All 30	0	0
How many drinks did you typically consume during the last 30 days on the days you drank?	Didn’t drink	188	85
	<1	20	9
	2	8	4
	3	4	2
	4	0	0
	>=5	0	0
How many times in your life have you consumed so much alcohol that you become really inebriated?	0	192	87
	1 or 2	20	9
	3 to 9	4	2
	>=10	4	2
How many times during your life have you run afoul of your family or friends, skipped school, or gotten into fights as a consequence of consuming alcohol?	0	200	91
	1or 2	16	7
	3 to 9	4	2
	>=10	0	0

Table 4.4 gives a summary on the global school based questionnaire

4.2.2 Family setup

This table determines if there is an association between students who have ever drunk alcohol and the family set-up they come from.

	who do you stay with				Total
	mother only	father only	mother and father	others	
Frequency	27	0	0	0	27
	1	9	148	27	185

Table 4.5: Relationship between family setup and alcohol use

The aim of this table was to establish whether some family setups could be the reason why students take alcohol. The respondents who drink alcohol were ask to define the setup of their family. The study found out all the students who drink alcohol lived with their mothers.

4.2.3 Relationship between occupation of parent and alcohol use.

The study's third goal was to see whether students' alcohol use was influenced by their family's financial situation. There parents of the students who drunk alcohol majority were self-employed as show in table below.

		occupation of parent					Total
		0	unemployed	formal employment	informal employment	self employed	
Frequency	Yes	0	0	0	0	27	27
	No	16	20	65	14	70	185

Table 4.6: relationship between occupation of parent and alcohol use

Findings from the table above show that most of the children who drunk alcohol had parents who were self-employed. This might be because kids from more wealthy backgrounds are more likely to have a global cultural orientation, which has been associated to an increase in alcohol consumption.

4.2.4. Parental control

During adolescence, the function of parental supervision becomes less obvious, and occasionally too much parental control might impede teenagers from growing in a healthy manner. Parental control remains crucial for adolescents with strict parental controlling thus generating negative emotions in adolescents. Parental Authoritative Questionnaire is divided into 3 scales; permissive, authoritarian and authoritative.

Permissive

The PAQ's permissive scale contains subscales for poor self-esteem, disregarding inappropriate conduct, and a lack of follow-through. On a scale of 1 to 5, the students' answers to their mothers' parenting behavior: As seen below, strongly disagree to firmly agree. The individual responses were further summed up, whereby each item comprises a score with a subscale range from 10 to 50. After summing the individual responses, the results were categorized as follows.

Sum	Frequency	Percentage (%)
2.00	5	2.3
15.00	9	4.1
17.00	4	1.8
18.00	5	2.3
19.00	9	4.1
20.00	8	3.6
26.00	4	1.8
27.00	4	1.8
28.00	8	3.6
29.00	5	2.3
30.00	8	3.6
31.00	13	5.9
32.00	12	5.5
33.00	18	8.2
34.00	24	10.9
35.00	11	5.0
36.00	28	12.7
37.00	14	6.4
38.00	9	4.1
41.00	9	4.1
48.00	4	1.8
Missing	9	4.1
Total	**220**	**100.0**

Table 4.7: Assessing the permissive parental control level

Parenting control is a well-researched conceptual classification of parents' interactions with their children as seen in the table above. In the study of parental responsiveness (warmth, support) and demandingness (behavioral control), three basic forms of parenting actions have been identified. The reliability of the PAQ in the permissive pattern was found to be $\alpha = 0.74$.

Authoritarian
Verbal hostility, physical punishment, punitive tactics, and defectiveness are all subscales of the PAQ's authoritarian scale. Using a scale of 1 to 5, respondents are given questions about their mother, and their replies range from strongly disagree to table 4.10 strongly agree. The table below gives an example of how parents are more authoritative. The individual responses were further summed up, whereby each item comprises a score with a subscale range from 10 to 50. After summing the individual responses, the results were categorized as follows.

Sum	Frequency	Percentage (%)
11.00	5	2.3
13.00	5	2.3
17.00	9	4.1
19.00	9	4.1
20.00	4	1.8
21.00	4	1.8
22.00	8	3.6
23.00	4	1.8
24.00	4	1.8
25.00	4	1.8
26.00	9	4.1
27.00	7	3.2
28.00	13	5.9
29.00	8	3.6
30.00	9	4.1
31.00	12	5.5
32.00	12	5.5
33.00	33	15.0
34.00	4	1.8
35.00	4	1.8
36.00	21	9.5
38.00	4	1.8
39.00	5	2.3
40.00	5	2.3
44.00	4	1.8
Missing	14	6.4
Total	**220**	**100.0**

Table 4.8: Assessing the authoritarian parental control level

Authoritarian parents, in contrast to permissive parents who are attentive to their children's emotional needs but are less structured and demanding, exert strict control over their children and emphasize ordered environments and respect to norms. The reliability of the PAQ in the authoritarian pattern was found out to be α=0.78.

Authoritative/Flexible

Good natured/easy-going and democratic involvement are all factors that go into determining whether or not someone is considered an authoritative figure.

Consistent yet flexible rules, as well as a high degree of warmth and nourishment, are all part of authoritative parenting. The individual responses were further summed up, whereby each item comprises a score with a subscale range from 10 to 50. After summing the individual responses, the results were categorized as follows.

Sum	Frequency	Percentage (%)
13.00	8	3.6
14.00	5	2.3
17.00	4	1.8
19.00	5	2.3
20.00	4	1.8
22.00	5	2.3
26.00	4	1.8
27.00	4	1.8
28.00	14	6.4
29.00	15	6.8
30.00	8	3.6
31.00	21	9.5
32.00	4	1.8
33.00	30	13.6
34.00	8	3.6
35.00	5	2.3
36.00	12	5.5
37.00	21	9.5
38.00	8	3.6
39.00	8	3.6
40.00	9	4.1

	43.00	5	2.3
	46.00	4	1.8
	50.00	5	2.3
Missing		4	1.8
Total		**220**	**100.0**

Table 4.9: Assessing the flexibility in parental control level

This mode of parenting explains the responsiveness of parental behavior to the children. The authoritarian parent has flexible policies in the home. A reliability of the PAQ in the authoritative pattern was found out to be α=0.86

4.3 Psychosocial factors that influence alcohol use.

The study's initial goal was to find out how common alcohol usage was among the students.

A family's social and economic circumstances were taken into account while calculating the prevalence of alcohol use. Findings showed that family economic status influence students' alcohol abuse to an extent whereby self-employed parents provide money to some of the pupils. Thus, some of the money they get tempts them to spend it on alcohol. International cultural orientation was connected with a greater usage of alcohol among students from more affluent families, according to Eide and Acuda (1996). In order to find out whether these features were linked to alcohol use, researchers employed a multivariate analysis.

4.4 To Assess the Level of Self-Esteem among the Pupils Who Use Alcohol.

The second goal was to determine the students' sense of self-worth among those who regularly use alcohol. The results are summarized as follows. 88% of those polled agreed that they felt less valuable and had scores below 15, whereas 9.5% had sores with values ranging from 15 to 25, indicating that they were within the typical range. Only 1.8 percent had a score greater than 25. Rosenberg self-esteem measure was employed. Scores of 15 to 25 are regarded typical, whereas scores of 15 or below indicate poor self-confidence.

The exam runs from 0 to 30. From 1 to 30, value represents the overall score of all pupils.

Value	**Frequency**	**Percentage**
.00	5	2.3
1.00	3	1.4
3.00	19	8.6
4.00	8	3.6
5.00	9	4.1
6.00	17	7.7
7.00	10	4.5
8.00	17	7.7
9.00	17	7.7
10.00	35	15.9
11.00	8	3.6
12.00	11	5.0
13.00	16	7.3
14.00	20	9.1
15.00	17	7.7
>15	4	1.8
>25	4	1.8
Total	**220**	**100**

Table 4.10 Students' self-esteem

According to Table 4.9, the majority of pupils scored below 15, suggesting that they have poor self-esteem. Those who use alcohol and those who do not use alcohol both have poor self-esteem. Individuals with low self-esteem have sentiments of inadequacy; they are unable to

escape self-destructive feelings of unworthiness; and they are readily sidetracked by environmental contacts when pursuing personal objectives.

4.5 To determine the association between psychosocial factors and alcohol prevalence among the students.

From the data, psychosocial factors that affected alcohol use among public primary school pupils were; occupation of the parent and the family set-up. And most pupils who had drunk alcohol grew up in families with strong policies with no explanations.

Tests of Between-Subjects Effects

Dependent Variable: have you ever drunk alcohol

Independent variable	Type III Sum of Squares	Df	Mean Square	F	Sig.
Corrected Model	1.258[a]	18	.070	5.058	.001
Intercept	368.345	1	368.345	26658.936	.001
Family set-up	.161	4	.040	2.918	.023
Economic Status	.180	5	.036	2.599	.027
economic * set-up	.547	9	.061	4.400	.001
Error	2.667	193	.014		
Total	836.000	212			
Corrected Total	3.925	211			

a. R Squared = .321 (Adjusted R Squared = .257)

Table 4.11 Relationship between the dependent and independent variable.

Using this table, researchers are trying to determine whether the dependent and independent variables are linked. Set-up of the family has a statistically significant connection (sig=.001). Demonstrating the existence of a substantial correlation between the two variables under study. Students would purchase alcohol for themselves (r squared =.321, R adjusted =.257), according to the study results given above. According to the R squared value (.321), a linear regression model can explain for 32.1 percent of the variation in alcohol dependency risk level. This indicated that parents' strictness helped the respondents to easily use alcohol when they have the opportunity.

Adequacy test

H0: there is no significant difference between full model and intercept only model

Against

H1: there is a significant difference between full model and intercept only model

The test used a 95 percent confidence level log-likelihood ratio test. According to the test findings, the intercept alone model (Likelihood ratio Chi-square=14.995, DF=3, P-value=0.002) was significantly different from the entire model fitted. This shows that at least one variable parameter was significant. Therefore we accept the null hypothesis.

Odds Ratio

Final multiple logistic regression models found that alcohol use prevalence and authoritative parental control were related with drinking, whereas self-esteem was adversely associated with drinking among both boys and girls.

	Boys		Girls	
Variable (referent)	OR	(95% CI)	OR	(95% CI)
Class 6	0.94	(.54, 1.61)	0.85	(.51, 1.41)
Class 7	1.36	(.81, 2.28)	1.09	(.68, 1.75)
Peer pressure				
Low	1.00		1.00	
Medium	0.76	(0.40, 1.46)	1.34	(.66, 2.72)
High	1.84	(0.98, 3.44)	**2.87**	(1.43, 5.74)
Self-esteem				
Low	1.00		1.00	
Medium	0.73	(.47, 1.15)	0.98	(.67, 1.45)
High	**0.55**	(.32, .95)	**0.02**	(.23, .77)

Table 4.12 Odds Ratio

Odds ratios were higher for gender as a psychosocial factor than other variables. Girls who liked to take risks and were influenced by their peers were more likely to drink. For males, peer pressure was significant when class was not included in the model, but when grade was included, it was not, indicating a confusing of class and peer pressure.

CHAPTER FIVE
DISCUSSION, CONCLUSIONS AND RECOMMENDATIONS

5.0 Introduction

An examination of the data is presented in this chapter, including its results, conclusions, and recommendations. The study's results reflect the study's objectives, and conclusions and recommendations were drawn as a result.

5.1 Discussion

Kilimani Primary School, a public elementary school in Westlands Sub-County, served as the site of this study. The major goal of this thesis was to find out how common alcohol consumption is among elementary school students in Westlands Sub-County, as well as the psychosocial aspects that impact this use. The prevalence rate was measured. Psychosocial factors that influence the use of alcohol were identified. From the analysis, the prevalence rate is 12.7%. For the purposes of the study, the researchers also wanted to evaluate whether or not there was a link between students' self-esteem and their usage of alcohol. The research was carried out using a descriptive method. Over 1000 students were surveyed as part of the study's target audience. A sample of 220 students was computed by Cochran's formulae.

Students were asked whether they would be interested to participate in the experiment and interview rules were provided as part of the data gathering process. Pupils have to sign parental agreement papers before participating in the research. The material acquired was purposefully arranged to entice further research. Initially, raw data was grouped into individuals and then analyzed for recurrence rates. The coding of sorted material was done by several subjects, as stated in the question. Analysis of this data was then carried out using the SPSS. Clear insights comprised of classification of frequencies and rate dissemination, measures of focal propensity and standard deviations. The dissected information was introduced in tables of recurrence and rate dispersion, structured presentations of tables and graphs.

From the study, the following findings were made from Table 4.1. Majority of the students in this study are aged 13 and 14 the active age for beginning adolescents. It's another indication of the growing concern about the increasing age at which most youngsters first begin abusing alcohol. Additionally, the researchers found a correlation between the onset of alcoholism in young males

and their gender, with younger men being more likely to develop alcoholism as adults. The demographic table shows that majority of the pupils (79%) are from class 7. This is because the respondents available and had parental consent to participate in this study because they are considered mature than their counterparts in the lower classes. The demographic information also shows that most of the respondents (76%) were girls. The findings support the motion that more focus has been put on the girl child. The girl-child is being empowered whereby most institutions push for support to ensure she gets education. Since public primary schools offer free primary education, more girls are enrolled in such institutions. This could also mean that they were a higher propensity for girls to participate in the study since they were the ones who gave verbal assent.

Furthermore, this research found that peer influence had a significant impact on alcohol usage. Table 4.2 shows that there is availability of alcohol to students in public primary school students. This is in agreement with Kaguthi, (2004) report that availability of alcohol is the major cause of alcohol use. Table 4.3 implies that peer pressure influences alcohol use amongst students. Alcohol usage among adolescents is strongly influenced by peers, according to Michigan University studies (1995). Pupils' peers introduce them to alcohol, offer alcohol, demonstrate how to use alcohol, and influence their perceptions of the substance. According to research, students' drinking habits are influenced by their family's structure and set-up. EG Broke et al. (1990) and Kandal & Andrews (1987) established that poor bonding among family members, poor child upbringing practices directly contributed to early alcohol consumption.

This research found a link between parental control and the use of alcohol by children. Parents may have a significant impact on their children's alcohol usage during adolescence by enforcing regulations that specifically address alcohol. As a result, the findings of the NACADA research indicating parental variables influencing alcohol consumption include a lack of parental support, monitoring, communication, and physical contact are corroborated. The lack of consistency in child discipline, animosity, or rejection are among factors that lead youngsters to seek consolation in drugs as a coping method. These factors include a lack of intimacy between parents and children, inadequate and inconsistent parental instruction, and a lack of watching or enough supervision that finally leads to the consumption of alcohol by teens. This is on the grounds that young people are allowed to impart their encounters and difficulties to the guardians and parental figures and get the important direction or support.

Authoritative parenting has been identified to have a negative effect on alcohol consumption patterns among teenagers. Alcoholism is more likely to develop early in the lives of children raised by parents in positions of power because they are more secretive, have lower self-esteem, and are thus more likely to develop (Frankling Glotzer, 2014). Parents' lack of support, monitoring, and communication are some of the parental characteristics that influence alcohol use, according to a research conducted by NACADA on parental participation in drug and substance misuse. Critical findings from this study indicate that family set-up and parental occupation influence alcohol use among pupils in public primary schools. This concurs with studies by Francis et al, (2014) noted that most of the pupils who adopted alcoholism were in public primary schools either lived in a family set up of mothers only, are Protestants and are more likely to have tasted alcohol due to peer pressure. Parental control was one of the factors that contributed to the kids' increasing alcoholic use, as did the inclination of parents to give them money. Another risk factor was the positive impact from peers who embraced alcoholic practices.

Alcohol usage and peer pressure have been shown to have a strong correlation in previous multivariate investigations. Adolescent drinking is predicted by authoritative parenting (Atwoli et al., 2011) and increases the probability of alcohol consumption among students. A substantial odds ratio of 1.84 for male peer pressure and a significant link between male peer pressure and alcohol consumption were not found in studies of teenage males. However, prior studies have often related these features to alcohol use (Atwoli et al., 2011). Drinking alcohol is associated to a broad variety of subjective attitudes and beliefs that may be changed via treatment, according to the results of this study. This shows that changes in students' beliefs and attitudes, rather than age, are to blame for the rise in alcohol usage among students.

These crucial psychosocial characteristics, therefore, may be targeted with effective interventions to avert the significant rise in alcohol consumption among elementary school students. Psychosocial factors may have had a direct or indirect impact on current drinking in the adjusted analysis. Drinking with people who drink may make alcohol more accessible, establish drinking as acceptable, and increase alcohol usage (Donovan JE) (2004). Moreover, low self-esteem contributes to alcohol use. Patock & Morgan-Lopez (2008) analysis identifies that parenting styles directly contributed to self-esteem, self-control, and attitudes towards alcohol consumption. Overprotection during the early stages of development directly contributed to poor

decision-making abilities during teenage life and these predisposed children to engaging in alcohol and substance abuse. Overprotection directly contributes to active alcohol consumption patterns as children get tempted to try their curiosity on some things while hiding from parents. The problem of low self-esteem was prevalent among male children compared to girls.

Students in Woreta town, Ethiopia's northwest, were surveyed to find out the frequency of drug usage and associated characteristics, according to Birhanu (2014). Among Woreta high school students, the most frequent drugs of abuse were found to be khat and alcohol, the survey showed. Drinking alcohol was the most popular drug of choice among teenagers. Male adolescent students were more likely to abuse drugs (Birhanu et al., 2014). Negative social standards, a family history of alcohol and drug use, poor academic accomplishment, and a lack of awareness of the dangers of substances are all linked to adolescent substance use (Birhanu et al., 2014). Individual-peer domain social skills and religious affiliation were shown to be protective characteristics that had an inverse or negative connection with adolescent drug use, according to Birhanu et al. (2014). Adolescent drug usage by mothers was also linked to having a high school diploma or a college diploma.

Another study was conducted in Trinidad and Tobago to investigate the incidence of drinking among school-age children. Trinidad and Tobago's elementary school students' alcohol use and risk factors were the focus of this research. To gather data, the National Alcohol and Drug Abuse Prevention Program surveyed 40 elementary schools in Trinidad and Tobago (NADAPP). Students in grades 3, 4, and 5 made up the sample, which was consisted of 8 to 15-year-olds (Agu et al., 2018). Underage drinking is a prevalent problem that has negative consequences for children's health, relationships, and safety, since one-third of all children have drunk alcohol at some time in their life (Agu et al., 2018). The same number of children (Agu et al., 2018) reported that they had ever been drunk (31.6 percent). It was shown that the likelihood of a father's lifetime alcohol intake was dramatically increased in children who didn't live with their father and in those whose father just had a high school diploma or less (*International Journal of Environmental Research and Public Health).* Alcohol use was associated with age 8–11 years, with children in the same age range being less likely to drink. Having a parent who has completed at least high school was connected with an increased lifetime risk of alcohol use, the researchers observed.

Bangladesh performed an international research to examine the prevalence and variables that impact the drinking habits of primary school students in the country's public schools (Hassan et al., 2020). This research analyzes nationally representative data to assess Bangladeshi high school students' alcohol and other drug use. Researchers (Hassan et al., 2020) found crucial implications for those in the field of adolescent drug abuse treatments in their research. Loneliness, anxiety, bullying, and sexual history were shown to be linked with students' use of alcohol and other substances, as were parental alcohol use, lack of peer support, and inadequate parental supervision (Hassan et al., 2020). Some patterns may be seen despite the fact that the interactions are inherently complicated. To further understand the causes, processes, and directionality of these interactions, longitudinal studies are required.

5.2 Conclusion

Pupils' alcohol usage may be influenced by psychosocial variables, and the findings of this research might be utilized to devise different policies in schools and at home. The study concludes that peer pressure is the main psychological factor that influences the use of alcohol for many students. In addition, some family setups are not usually concerned about their children thus, prompting the children to continuously engage in drinking behavior. Parents play major role on influencing what lifestyles the children adopt, if the parents do buy alcohol and drink in front of the children this could be a major feature of influence.

Children who encounter low self-esteem from families that do not value them of their presence influence them to abuse alcohol. Therefore, individuals with low self-esteem have feelings of insufficiency; they are unable to avoid the self-destructive feelings of unworthiness and are easily distracted by environmental encounters in the pursuit of their personal goals. The study also established that peer pressure influence students’ alcohol abuse whereby some students join companies that encourage them to take alcohol, some students are advised that taking alcohol reduces stress and other students become alcoholic due to being jeered at by friends who consider not taking alcohol childish. The study also concludes that the occupation of the parent influence alcohol use, whereby some parents give money to their children. In return the children misuse the money by using it to buy alcohol for themselves and for friends. Parents who are financially stable also buy alcoholic drinks and keep in their house and students were tempted to drink and ended up as alcoholics.

The study establishes that most religions have a perception towards alcohol abuse. Although religion is important, some students ignore the religion and go against their beliefs. Samples of those who drink are Protestants. The study also established that the home environments and ready availability of alcohol contributed to alcohol abuse amongst students. Some schools were located a few meters from wine shops/bars which provided easy access to alcohol. In addition, Authoritative parenting has been identified to have a negative effect on alcohol consumption patterns among teenagers. Children raised by domineering parents are secretive, exhibit certain undesirable behavioral patterns as a result of poor self-esteem, and are therefore more prone to develop alcoholism during their formative years.

5.3 Recommendations

As a result, the researcher has come up with the following suggestions for curbing alcohol addiction among students in public elementary schools across Westlands Sub-County and the nation as a whole.

First, students ought to focus on their self-identity and whom they hanging out with. On the off chance that they are hanging out with a gathering in which the lion's share of students is drinking liquor to get high, they might need to consider making some new companions. They might be made a beeline for a liquor issue on the off chance that they keep on hanging around other people who routinely drink liquor. It's important for students to have people they can rely on, people they can talk to about life, life's issues, and their own decisions concerning alcohol as they become older. The opportunity to benefit from someone else's fortunate interactions might help put things in perspective and be priceless.

Second, students should avoid letting alcohol and other drugs interfere with their relationships with their classmates. Having a discussion with your parents about the dangers of drinking may be highly beneficial. Liquor education is necessary for these young men. They can't rely on the misconceptions and misinformation spread by their friends and the internet. Being taught how to make the correct decisions is a part of their ability to make the right decisions. They ought to learn about Alcohol and, as they learn, impart what they are figuring out to their companions and their family.

Third, parents and teachers ought to set up firm standards and controls at home with respect to what time children ought to return home and other family desires furthermore abstain from sending their kids to purchase liquor and drinking a long way from their youngsters' watch. Alcoholic Drink Control Law, 2010 mandates that bars and wine and spirit businesses within a 300m radius be under government control. The Ministry of Internal Security under the Office of the President is responsible for carrying out this responsibility.

In addition, school environments should keep in mind the end goal to find liquor addiction among auxiliary school students, there is requirement for a great school environment, which energizes lively co-educational module exercises, for example, sports, music, dramatization, clubs and social orders. Such exercises will give students a solid feeling of having a place and reason in life in this manner decreasing fatigue and inaction both of which are decidedly connected with liquor addiction among the students. In addition, some parents should stop giving their children so much money a considerable measure of pocket cash that monetarily engages them to obtain alcohol.

Lastly, the government should take control to manage the offer of liquor through permitting, bundling, estimating, limiting the time of purchasers and directing opening hours for the offering focuses. This will guarantee that the offering focuses are found far from school premises, little compact bundles are nullified, costs are non-reasonable to students, buyers beneath the period of larger part are not available to liquor and offering focuses are just operational amid the night. The school direction and advising division ought to compose visit-guiding sessions to help students to remember the negative long-haul impacts of alcohol use abuse. Furthermore, guardians, instructors and other group individuals ought to go about as good examples for the students by avoiding drinking.

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APPENDICES

APPENDIX 1: Socio-Demographic Questionnaire

TODAYS Date: ______________________________ Serial Number: ___________

Age in Years______________________

BIRTH DATE: _______DATE________ MONTH: ________YEAR: _________

1. SEX
   i. Female
   ii. Male
2. CLASS ENROLLED
   i. Class 6
   ii. Class 7
   iii. Class 8
3. OCCUPATION OF PARENT
   i. Unemployed
   ii. Formal Employment
   iii. Informal Employment
   iv. Self- Employed
4. RELIGION
   i. Catholic
   ii. Protestant (Other Christians but not Catholic)
   iii. Muslim
   iv. Others specify.

5. WHOM DO YOU LIVE WITH
    i. Mother only
    ii. Father only
    iii. Mother and father
    iv. Others specify

6. Had you ever drunk alcohol if yes go to part two of the question
    i. YES
    ii. NO

PART 2

Who did you first drink alcohol with whom

i. Parents
ii. My peers
iii. Alone
iv. Others specify

APPENDIX 2: ROSENBERG SELF ESTEEM SCALE

A self-esteem scale developed by Rosenberg. Self-esteem was assessed using the RSES 14, a questionnaire developed by Rosenberg. There are 10 items in all, five that are positive and five that are negative, all of which are graded on a four-point scale from strongly agree (3) to strongly dislike (0). A higher score indicates a more positive view of oneself. In general, I'm happy with my self-worth, but I've had moments when I've thought I'm a terrible person. An internal consistency dependability of 0.85 to 0.88 was discovered. The reliability was likewise reported to be 0.88.

	Personal Views on Self-esteem	**Strongly agree**	**Agree**	**Disagree**	**Strongly disagree**
1.	I believe that I am a person who is at least on an equal footing with others.	32%	56%	4%	4%
2.	In my opinion, I possess a variety of positive traits.	48%	38%	5%	5%
3.	I'm inclined to believe that I'm a failure as a whole.	6%	17%	31%	42%
4.	I'm able to do tasks as well as most individuals.	33%	42%	12%	8%
5.	I don't think I have anything to be proud of.	5%	18%	47%	24%
6.	Positivity is my default setting when it comes to dealing with yourself	50%	39%	8%	3%
7.	On the whole, I'm content with myself.	50%	36%	2%	6%
8.	I wish I had more self-respect.	39%	43%	6%	7%
9.	At times, I'm certain that I'm completely ineffective.	9%	40%	24%	22%
10	At times, I believe I am completely useless.	13%	36%	18%	26%

APPENDIX 3: GSHS Core Questionnaire Alcohol Use Module

GSHS Core Questionnaire Alcohol Use Module

The next 6 questions ask about drinking alcohol. This includes drinking COUNTRY SPECIFIC EXAMPLES. Drinking alcohol does not include drinking a few sips of wine for religious purposes. A "drink" is a glass of wine, a bottle of beer, a small glass of liquor, or a mixed drink.

1. How old were you when you had your first drink of alcohol other than a few sips?
   - I have never had a drink of alcohol other than a few sips
   - 7 years old or younger
   - 8 or 9 years old
   - 10 or 11 years old
   - 12 or 13 years old
   - 14 or 15 years old
   - 16 or 17 years old
   - 18 years old or older

2. During the past 30 days, on how many days did you have at least one drink containing alcohol?
   - 0 days
   - 1 or 2 days
   - 3 to 5 days
   - 6 to 9 days
   - 10 to 19 days
   - 20 to 29 days
   - All 30 days

3. During the past 30 days, on the days you drank alcohol, how many drinks did you **usually** drink per day?
   - I did not drink alcohol during the past 30 days
   - Less than one drink
   - 1 drink
   - 2 drinks
   - 3 drinks
   - 4 drinks
   - 5 or more drinks

4. During the past 30 days, how did you **usually** get the alcohol you drank? SELECT ONLY ONE RESPONSE.
   - I did not drink alcohol during the past 30 days
   - I bought it in a store, shop, or from a street vendor
   - I gave someone else money to buy it for me
   - I got it from my friends
   - I got it from my family
   - I stole it or got it without permission
   - I got it some other way

Staggering when walking, not being able to speak right, and throwing up are some signs of being really drunk.

5. During your life, how many times did you drink so much alcohol that you were really drunk?
   - 0 times
   - 1 or 2 times
   - 3 to 9 times
   - 10 or more times

6. During your life, how many times have you got into trouble with your family or friends, missed school, or got into fights, as a result of drinking alcohol?
   - 0 times
   - 1 or 2 times
   - 3 to 9 times
   - 10 or more times

2013 GSHS Core Questionnaire Modules
Updated: 01 January 2013

APPENDIX 4: Parental Authority Questionnaire

Parental Authority Questionnaire

Instructions: Circle the number on the 5-point scale (1 = strongly disagree, 5 = strongly agree) that best expresses how that statement pertains to you and your mother for each of the following statements. Try to think about each sentence in terms of your relationship with your mother as you grew up in the house. There are no right or incorrect solutions, so don't spend a lot of time on any one thing. Your entire impression is important to us. Be sure not to omit any items.

1 = Strongly disagree

2 = Disagree

3 = Neither agree nor disagree

4 = Agree

5 = Strongly Agree

---

1. When I was a kid, my mother believed that in a well-run household, children should be able to make their own decisions just as often as their parents.

1 2 3 4 5

---

2. My mother believed that even if her children didn't agree with her, forcing them to comply to her views was in their best interests.

1 2 3 4 5

3. As a child, if my mother instructed me to do anything, she expected me to do it instantly without any questioning.

1 2 3 4 5

4. 4. As I grew up, my mother explained the rationale for the family policy to the children in the family when it was formed.

1 2 3 4 5

5. When I complained about the rigidity of our house rules, my mother always encouraged me to talk it out with her in a constructive manner.

1 2 3 4 5

6. My mother has always believed that her children should be able to make up their own minds and do what they want, even if this goes against what their parents may think is best for their children.

1 2 3 4 5

7. As a child, my mother forbade me from questioning any of her decisions.

1 2 3 4 5

8. While I was growing up, my mother used logic and discipline to manage the activities and choices of the family's children.

1 2 3 4 5

9. My mother has always believed that parents should use greater force to get their children to behave properly.

1 2 3 4 5

10. When I was a child, my mother did not believe that I was required to follow rules and regulations of conduct just because they had been created by someone in power..

1 2 3 4 5

11. As I grew older, I was aware of the expectations my mother had for me in my family, but I also felt free to debate those expectations with her when I believed they were unrealistic.

1 2 3 4 5

12. My mother believed that sensible parents should instill in their children an early understanding of who is in charge in the family.

1 2 3 4 5

13. When I was a child, my mother seldom set expectations or rules for my conduct.

1 2 3 4 5

14. During my childhood, my mother generally acted in accordance with the wishes of the family's children while making family choices.

1 2 3 4 5

15. As my family's children grew older, my mother continually provided us with sensible and objective instruction and counsel.

1 2 3 4 5

16. When I was a child, my mother would get enraged whenever I attempted to dispute with her.

1 2 3 4 5

17. My mother thinks that most issues in society would be addressed if parents would not limit their children's activities, choices, and aspirations while they are growing up.

1 2 3 4 5

18. As I grew older, my mother made it clear to me what conduct she expected of me and how she would discipline me if I fell short of her standards.

1 2 3 4 5

19. As I grew older, my mother left me to make the majority of decisions on my own without much instruction from her.

1 2 3 4 5

20. When I was a kid, my mother considered the children's ideas when making family choices, but she would not choose anything merely because the children want it.

1 2 3 4 5

21. My mother did not consider herself to be in charge of controlling and guiding my conduct as I grew older.

1 2 3 4 5

22. As I grew older, my mother established definite rules of conduct for the children in our house, but she was observed to adapt those standards to the unique needs of each of the family's children.

1 2 3 4 5

23. As I grew older, my mother directed my conduct and activities, and she expected me to follow her lead, however, she was always willing to listen to my concerns and debate the direction with me.

1 2 3 4 5

24. As I grew older, my mother enabled me to develop my own perspective on family issues and usually let me to determine for myself what I would do.

1 2 3 4 5

25. My mother has always believed that the majority of society's issues might be resolved if we could convince parents to discipline their children severely and brutally when they fail to do what they are meant to do as they grow up.

1 2 3 4 5

26 . As I grew older, my mother often communicated to me precisely what she expected me to accomplish and how she expected me to do it.

1 2 3 4 5

27. When I was a child, my mother set firm boundaries for my conduct and hobbies, but she was also forgiving when I disagreed with her. 1 2 3 4 5

28. When I was a kid, my mother did not exert control over the actions, activities, and wishes of the family's children.

1 2 3 4 5

29. As I grew older, I was aware of the expectations my mother had for me in the family, and she urged that I live up to them simply out of respect for her authority.

1 2 3 4 5

30. As I grew older, if my mother made a family choice that harmed me, she was expected to address it with me and to accept her error if she made one.

1 2 3 4 5

Description: The PAQ is designed to measure parental authority, or disciplinary practices, from the point of view of the child (of any age).

The PAQ has three subscales:

Permissive (P: items 1, 6, 10, 13, 14, 17, 19, 21, 24 and 28), authoritarian (A: items 2, 3, 7, 9, 12, 16, 18, 25, 26 and 29), and authoritative/flexible (F: items 4, 5, 8, 11, 15, 20, 22, 23, 27, and 30). Mother and father forms of the assessment are identical except for references to gender.

Scoring: The PAQ is scored easily by summing the individual items to comprise the subscale scores. Scores on each subscale range from 10 to 50.

Author: Dr. John R. Buri, Department of Psychology, University of St. Thomas, 2115 Summit Avenue, St. Paul, MN 55105.

Source: Buri, J.R. (1991). Parental Authority Questionnaire, Journal of Personality and Social Assessment, 57, 110-119.

APPENDIX 5: Sample Child Consent Form

UNIVERSITY OF NAIROBI (UoN)	KNH-UoN ERC	KENYATTA NATIONAL HOSPITAL (KNH)
COLLEGE OF HEALTH SCIENCES	EMAIL:uonknh_erc@uonbi.ac.ke	P.O.BOX 20723 Code 00202
P.O.BOX 19676 Code 00202	Website:http://www.erc.uonbi.ac.ke	
Telegrams: varsity		Tel: 726300-9
	Facebook: https://www.facebook.com/uonknh.erc	Fax: 725272
(254-020) 2726300 Ext 44355	Twitter: @UONKNH_ERC	Telegrams: MEDSUP, Nairobi

STUDIES INVOLVING CHILDREN

Sample Child Consent Form

Sample Minor Consent Document

Project Title: *PSYCHOSOCIAL FACTORS ASSOCIATED WITH ALCOHOL USE IN SCHOOL GOING CHILDREN IN PUBLIC PRIMARY SCHOOLS IN WESTLANDS SUBCOUNTY, NAIROBI.*

Investigator(s): **DR NELLY KAMWALE**

We are doing a research study about whether there is an association between Psychosocial Factors and alcohol use among primary school pupils attending Kilimani primary school. I was conduct this study together with eight study assistants. This is medical research, and you are required to understand the following that applies to all in medical research. I am (Dr. Nelly Kamwale from the University of Nairobi. I'm doing research to determine (why some students use alcohol while others do not). We are requesting your participation in a research project assessing alcohol usage.

We were commissioned to conduct this study (ask you some questions about how you feel about school, home, and how you get along with your classmates). We kept all of your responses private

and did not reveal them to anybody (including your instructor or parent(s)/guardian). They were visible only to those working on the research at the University of Nairobi.

Permission has been granted to undertake this study by the Kenyatta National Hospital-University of Nairobi

Ethics and Research Committee (KNH-UoN ERC Protocol No.)

This research study is a way to learn more about people. At least 300

children will be participating in this research study with you.

If you decide that you want to be part of this study, you will be asked to ***answer some few questions about factors affecting alcohol use the time involved was be about forty minutes.***

There are a few details about this study that you should be aware of. That you will complete the four questionnaires.

Not everyone who participated in this study benefited from it.

A benefit is when something positive occurs in your life. We believe that one of these benefits is being counseled about alcohol use. If you do not want to participate in this research project, we will inform you of other treatment options.

When this research is complete, we will create a report summarizing our findings. This report will contain your name or indicate that you participated in the study.

You are not required to participate in this research if you do not choose to.

If you wish to pause after we begin, that is also acceptable.

Your parents are also aware of the study.

Please sign your name if you decide to participate in this study.

I,_______________________________________, want to be in this research study.

______________________________ ___________________________

(Signature/Thumb Stamp) (Date)

APPENDIX 6: Sample Parental Consent Form

UNIVERSITY OF NAIROBI (UoN)	KNH-UoN ERC	KENYATTA NATIONAL HOSPITAL (KNH)
COLLEGE OF HEALTH SCIENCES	EMAIL:uonknh_erc@uonbi.ac.ke	P.O.BOX 20723 Code 00202
P.O.BOX 19676 Code 00202	Website:http://www.erc.uonbi.ac.ke	
Telegrams: varsity		Tel: 726300-9
	Facebook: https://www.facebook.com/uonknh.erc	Fax: 725272
(254-020) 2726300 Ext 44355	Twitter: @UONKNH_ERC	Telegrams: MEDSUP, Nairobi

STUDIES INVOLVING CHILDREN PARTICIPANT INFORMEDATION AND CONSENT FORM

SAMPLE PARENTAL CONSENT FORM

(To be administered in English or any other appropriate language)
Title of Study: P*SYCHOSOCIAL FACTORS ASOCIATED WIT ALCOHOL USE IN SCHOOL GOING CHILDREN IN PUBLIC PRIMARY SCHOOLS IN WESTALANDS SUB-COUNTY*

Principal Investigator/and institutional affiliation: DR. NELLY KAMWALE/UNIVERSITY OF NAIROBI
Co-Investigators and institutional affiliation: ____
Introduction
I'd like to inform you about a study being undertaken by the researchers named above. The goal of this permission form is to provide you with information that will assist you in determining whether or not to enroll your kid in the research. You are welcome to ask any concerns regarding the research's aim, what will happen if your kid participates, the potential dangers and benefits, your child's rights as a volunteer, or anything else about the research or this form that is unclear. After we have satisfactorily addressed all of your questions, you may decide whether or not to enroll your kid in the research. This is referred to as 'informed consent.' Once you have comprehended and consented to your child's participation in the research, I was requesting that you sign your name on this form.
You should have a broad understanding of the principles that apply to all participants in medical research:

i) Your child decision to participate is entirely voluntary.

ii) You child may withdraw from the study at any time without necessarily giving a reason for his/her withdrawal.

iii) Refusal to participate in the research was not affecting the services your child is entitled to in this health facility or other facilities.

May I continue? YES / NO

In the case of minors under the age of 18, we tell their parents or guardians of the study's findings. Your consent is required for your kid to participate in this research. We will provide you with a copy of this form for your records.

If the kid is old enough to understand what is going on, he/she would also have to consent to participate in the research after being properly informed.

WHAT IS THE PURPOSE OF THE STUDY?

The researchers listed above are interviewing individuals who are children in a primary school. The purpose of the interview is to find out about factors influencing alcohol use______________. Participants in this research study were asked questions about alcohol use.

There were approximately 300 participants in this study randomly chosen. We are asking for your consent to consider your child to participate in this study.

WHAT WAS HAPPEN IF YOU DECIDE YOU WANT YOUR CHILD TO BE IN THIS RESEARCH STUDY?

If you agree for your child to participate in this study, the following things will happen: To ensure that you feel at ease, you will be questioned by a skilled interviewer in a discreet setting where responding questions is easy. 40 minutes was the time allotted for the interview. Self-esteem, parental control, and peer influence were all discussed in depth, as was the impact of these factors on alcohol use. After the interview is over, we'll be conducting therapy sessions for the kids. A phone number where we can reach you in the event of an emergency is something we'll need from you. Your contact information was never shared with anyone else if you agreed to participate in this survey. For example, if your youngster has been drinking alcohol, we may need to notify you.

ARE THERE ANY RISKS, HARMS, DISCOMFORTS ASSOCIATED WITH THIS STUDY

Medical research has the ability to bring about psychological, social, emotional, and bodily harm.

Always make an effort to reduce the dangers. There is a danger of losing privacy if you participate in the research. We promise to keep any information you share with us as private as possible. We used a password-protected computer database to identify your kid and kept all of our paper records in a closed filing cabinet. It is conceivable that someone may find out that your kid participated in this research and get information about your child. However, no technique of safeguarding confidentiality can be completely secure.

You may also find it difficult to answer questions during the interview. If you don't want to answer any of the questions, you may do so. When you were given a question during the interview, you might decline to answer it.

Having to answer some questions may be awkward for you. We will do everything in our power to ensure that this takes place in a private setting. Furthermore, all of the study staff and interviewers are experts in these examinations/interviews. Additionally, some questions can be stressful.

Your kid will get treatment from the study staff or be sent to a specialist for more serious issues.

ARE THERE ANY BENEFITS BEING IN THIS STUDY?

Counseling for you and your kid may be available for free, as well as information on alcohol use and other variables that may be related with it. If your kid needs medical attention, we'll get them to a hospital. Also, the information you gave us helped us better understand the children, which was really helpful. This is a significant contribution to the fields of psychology and science.

WAS BEING IN THIS STUDY COST YOU ANYTHING?

The study was not cost you anything all we require is your time.

IS THERE REIMBURSEMENT FOR PARTICIPATING IN THIS STUDY?

They was be no direct reimbursement for the study but children was benefit from free guidance and counseling

WHAT IF YOU HAD QUESTIONS IN FUTURE?

This website includes a phone number and a text-message contact for those who have questions or concerns regarding their child's participation in this research.

For more information about your child’s rights as a research participant you may contact the Secretary/Chairperson, Kenyatta National Hospital-University of Nairobi Ethics and Research Committee Telephone No. 2726300 Ext. 44102 email uonknh_erc@uonbi.ac.ke.

If the call is for study-related communication, the research staff will reimburse you for the expenses.

WHAT ARE YOUR OTHER CHOICES?

It is entirely up to you whether or not to allow your kid to take part in this study. You have complete discretion over whether or not your kid participates in the research, and you will not be penalized or miss out on any of the advantages. When you told the research personnel, your child's participation in the trial was immediately halted. If you don't want to explain why you're pulling your kid from school, you don't have to. There was no effect on your kid's services at this health facility or any other health facilities when you took your child out of the trial.

For more information, contact DR KAMWALE at UON from 8.00AM to 6.00PM.

CONSENT FORM (STATEMENT OF CONSENT)

Since the subject of this research is a minor, he or she is unable to provide their informed permission (a person less than 18 years of age). As a parent, you are being asked to allow the research to involve your kid.

Parent/guardian statement

I have either read this permission form or had it read out to me before I agreed to participate in this experiment. One of my study counselors and I had discussed this study. In a language I could comprehend, he or she had answered my queries. I'd been briefed on the drawbacks and upsides. I realize that after signing this permission form, I received a copy of it. You and your kid are free to leave at any point if you don't want to take part in this research.

I am aware that every attempt has been taken to maintain the privacy of information pertaining to my own and my child's personal identify.

To my knowledge, I had not relinquished any of my child's legal rights as a research subject by completing this permission form.

I voluntarily agree to my child's participation in this research study:

Yes No

I agree to had my child undergo_____testing: Yes No

I agree to had (**define specimen**) preserved for later study: Yes No

I agree to provide contact information for follow-up: Yes No

Parent/Guardian signature /Thumb stamp:__________________Date

Parent/Guardian printed name:

Researcher's statement

To my knowledge, the participant indicated above has provided his or her informed permission to participate in this research project after I communicated all the pertinent facts to him or her.

Date: ______________________________**Signature**: _______________________

Role in the study:_______________________________________*[i.e. study staff who* explained *informed consent form.]*

Witness Printed Name (*If witness is necessary*)

Signature:_____________________

Date: ____________________________