REPUBLIC OF KENYA

NACADA
FOR A NATION FREE FROM ALCOHOL AND DRUG ABUSE

TWENTY THIRD (23RD) EDITION OF BIANNUAL REPORT ON THE STATUS OF ALCOHOL AND DRUG ABUSE CONTROL IN KENYA

Prepared for
Parliament of Kenya (National Assembly and Senate)

Prepared by the Chief Executive Officer
National Authority for the Campaign Against Alcohol and Drug Abuse
For the Reporting Period of July – December 2025

NATIONAL AUTHORITY FOR THE CAMPAIGN AGAINST ALCOHOL AND DRUG ABUSE

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LIST OF ABBREVIATIONS

ADA	Alcohol and Drug Abuse
ADCA	Alcoholic Drinks Control Act, 2010
AJADA	African Journal of Alcohol and Drug Abuse
ANU	Anti-Narcotics Unit
AUD	Alcohol Use Disorder
CEO	Chief Executive Officer
CSOs	Civil Society Organizations
DCI	Directorate of Criminal Investigations
DSA	Drugs and substances of Abuse
DSU	Drugs and Substance Use Disorders
JKIA	Jomo Kenyatta International Airport
MDAs	Ministries, Department and Agencies
MoINA	Ministry of Interior and National Administration
NACADA	National Authority for the Campaign against Alcohol and Drug Abuse
NDO	National Drug Observatory
NPS	National Police Service
NTC	National Technical Committee on Drug Trafficking and Abuse
SUDs	Substance Use Disorders

T&R	Treatment and Rehabilitation
UNODC	United Nations Office on Drugs and Crime
WHO	World Health Organization

MESSAGE FROM THE CHIEF EXECUTIVE OFFICER

I present the *23rd Biannual Report on the Status of Alcohol and Drug Abuse Control in Kenya*, covering the period of July – December 2025, to both Houses of Parliament to facilitate strategic decisions through the Cabinet Secretary for Interior and National Administration. This report is published in compliance with the provisions of Section 5(j) and 26(c) of the National Authority for the Campaign Against Alcohol and Drug Abuse (NACADA) Act, 2012.

Alcohol and drug abuse in Kenya remains a significant and evolving public health, social, and security challenge. The current situation is characterized by widening treatment gaps, changing patterns of substance use, increasing availability of cannabis, and the rapid emergence of synthetic drugs and new psychoactive substances (NPS), which are reshaping the country's drug landscape and placing unprecedented pressure on prevention, treatment, and enforcement systems.

A major constraint continues to be inadequate financing, which limits the scale, reach, and effectiveness of prevention, treatment, rehabilitation, and supply reduction interventions. Consequently, the country is unable to achieve adequate national coverage and sustain evidence-informed responses.

Kenya also faces a significant treatment and rehabilitation deficit, with an estimated 2,707,266 people in need of treatment services against a national treatment capacity of barely 10,000 clients per year. The gap is exacerbated by limited public treatment facilities, high treatment costs, shortages of specialized personnel, and inadequate community-based and outpatient services, leaving the majority of those affected without access to care.

The cannabis market continues to expand, with record-high cannabis seizures during the reporting period, an indication of increasing availability, trafficking, and consumption. This trend is driven by sustained supply and distribution networks, growing demand particularly among young people, and the on-going global, regional and local legalization debates contributing to reduced perceptions of risk.

Treatment and rehabilitation data also indicate a worrying trend of under-age children aged 14–16 years seeking addiction treatment services, with cannabis accounting for the primary substance of use. The trend suggests early initiation into drug use among school-going children, exposing them to adverse health, educational, social, and developmental consequences.

At the same time, Kenya is witnessing a significant shift in the illicit drug market from traditional narcotics such as heroin and cocaine towards synthetic drugs, particularly methamphetamine and ketamine. Synthetic drugs pose heightened public health and security risks due to their potency, addictive nature, accessibility, and the adaptability of production and distribution networks.

A further concern is the emergence of new psychoactive substances (NPS), including benzofurans, alpha-ethyltryptamine, and synthetic cathinones. These substances are often designed to circumvent existing drug control frameworks, making detection, regulation, and public health responses more challenging while exposing users to unpredictable and severe health consequences.

The national response is further constrained by limited forensic and analytical capacity for the detection, identification, and monitoring of emerging substances. Inadequate laboratory infrastructure, insufficient specialized equipment, and limited technical expertise hinder timely identification of emerging drug threats and evidence-based interventions.

Drug trafficking methods are also becoming increasingly sophisticated. The growing exploitation of air cargo systems for drug trafficking reflects the adaptation of criminal networks to enforcement pressures, providing a less visible and more difficult-to-trace trafficking channel that conceals the identities of traffickers and exploits existing detection gaps.

Overall, the evolving drug situation in Kenya calls for a well-resourced, coordinated, and multi-sectoral national response that integrates prevention, treatment, rehabilitation, enforcement, research, and regional collaboration to effectively reduce drug supply, demand, and associated social, health, and security harms.

I therefore submit this report for your attention.

CHRP. Dr. Anthony Omerikwa, MBS

Chief Executive Officer.

CHAPTER ONE: INTRODUCTION

1.1 Background

This is the 23rd progressive report on the status of alcohol and drug abuse control in Kenya. The report is a requirement under Section 5(j) of NACADA Act, 2012. The Authority in collaboration with other lead agencies is required to submit an alcohol and drug abuse control status report biannually to both Houses of Parliament through the Cabinet Secretary for Interior and National Administration. This report covers the period of July – December 2025.

1.2 Status of alcohol and drug abuse in Kenya

1.2.1 General population

According to a survey conducted by NACADA in 2022 in collaboration with the Kenya National Bureau of Statistics and the Tobacco Control Board, 17.5% (4,733,135) of Kenyans aged 15 – 65 years were currently using at least one drug or substance of abuse; 11.8% (3,293,495) were currently using alcohol; 8.5% (2,305,929) were currently using tobacco; 3.6% (964,737) were currently using *khat*; 1.9% (518,807) were currently using cannabis; and 0.2% (60,407) were currently using prescription drugs (Table 1).

Table 1: Current use of drugs and substances of abuse in Kenya

Drug/ Substance	Prevalence	No. of Kenyans
At least one substance of abuse	17.5	4,733,135
Alcohol	11.8	3,199,115
Tobacco	8.5	2,305,929
Khat	3.6	964,737
Bhang/ marijuana	1.9	518,807
Prescription drugs	0.2	60,407

Source: NACADA, 2022

The survey also showed that 5.0% (1,357,040) of Kenyans aged 15 – 65 years were addicted to alcohol use; 3.3% (887,627) were addicted to tobacco use; 0.9% (234,855) were addicted to cannabis use; and 0.8% (227,744) were addicted to *khat* use (Table 2).

Table 2: Severe substance use disorders (SUDs) (addiction) in Kenya

Drug/ Substance	Prevalence	No. of Kenyans
Alcohol	5.0	1,357,040
Tobacco	3.3	887,627
Cannabis	0.9	234,855
Khat	0.8	227,744

Source: NACADA, 2022

1.2.2 Prevalence of drugs and substance use among university students in Kenya

In 2024, NACADA commissioned a study to assess the "Status of Drugs and Substance Use (DSU) among University Students in Kenya". The study showed that 40.5% of university students in Kenya had used at least one drug or substance of abuse in their lifetime and another 26.6% were currently using at least one drug or substance of abuse.

Findings on individual drugs showed that 18.6% of university students were currently using alcohol followed by tobacco (12.0%), cannabis (10.7%), khat (10.2%), inhalants (4.3%), prescription drugs (2.2%), heroin (1.7%), cocaine (1.6%), and methamphetamine (1.4%) (Table 3).

Table 3: Summary of past-month use of DSA among university students in Kenya

Substance	Prevalence (%)	Population affected
Alcohol	**18.6**	**1 in every 5**
Cigarettes	7.2	1 in every 14
Vape/ e- cigarettes	5.8	1 in every 17
Shisha	4.6	1 in every 22
Nicotine pouches	4.2	1 in every 24
Kuber	2.8	1 in every 36
Snuff/ chewed tobacco	2.6	1 in every 38
At least one tobacco product	**12.0**	**1 in every 8**
Cannabis smoked	9.1	1 in every 11
Cannabis edibles	6.4	1 in every 16
At least one type of cannabis	**10.7**	**1 in every 9**
Miraa	8.4	1 in every 12
Muguka	8.2	1 in every 12
At least one type of khat	**10.2**	**1 in every 10**
Inhalants	4.3	1 in every 23

Substance	Prevalence (%)	Population affected
Prescription drugs	2.2	1 in every 45
Heroin	1.7	1 in every 59
Cocaine	1.6	1 in every 63
Methamphetamine	1.4	1 in every 71
At least one drug or substance of abuse	**26.6**	**1 in every 4**

Source: NACADA, 2024

The study also revealed a high burden of severe alcohol use disorders where 8.7% of university students were struggling with alcohol addiction.

1.2.3 Public sector workplace

In 2021, NACADA conducted another survey to determine the status of alcohol and drug abuse (ADA) among employees in the public sector workplace in Kenya. Findings on lifetime use showed that 44.5% of the employees had ever used alcohol, 15.3% had ever used tobacco, 11.3% khat, 8.2% cannabis, 2.3% prescription drugs, 1.3% cocaine and 1.2% heroin.

Findings on current (30-day) use showed that alcohol was the most widely used substance with a prevalence of 23.8% followed by tobacco (4.8%), khat (2.9%), cannabis (1.9%), 1.0% prescription drugs (1.0%), heroin (0.8%) and cocaine (0.8%) (Table 4).

Table 4: Drugs and substance use among employees in the public sector workplace in Kenya

Drug/ substance	Lifetime prevalence (%)	Current (30-day) prevalence (%)
Alcohol	44.5	23.8
Tobacco	15.3	4.8
Khat	11.3	2.9
Cannabis	8.2	1.9
Prescription drugs	2.3	1.0
Heroin	1.2	0.8
Cocaine	1.3	0.8

Source: NACADA, 2021

Data also showed that the prevalence of alcohol use disorders (AUD) among employees in the public sector workplace in Kenya was 13.2%. Further categorization of AUDs by severity showed that 5.7% of the employees in the public sector workplace had a mild alcohol use disorder (AUD), 3.0% had a moderate AUD while 4.5% had a severe AUD. This implied that approximately 30,384 employees in the public sector workplace had a severe AUD and therefore in need of addiction treatment services.

1.2.4 Emerging drug use trends in Kenya

NACADA conducted a nationwide study in 2025 on "Wastewater Analysis to Assess Emerging New Psychoactive Substances (NPS) and Illicit Drug Use in Kenya" across the eight regions. A total of 152 samples were collected and analyzed by the Government Chemist.

The findings showed that cannabis, heroin, and cocaine are the most commonly used illicit drugs in Kenya. The most frequently abused prescription drugs were diazepam, trihexyphenidyl (artane), amitriptyline, and tramadol.

The study confirmed the presence of three NPS categories: alpha-ethyltryptamine, benzofurans, and synthetic cathinones. Other emerging psychoactive substances detected included methamphetamine, MDMA (ecstasy), psilocybin, and DMT. Evidence also suggested the existence of small-scale clandestine laboratories involved in the production of synthetic stimulants e.g. methamphetamine.

Overall, the study highlights growing and evolving drug use patterns in Kenya with evidence suggesting that these substances are also being used at community level.

1.3 Institutional, policy and legal framework

1.3.1 Institutional framework for alcohol and drug abuse control in Kenya

The National Authority for the Campaign against Alcohol and Drug Abuse (NACADA) is a State Corporation established under the NACADA Act, 2012 in the Ministry of Interior and National Administration.

NACADA is mandated to coordinate a national response against alcohol and drug abuse as outlined in the NACADA Act 2012 and the Alcoholic Drinks Control Act (ADCA) 2010. The NACADA Act provides for a Board of Directors to guide on the strategic direction geared towards achievement of the Authority's mandate.

The Authority also provides secretarial services to the National Alcohol Control Committee established under the Kenya Gazette Notice 9775 of 27th November 2020. The committee is mandated to ensure consumer protection from illicit adulterated alcoholic beverages in Kenya. This committee replaced the National Inter-Agency Committee for Control of Alcoholic Drinks and Combat of Illicit Brews which had been established under the Kenya Gazette Notice 5069 of July 10, 2015.

To facilitate inter-agency collaboration and liaison among lead agencies responsible for alcohol and drugs demand reduction and supply suppression, the Authority convenes the National Technical Committee on Drug Trafficking and Abuse (NTC). The committee has membership drawn from the Ministry of Interior and National Administration, Directorate of Public Health, Pharmacy and Poisons Board, State Department of Immigration and Registration of Persons, Government Chemist Department, Anti-Narcotics Police Unit, National Police Service, Kenya Prisons Service, Kenya Revenue Authority, Kenya Airports Authority, Kenya Ports Authority, State Law Office, Kenya Bureau of Standards and the National Intelligence Service. The committee facilitates establishing plans of action, strategies and collaboration in the development, implementation and enforcement of laws and policies relating to drug abuse control. The Authority has also established the County Inter-Agency Committees on Alcohol and Drug Abuse Control in all the 47 counties.

The adoption of the United Nations Conventions has made it compulsory for Member States to regularly report on the drugs situation as well as on interventions, covering both supply and demand reduction. NACADA has therefore established a National Drug Observatory (NDO) that coordinates data collection, collation and reporting in order to facilitate the country to meet its national, regional and international reporting obligations.

The membership comprises all members of the NTC including the Assets Recovery Agency, Financial Research Centre, National AIDS and STIs Control Programme, Anti-Narcotics Unit, Directorate of Criminal Investigations, Pharmacy and Poisons Board, Government Chemist, Kenya Prisons, Judiciary, Customs and Kenya Coast Guard Service.

1.3.2 Policy and legal framework

The Constitution of Kenya, 2010 provides that all ratified protocols of international law; treaties; and conventions; become part of the Kenyan law. The country has ratified all the three United Nations Conventions on Narcotic Drugs and Psychotropic Substances of 1961, 1971 and 1988. Towards the domestication of these Conventions, the Narcotic Drugs and Psychotropic Substances (Control) Act, 1994 was enacted. It makes provision with respect to the control of the possession and trafficking of narcotic drugs and psychotropic substances as well as cultivation of controlled plants.

The Proceeds of Crime and Anti-Money Laundering Act, 2009 creates a comprehensive legislative framework to combat the offense of money laundering in Kenya. It also provides for the identification, tracing, freezing, seizure and confiscation of the proceeds of crime related to drugs. In addition, the Alcoholic Drinks Control Act, 2010 provides for the control of production, sale, and consumption of alcoholic drinks while the Tobacco Control Act, 2007 provides for the control of manufacture and production of tobacco products in Kenya.

CHAPTER TWO: ENFORCEMENT

This section presents enforcement data on seizures of illicit alcohol, narcotic drugs and other nationally and internationally controlled psychoactive substances.

2.1 Illicit alcohol control

The Alcoholic Drinks Control Act (2010) is the principal legislation in the enforcement of laws related to production, distribution, sale and consumption of alcohol. This Act has enabled the County Governments to enact their respective County Alcoholic Drinks Control Act.

During the reporting period, data on illicit alcohol seizures showed that a total of 3,377,384 litres of illicit alcohol was seized nationally. County specific data showed that Kakamega accounted for the highest seizures of illicit alcohol (386,916 litres) followed by Kisii (366,936), Trans Nzoia (348,574), Mombasa (312,185 litres), Nairobi (275,845 litres), West Pokot (221,338 litres), Meru (207,031 litres), Uasin Gishu (115,447 litres), Busia (101,953 litres), Migori (98,900 litres) and Nandi (98,688 litres) (Table 5).

In terms of seizures of individual alcohol categories, data showed that a total of 341,216 litres of chang'aa was seized nationally. County specific data showed that West Pokot accounted for the highest seizures of chang'aa (35,105 litres), followed by Trans Nzoia (33,446 litres), Nakuru (30,676 litres), Mombasa (23,130 litres) and Kakamega (21,745 litres) (Table 5).

Statistics on *kangara* showed that a total of 2,356,082 litres were seized in the reporting period. County specific data showed that Kakamega accounted for the highest seizures of *kangara* (347,929 litres) followed by Kisii (334,940 litres), Mombasa (265,300 litres), Trans Nzoia (181,768 litres) and Nairobi (170,740 litres) (158,900 litres) (Table 5).

Data on other types of traditional alcohol showed that a total of 627,389 litres were seized in the reporting period. County specific data showed that Meru accounted for the highest seizures (195,677 litres) followed by Trans Nzoia (133,360 litres), Nairobi (87,970 litres), West Pokot (26,723 litres) and Tharaka (20,650 litres) (Table 5).

Table 5: Illicit alcohol seizures by county

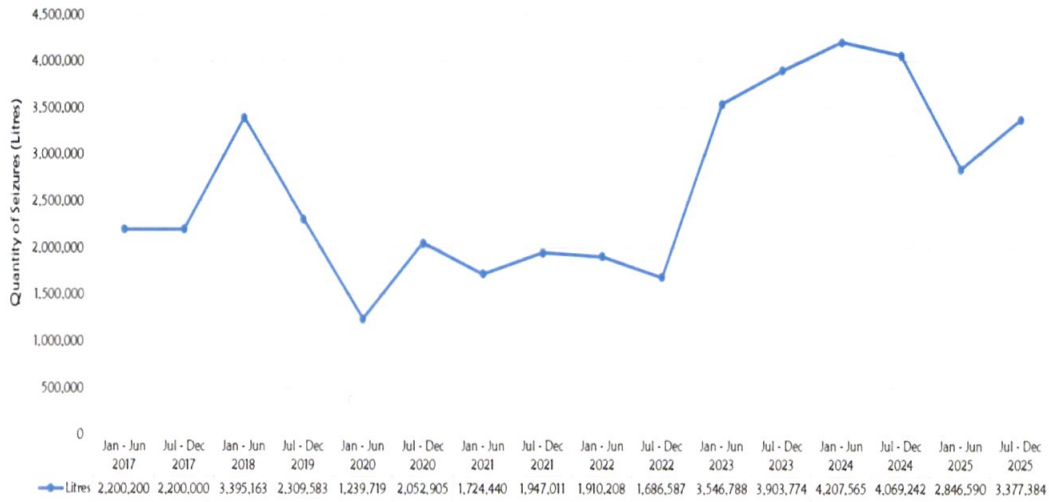
County	Chang'aa (ltrs)	Kangara (ltrs)	Other traditional alcohol (ltrs)	Illegal neutral spirits (ltrs)	Illegal ethanol (ltrs)	Counterfeit alcohol (ltrs)	Total alcohol seizures (ltrs)
Kakamega	21,745	347,929	17,242	-	-	-	**386,916**
Kisii	14,264	334,940	17,532			200	**366,936**
Trans Nzoia	33,446	181,768	133,360	-	-	-	**348,574**
Mombasa	23,130	265,300	16,626	7,128	-	-	**312,185**
Nairobi	16,897	170,740	87,970	44	-	194	**275,845**
West Pokot	35,105	158,900	26,723	-	-	610	**221,338**
Meru	6,133	4,474	195,677		608	139	**207,031**
Uasin Gishu	11,458	99,086	3,314	-	1,380	209	**115,447**
Busia	86,063	10,106	5,784	-	-	-	**101,953**
Migori	5,065	93,575	260	-	-	-	**98,900**
Nandi	7,477	81,935	411	-	-	8,865	**98,688**
Siaya	3,005	89,484	4,556			56	**97,101**
Nakuru	30,676	46,832	16,868		148	361	**94,884**
Bungoma	4,410	56,555	15,610	15	-	-	**76,590**
Laikipia	3,824	66,619	40			24	**70,506**
Homa Bay	2,10.5	67,006	23	-	-	3	**67,032**
Nyamira	5,513	54,514	2,508	-	-	2	**62,537**
Elgeyo Marakwet	3,099	35,573	16,231	850		1,040	**56,793**
Kisumu	3,083	52,900	25	-	-	2	**56,010**
Baringo	1,492	43,551	3,728			190	**48,961**
Kericho	5,879	24,294	5,657			8,002	**43,832**
Tharaka Nithi	510	600	20,650	-	-	10	**21,770**
Machakos	833	16,837	95	-	-	552	**18,317**
Samburu	1,030	15,220	20	-	-	-	**16,270**
Nyeri	15	623	-	-	-	15,000	**15,638**
Narok	2,970	8,507	3,700	-	-	-	**15,177**
Taita Taveta	178	2,916	6,053	-	-	3,942	**13,088**
Murang'a	1,331	9,730	433	78	-	-	**11,572**
Marsabit	4,700	3,277	1,318	-	-	-	**9,295**
Kiambu	2,329	4,416	1,400	21	20	-	**8,186**

County	Chang'aa (ltrs)	Kangara (ltrs)	Other traditional alcohol (ltrs)	Illegal neutral spirits (ltrs)	Illegal ethanol (ltrs)	Counterfeit alcohol (ltrs)	Total alcohol seizures (ltrs)
Vihiga	4,186	1,950	250	-	-	-	**6,386**
Kirinyaga	61	-	5,674	-	-	-	**5,735**
Lamu	67	-	5,389	-	-	-	**5,456**
Kitui	-	799	3,324	-	-	334	**4,457**
Kwale	20	160	2,904	610	-	-	**3,694**
Kajiado	574	-	598			2,062	**3,234**
Embu	-	2,230	939	-	-	-	**3,169**
Makueni	10	220	2,123	-	-	-	**2,353**
Isiolo	589	1,042	632	-	-	-	**2,263**
Kilifi	50	1,474	590	-	-	-	**2,114**
Tana River	-	-	1,115	-	-	-	**1,115**
Garissa	-	-	37	-	-	-	**37**
Total	**341,216**	**2,356,082**	**627,389**	**8,746**	**2,155**	**41,795**	**3,377,384**

Source: MoINA, July – December 2025

Figure 1 shows that there was an increase in illicit alcohol seizures during the reporting period. Data showed that a total of 3,377.384 litres of illicit alcohol was seized during the reporting period of July – December 2025.

Figure 1: Trend of illicit alcohol seizures nationally



2.2 Narcotic drugs and psychotropic substances control

"The Narcotic Drugs and Psychotropic Substances Control Act, 2022" is the principal legislation in the enforcement of laws related to the control of narcotics and psychotropic substances.

2.2.1 Cannabis control

Cannabis is the most widely used narcotic drug in Kenya. Most of the cannabis used in Kenya usually originates from the neighbouring countries of Ethiopia, Tanzania and Uganda as well as local cultivation. Kenya is therefore a key destination country for cannabis within the Eastern African region.

During the reporting period, data on cannabis seizures showed that a total of 21,080.3 kgs of cannabis were seized nationally, the highest seizure ever recorded in a biannual period. Analysis of county specific data showed that Mombasa accounted for the highest seizures of cannabis (3,332.7 kgs) followed by Kiambu (2,016 kgs), Nairobi (2,001 kgs), Kakamega (1,675 kgs), Kilifi (1,173.6 kgs), Homabay (937.7 kgs), Nakuru (805.7 kgs), Bomet (632.2 kgs), Murang'a (628.8 kgs) and Kwale (613.8 kgs). This data is presented in Table 6.

Table 6: Cannabis seizures by county

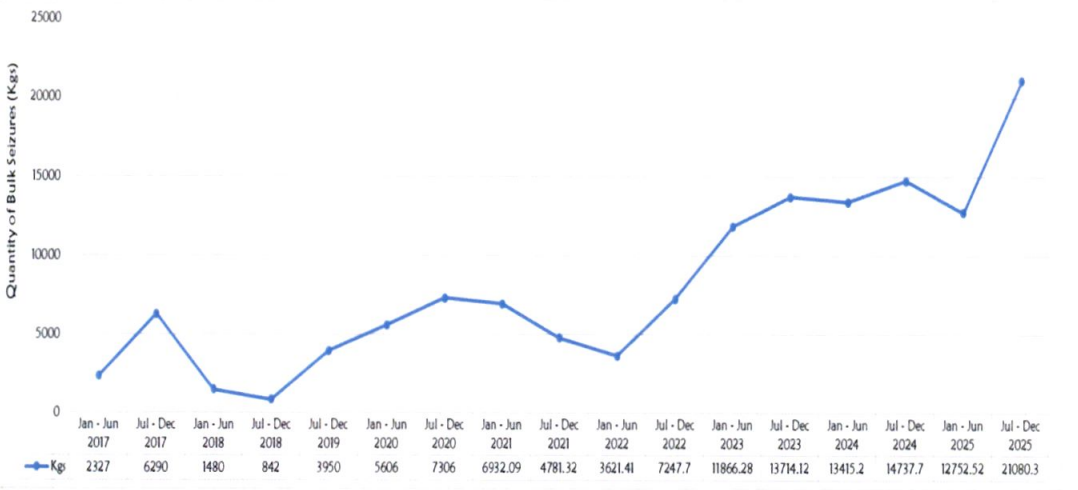
County	No. of persons arrested for possession	No. of persons arrested for trafficking	No. of persons arrested for cultivation	Total no. of persons arrested	Quantity seized (Kg)
Mombasa	75	37	0	112	**3,332.7**
Kiambu	408	111	3	522	**2,016**
Nairobi	282	140	0	422	**2,001**
Kakamega	74	9	11	94	**1,675**
Kilifi	52	35	3	90	**1,173.6**
Homa Bay	23	12	1	36	**973.7**
Nakuru	80	8	5	93	**805.7**
Bomet	31	4	1	36	**632.2**
Murang'a	176	44	3	223	**628.8**
Kwale	24	8	8	40	**613.8**
Laikipia	52	2	1	55	**606**
Machakos	51	0	2	53	**541.7**
Kericho	37	2	1	40	**515.6**

County	No. of persons arrested for possession	No. of persons arrested for trafficking	No. of persons arrested for cultivation	Total no. of persons arrested	Quantity seized (Kg)
Kisii	86	13	6	105	**505.4**
Uasin Gishu	28	4	1	33	**493.7**
Narok	22	24	0	46	**472.2**
Nandi	22	0	0	22	**411.8**
Bungoma	57	1	3	61	**402.8**
Embu	60	22	12	94	**373.3**
Makueni	36	2	1	39	**311**
Busia	14	16	1	31	**285.7**
Vihiga	42	1	1	44	**268.1**
Siaya	16	1	2	19	**257.7**
Meru	33	17	4	56	**255.6**
Nyeri	74	10	1	85	**244.9**
Kisumu	2	3	0	5	**168.5**
Migori	7	10	0	17	**131.1**
Kajiado	27	4	1	32	**119.5**
Trans Nzoia	8	4	0	12	**114.7**
Kirinyanga	93	3	2	98	**100.2**
Wajir	16	0	0	16	**96**
Kitui	34	15	1	50	**93.7**
Tana River	5	1	0	6	**85.9**
Samburu	1	1	0	2	**68.3**
Tharaka Nithi	24	0	0	24	**67.2**
Elgeyo Marakwet	1	0	8	9	**50.1**
Garissa	4	2	0	6	**40**
Nyandarua	22	1	0	23	**30**
Isiolo	6	7	0	13	**24.7**
Marsabit	2	0	0	2	**23**
West Pokot	4	0	2	6	**15**
Taita Taveta	10	1	1	12	**5.3**
Nyamira	17	2	2	21	**5.3**
Lamu	19	1	0	20	**0.1**
KAPU	0	3	0	3	**43.7**
Totals	**2,157**	**581**	**88**	**2,840**	**21,080.3**

Source: NPS, ANU and DCI, July – December 2025

Figure 2 shows that there was a sharp increase in the quantity of bulk seizures for cannabis during the reporting period from 12,752.52 kgs in January – June 2025 to 21,080.3 kgs in July - December 2025. Generally, the trend shows that there has been a steady rise in the seizures for cannabis from January – June 2022.

Figure 2: Trend of cannabis seizures nationally



2.2.2 Heroin control

Heroin is an illegal opioid and an extremely addictive drug derived from the opium poppy plant. Heroin is the second most widely used narcotic drug in Kenya after cannabis.

During the reporting period, data on heroin seizures showed that a total of 1.11 kgs of heroin were seized nationally. These seizures were made in Mombasa, Nairobi, Nyeri and Tana River counties (Table 7).

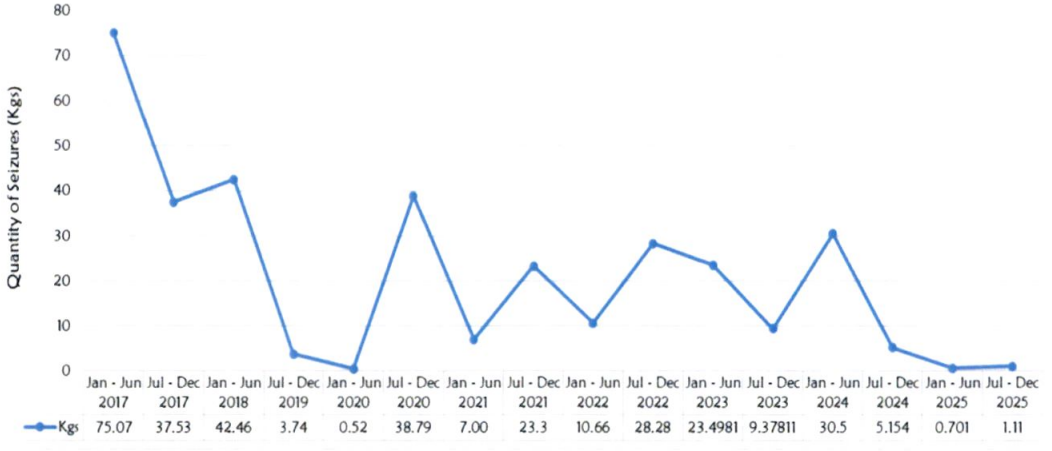
Table 7: Heroin seizures by county

County	No. of persons arrested	Quantity seized (Kg)
Mombasa	8	0.65
Nairobi	1	0.31
Nyeri	2	0.03
Tana River	3	0.12
Total	**14**	**1.11**

Source: NPS, ANU and DCI, July – December 2025

Figure 3 shows that the trend of heroin seizures had increased marginally from 0.701 kgs (January - June 2025) to 1.11 kgs (July - December 2025). But overall, heroin seizures have been on a downward trend.

Figure 3: Trend of heroin seizures nationally



2.2.3 Cocaine control

Cocaine is an illegal and highly addictive stimulant drug under international control. During the reporting period, data showed that a total of 2.09 kgs of cocaine were seized in the country. These seizures were made in Mombasa, Nairobi, Kwale and the Jomo Kenyatta International Airport (JKIA) (Table 8).

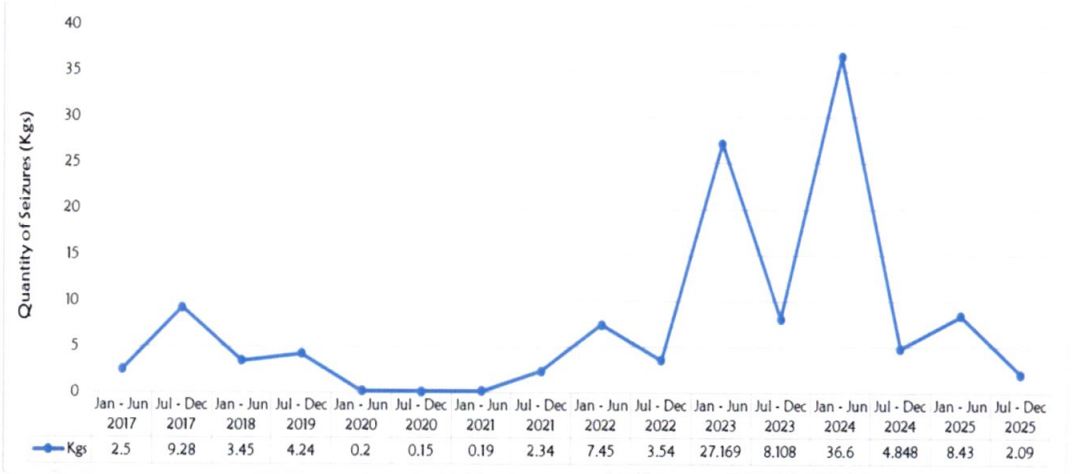
Table 8: Cocaine seizures by county

County	No. of persons arrested	Quantity seized (Kg)
Mombasa	1	0.41
Nairobi	9	0.44
Kwale	1	0.01
JKIA	4	1.23
Total	**15**	**2.09**

Source: NPS, ANU and DCI, July – December 2025

Figure 4 showed a decline in cocaine seizures from 8.43 kgs (January – June 2025) to 2.09 kgs (July – December 2025).

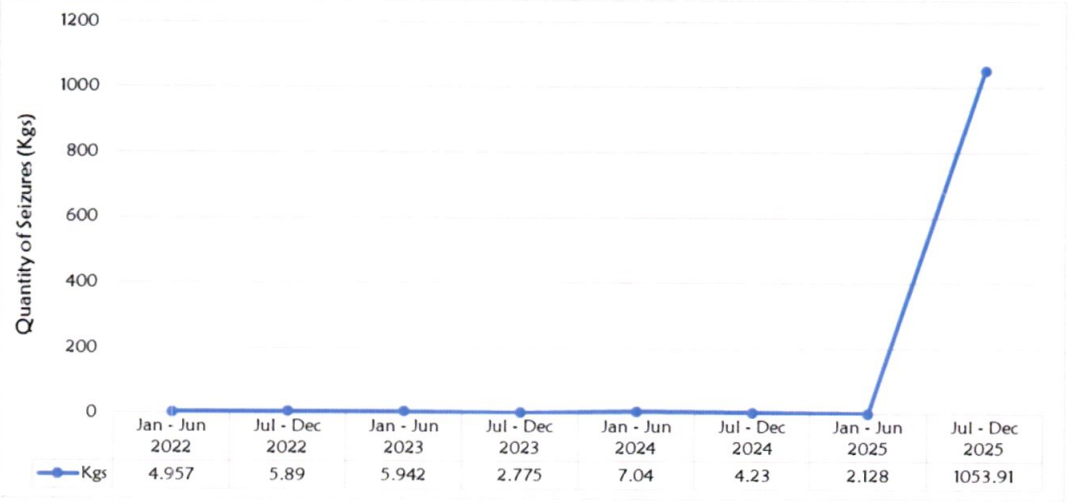
Figure 4: Trend of cocaine seizures nationally



2.2.4 Methamphetamine control

Methamphetamine is a synthetic drug and part of the group of drugs called amphetamine-type stimulants (ATS). During the reporting period, 9.2 kgs were seized at the JKIA and 1,044.29 kgs were seized in Mombasa. A total of 1,053.91 kgs of methamphetamine were seized in the country, recording the highest seizure since this drug first emerged in Kenyan market in the year 2022 (Figure 5).

Figure 5: Trend of methamphetamine seizures nationally



2.2.5 Control of other substances

During the reporting period, 6.41 kgs of ketamine were seized at the JKIA, 25 tablets of cozepam were seized in Kisii and 6 tablets of cozepam were seized in Isiolo (Table 9). Ketamine is an emerging synthetic drug in Kenya.

Table 9: Seizures of other substances by county

County	Type of drug	Tablets	Kgs
Kisii	Cozepam	25	-
Isiolo	Cozepam	6	-
JKIA	Ketamine	-	6.41

Source: NPS, ANU and DCI, July – December 2025

2.3 Trafficking routes for narcotic drugs

Drug trafficking is a global illicit trade involving the cultivation, manufacture, distribution and sale of psychoactive substances which are subject to national and international control. In the reporting period, the commonly trafficked substances in Kenya were cocaine, methamphetamine and ketamine. Nairobi has emerged as a key gateway to the East African region due its geographic location and global connectivity to the major world destinations. This strategic positioning makes Kenya an attractive transit route for drug trafficking.

2.3.1 Cocaine trafficking routes

Cocaine is primarily produced in the Andean region of South America, particularly in Colombia, Peru, and Bolivia. Cocaine trafficking is dominated by South America–North America and South America–Europe routes, with West Africa serving as a major transit corridor for shipments destined for European and, increasingly, African markets. Inbound – outbound data on cocaine seizures for July – December 2025 showed that Ethiopia was the country of origin for cocaine destined for Kenya (Figure 6).

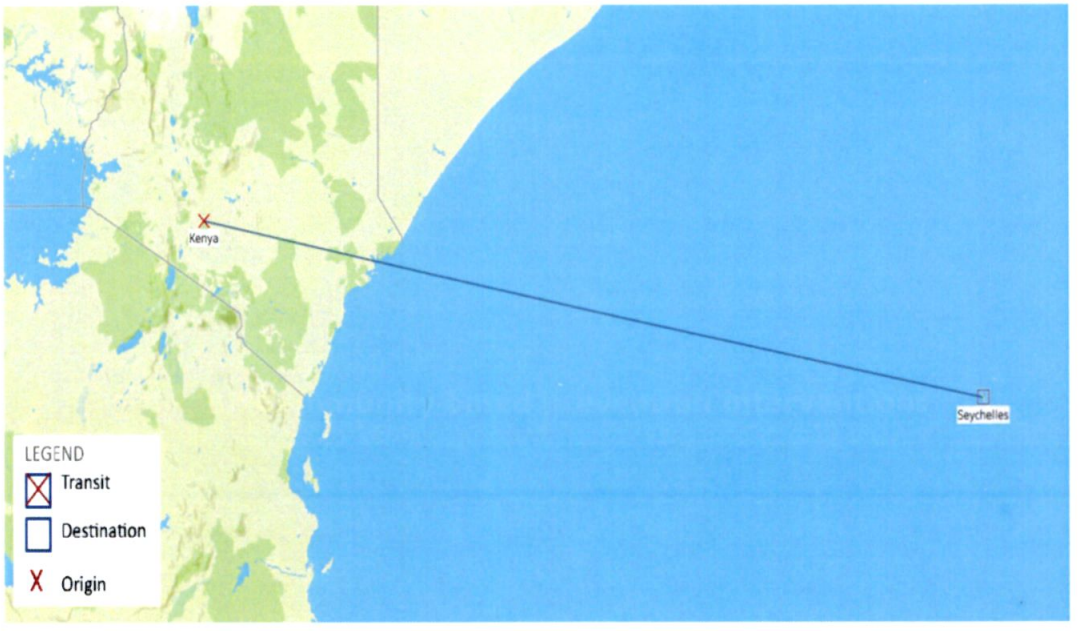
Figure 6: Cocaine trafficking routes

Source: ANU, July – December 2025

2.3.2 Methamphetamine trafficking routes

Methamphetamine is part of the group of drugs called amphetamine-type stimulants (ATS). It is a synthetic drug that is usually manufactured in clandestine (illegal) laboratories. Major production centers are located in East and Southeast Asia, particularly the Golden Triangle, as well as parts of Myanmar and China. Significant production also occurs in Mexico for the North American market. Methamphetamine is primarily trafficked along Southeast Asia–East Asia, Mexico–United States, Asia–Oceania, and Asia–Africa–Europe routes, using land, air, maritime, and parcel delivery networks to supply global markets. Inbound – outbound data on methamphetamine seizures for July – December 2025 showed that Kenya was the country of origin for methamphetamine destined for Seychelles (Figure 7).

Figure 7: Methamphetamine trafficking routes



Source: ANU, July – December 2025

2.3.3 Ketamine trafficking routes

Ketamine is a synthetic drug that was originally developed for medical and veterinary use as a dissociative anesthetic. It is legally used in hospitals for anesthesia, pain management, and, in some countries, treatment of resistant depression. However, it is increasingly being diverted for non-medical use because it can produce feelings of detachment from reality, hallucinations, and altered perception. Illicit ketamine is trafficked globally through criminal networks using air, sea, and postal routes. It is often sourced through diversion from legitimate manufacturers or produced in clandestine laboratories. Major trafficking routes originate from countries such as India and China, moving through East and Southeast Asian transit hubs including Thailand, Malaysia, and Hong Kong. From these hubs, shipments are transported to consumer markets across Asia, Europe, Africa, and Oceania. Inbound – outbound data on ketamine seizures for July – December 2025 showed that Kenya was the country of origin for ketamine destined for Australia and Brazil (Figure 8).

Figure 8: Ketamine trafficking routes

Source: ANU, July – December 2025

CHAPTER THREE: PREVENTION AND MITIGATION OF ALCOHOL AND DRUG ABUSE

3.1 Introduction

This chapter presents the major achievements on prevention and mitigation of alcohol and drug abuse in Kenya. The strategies include enhancing public education and advocacy through drug demand reduction initiatives; promotion of quality treatment, rehabilitation and reintegration of persons with substance use disorders (SUDs); and strengthening compliance to alcohol and drug policies, laws, regulations and standards. With the devolved system of governance in Kenya, liquor licensing and drug control functions have been assigned to the County Governments. Priority therefore focuses on strengthening partnerships and collaborations at the county level to enhance uptake of devolved functions.

3.2 Public education and advocacy

Public education and awareness on alcohol and drug abuse (ADA) is an important pillar in prevention. The general aim of alcohol and drug use prevention is to attain a healthy and safe development of children and youth in order to realize their full potential and become contributing members of their community and society. During the reporting period, the Authority continued to partner with various stakeholders to implement evidence informed programs and interventions in schools and the community. Through these programs the Authority sought to mitigate the health, social, and economic problems associated with alcohol and drug use in the country.

3.2.1 School based prevention interventions

Learning institutions are regarded as the second most powerful socialization agent for children and young people after their families. They therefore form an important setting for interventions aimed at alcohol and drug use prevention. Schools play a significant role to equip learners with key life skills, imparting them with accurate knowledge and establishing sound values base in relation to health and drug use prevention.

The Authority in partnership with the Ministry of Education and the Teachers Service Commission and various civil society organizations held dissemination forums for the National Guidelines for Alcohol and Substance Use Prevention and Management in basic education institutions. The guidelines were developed with the aim of providing a framework for evidence-based approaches to alcohol and drug abuse demand reduction measures in basic education institutions across the country.

During the period, 17,154 teaching staff, learners and parents were reached in partnership with multiple partners in the following 25 counties: Samburu, Kisumu, Nyeri, Busia, Kiambu, Mombasa, Nakuru, Garissa, Kilifi, Kajiado, Narok, Turkana, Marsabit, Mandera, Wajir, Meru, Embu, Kitui, Machakos, Kericho, Uasin Gishu, Kakamega, Vihiga, Migori and Kwale.

The Authority also disseminated the report on the "Status of Drugs and Substance Use among University Students in Kenya" in 12 tertiary institutions in Bungoma, Busia, Nakuru, Kilifi, Bomet, Kitui, Kisumu, and Kwale counties to support the identification and implementation of appropriate interventions.

3.2.2 Community based prevention interventions

Community-based prevention programs are effective in addressing challenges caused by alcohol and drug use and their resultant consequences. Such programs are largely coordinated by non-state actors at local levels including community coalitions comprising representatives from organizations within the community.

During the period, the Authority participated in the commemoration of the World Mental Health Day in the counties of West Pokot, Uasin Gishu, Baringo, Kakamega, and Nyeri. This event was commemorated in partnership with state and non-state actors. This included Community-Based Organizations; Faith Based Organizations; County Governments and other stakeholders supporting the campaign. This year's theme, *"Access to Services – Mental Health in Catastrophes and Emergencies,"* calls attention to the millions of people whose psychological wellbeing is disrupted by disasters, conflict, displacement, disease outbreaks, and other emergencies.
The Authority also collaborated with other stakeholders to commemorate the World Aids Day in the counties of Kitui, Mombasa, Marsabit, Lamu, Kwale, and Kisumu. The theme for the 2025 commemoration was "*Overcoming Disruption, Transforming the AIDS Response*", which placed emphasis on the need for stakeholders to turn setbacks into transformation and ensure the HIV response becomes more resilient, inclusive, and sustainable.

Additionally, the Authority, in collaboration with the various religious institutions affiliated to Christians, Muslims and Hindus, conducted capacity building sessions on ADA prevention reaching 995 religious leaders across the counties of Turkana, Nyandarua, Kwale, Kakamega, Kitui, Garissa, Kericho, Meru, Homa Bay, Laikipia, Taita-Taveta, Machakos, Bungoma, Isiolo, and Narok.

The aim of this program was to empower and equip these leaders with knowledge and skills needed to support the Authority in raising awareness on the effects of ADA within their respective communities including support for persons with SUDs to access treatment and care services.

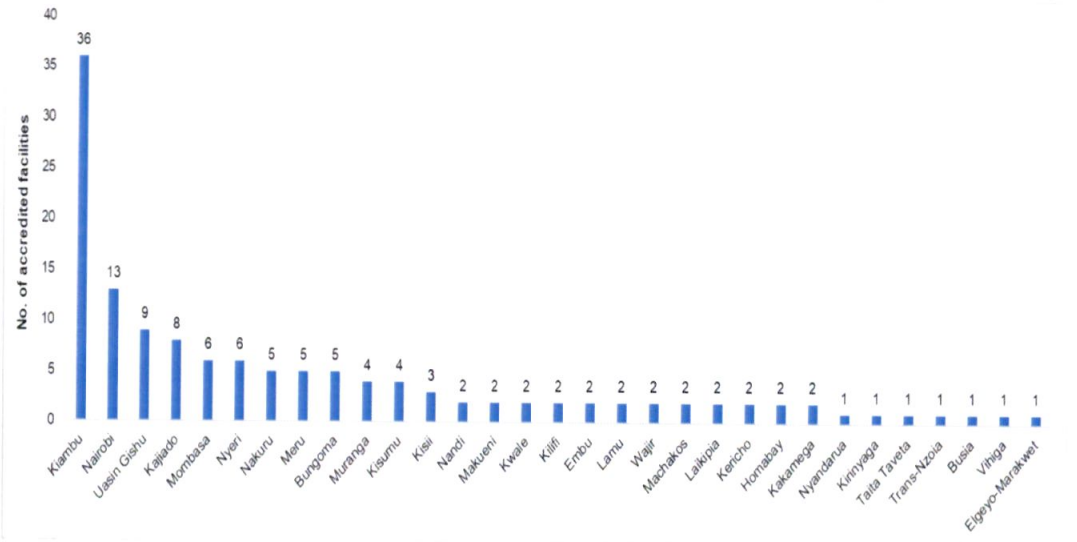
Lastly, the Authority collaborated with key stakeholders to disseminate the National Policy for the Prevention, Management & Control of Alcohol, Drugs & Substance Abuse, 2025.Through this engagement, the policy was disseminated to 4,124 stakeholders across 15 counties, with the aim of enhancing awareness, understanding, and adoption. This process is intended to strengthen implementation at both national and county levels.

3.3 Access to quality and holistic treatment and rehabilitation services

SUDs continue to be a major public health problem in Kenya with increasing unmet need for treatment and rehabilitation services. During the reporting period, the Authority implemented a 100-day Rapid Results Initiative on alcohol and drug control to assess compliance of drug treatment and rehabilitation (T&R) facilities with the national standards for treatment of persons with SUDs. During the RRI period, a total of 231 facilities were inspected across 36 counties in Kenya. This exercise was conducted in collaboration with a multi-agency team comprising NACADA, Kenya Medical Practitioners and Dentist Council, Pharmacy and Poisons Board, Public Health Department and respective County Governments.

From the assessment report, 135 facilities were accredited; 31 facilities did not meet the threshold for accreditation; 14 facilities were recommended for closure; and 51 facilities were not operational at the time of inspection due to outstanding issues e.g. ongoing renovations, voluntary closure, or change of use. Figure 9 below presents a summary of accredited treatment and rehabilitation facilities in Kenya.

Figure 9: Number of accredited treatment and rehabilitation facilities in Kenya



Source: Accreditation inspection report, 2026

As well, NACADA continued to provide outpatient and inpatient treatment and rehabilitation services at the Miritini Treatment and Rehabilitation Center in Mombasa County. A total of 419 persons with SUDs at the Miritini Treatment and Rehabilitation Centre were supported under the outpatient program and another 40 clients were supported under the inpatient program.

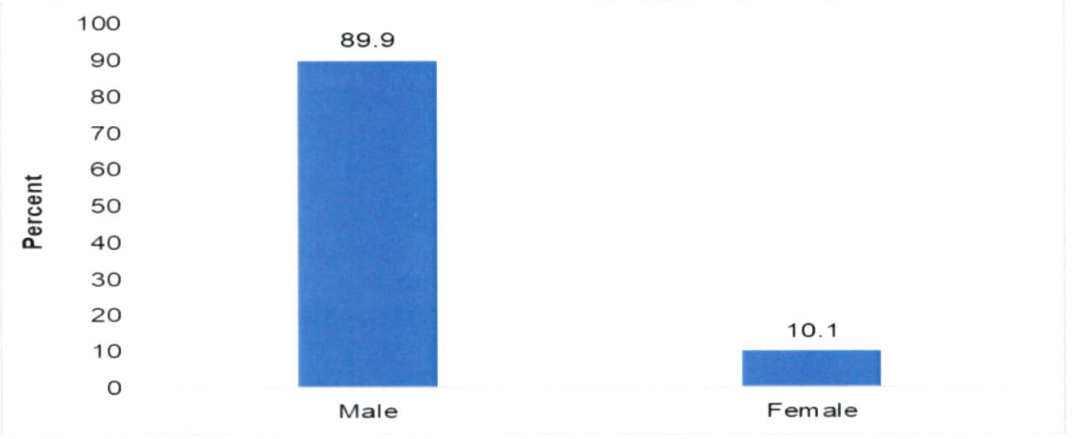
3.4 National drug observatory treatment data for January – December 2025

The national drug observatory (NDO) treatment data for January – December 2025 covered 96 reporting facilities which attended a total of 4903 clients. A standard tool was used to collect operational data from the accredited treatment and rehabilitation facilities in Kenya.

3.4.1 Gender of clients seeking treatment for SUDs

Figure 10 shows that more males were seeking treatment services for SUDs (89.9%) compared females (10.1%).

Figure 10: Sex of clients seeking treatment for SUDs (n=4903)



Source: Treatment data, 2025

3.4.2 Age distribution of clients seeking treatment for SUDs

Table 10 reveals that over 74 percent of the clients seeking addiction treatment services were aged between 15 to 39 years. Analysis reveals that there is an emerging and worrying trend with the growing population of adolescents accessing addiction services before the age of 18 years (Table 10).

Table 10: Age distribution of clients seeking treatment for SUDs

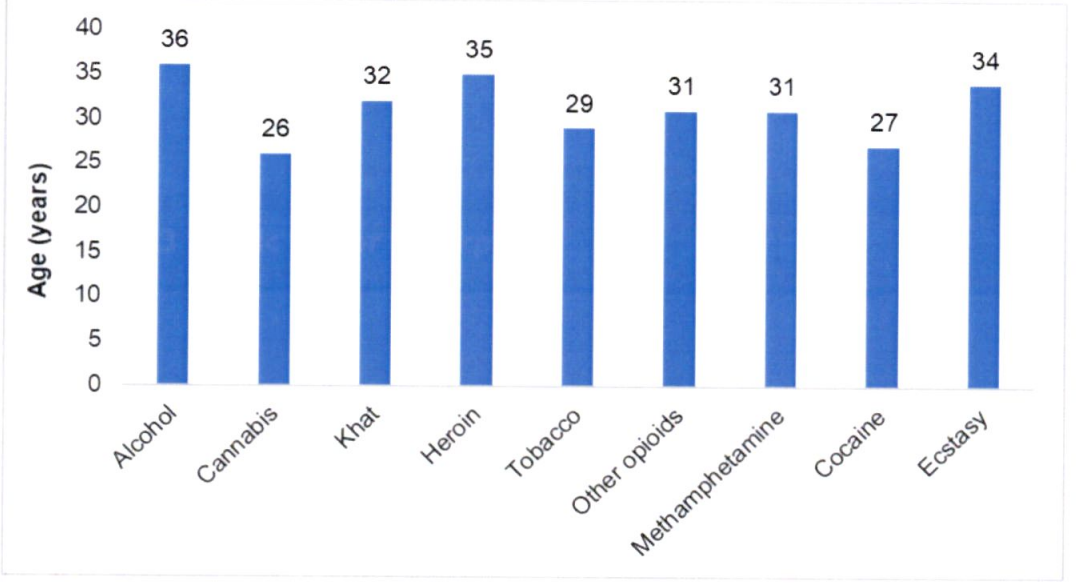
Age group	No. of cases (n)	Percent (%)
10-14	16	0.3
15-19	733	15.0
20-24	657	13.4
25-29	875	17.8
30-34	743	15.2
35-39	702	14.3
40-44	516	10.5
45-49	284	5.8
50-54	203	4.1
55-59	84	1.7
60-64	53	1.1
65+	37	0.8
Total	**4903**	**100.0**

Source: Treatment data, 2025

3.4.3 Average age of clients seeking treatment for SUDs

Figure 11 shows that the average age of clients seeking treatment for SUDs ranged from 26 – 36 years. However, the clients seeking treatment for cannabis, cocaine and tobacco recorded the lowest average ages of 26, 27 and 29 years respectively.

Figure 11: Average age of clients seeking treatment for SUDs (n=4903)

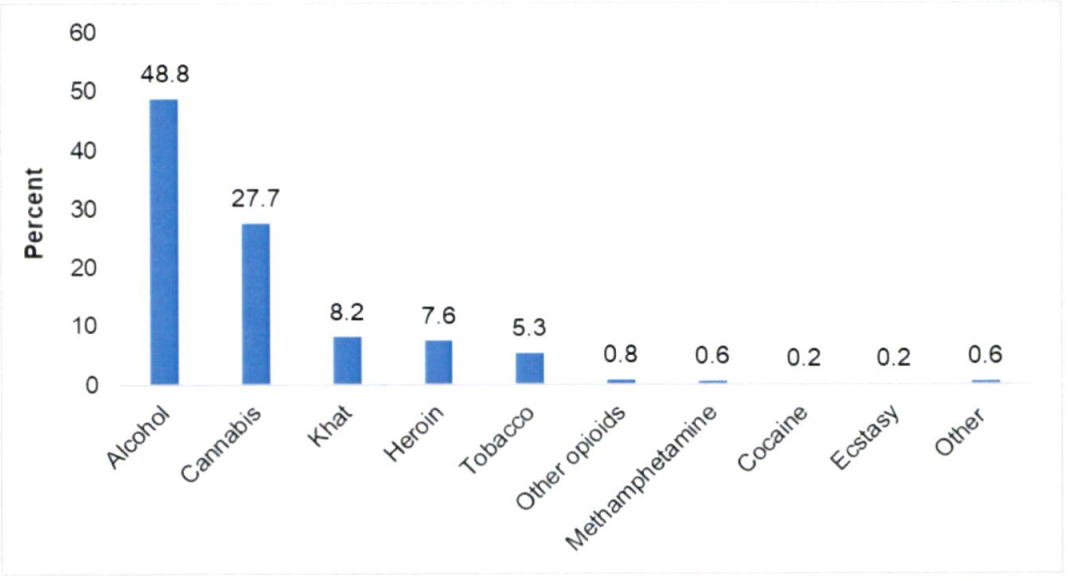


Source: Treatment data, 2025

3.4.4 Primary drug or substance under treatment

According to Figure 12, alcohol the highest overall burden of SUDs among clients seeking addiction treatment services in Kenya (48.8%) followed by cannabis (27.7%), *khat* (8.2%), heroin (7.6%), tobacco (5.3%), other opioids (0.8%), methamphetamine (0.6%), cocaine (0.2%) and ecstasy (0.2%). It is important to appreciate the growing burden of cannabis as a primary substance among clients seeking addiction treatment services.

Figure 12: Primary drug or substance under treatment (n=4903)



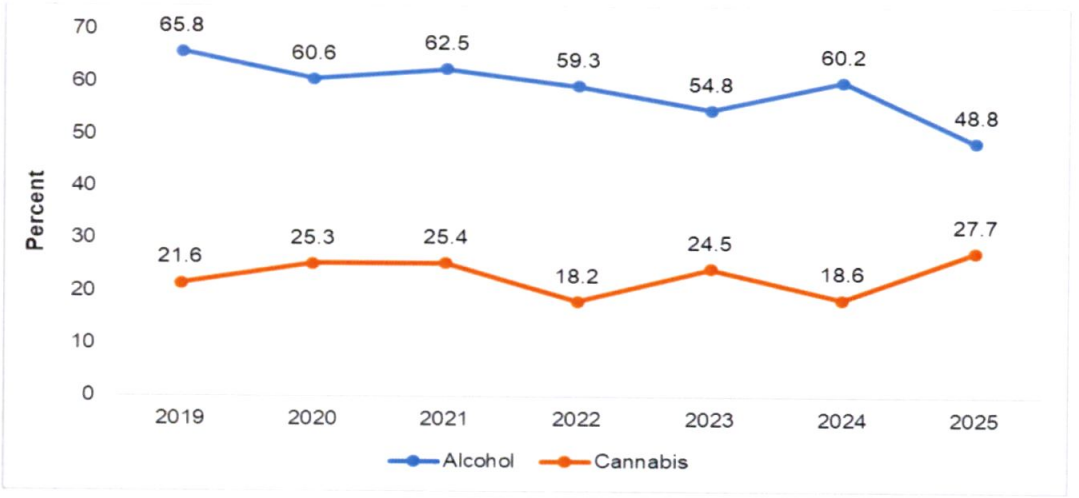
Source: Treatment data, 2025

The treatment data also revealed other substances of abuse that were being used as secondary drugs by clients accessing addiction treatment. These substances included amitriptyline, rohypnol, artane, barbiturates, codeine, tramadol, diazepam, ketamine, methadone, pethidine, morphine, pregabalin and jet fuel.

3.4.5 Trend of alcohol and cannabis as primary substances among clients seeking treatment

Figure 13 presents a trend analysis comparing alcohol and cannabis as primary substances among clients seeking addiction treatment in Kenya. Analysis reveals that the gap between the burden of alcohol and cannabis related addiction is narrowing, although alcohol continues to account for a substantially greater overall burden of SUDs.

Figure 13: Trend of alcohol and cannabis as primary substances among clients seeking treatment

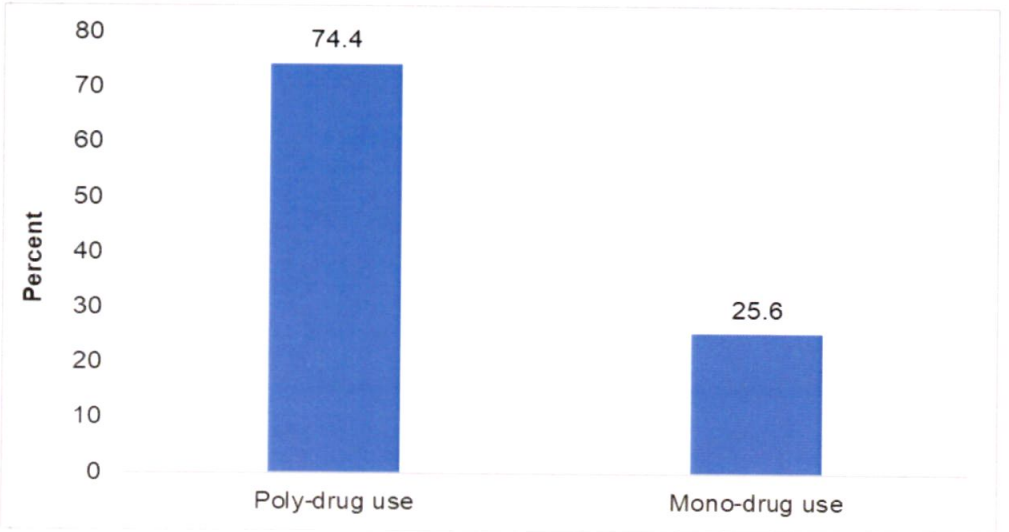


Source: Treatment data, 2019 - 2025

3.4.6 Poly-drug use among clients seeking treatment for SUDs

Figure 14 shows that 74.4% of the clients seeking treatment for SUDs in 2025 had presented with problems of poly-drug use while 25.6% were mono-drug users. This presents unforeseen challenges to the overall outcome of addiction treatment.

Figure 14: Polydrug use among clients seeking treatment for SUDs (n=4903)

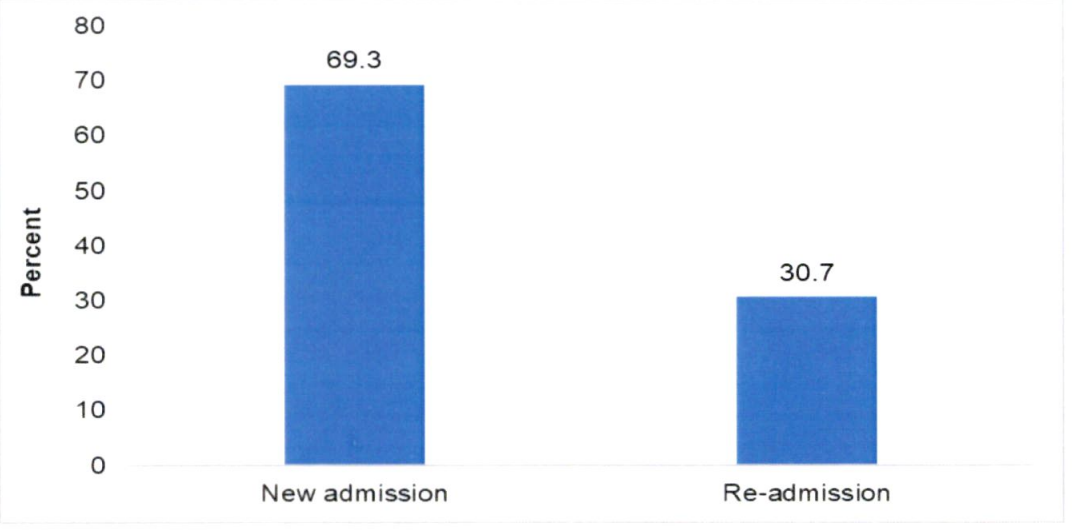


Source: Treatment data, 2025

3.4.7 Type of admission for clients seeking treatment for SUDs

Data shows that the new admission cases accounted for 69.3% of all addiction treatment admissions while 30.7% were clients on re-admission having accessed treatment services before. This shows that relapse continues to be a major setback in addiction recovery (Figure 15).

Figure 15: Type of admission for clients seeking treatment for SUDs (4903)

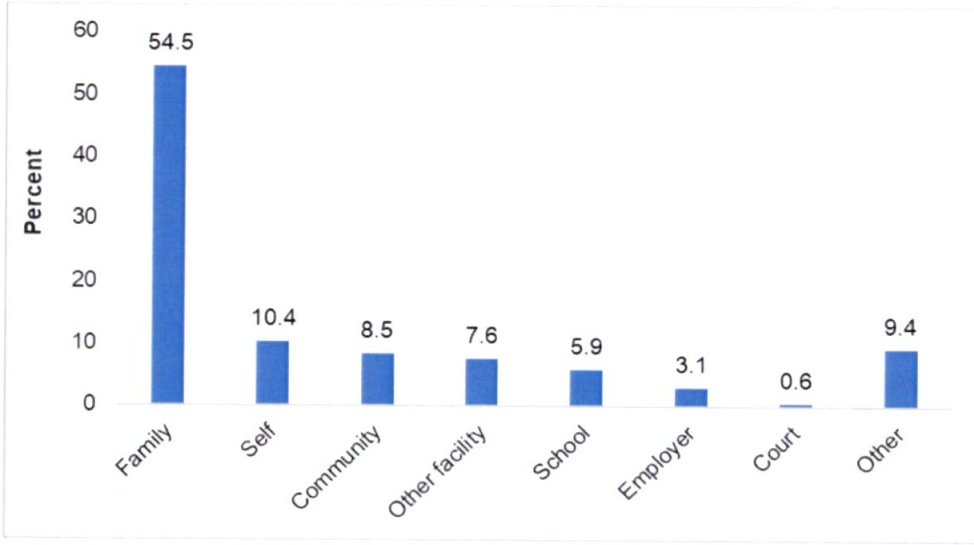


Source: Treatment data, 2025

3.4.8 Mode of referral for T&R services

Figure 16 shows the importance of the family on management of T&R services where 54.5% of the referrals were from family. It is also important to note that schools are also emerging as a point of referral for students struggling with SUDs (5.9%).

Figure 16: Mode of referral for T&R services

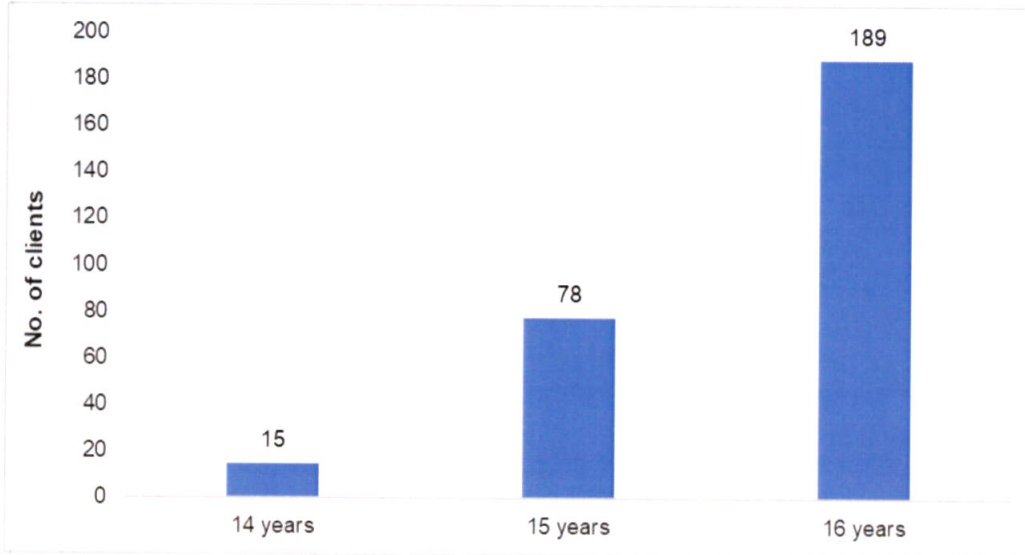


Source: Treatment data, 2025

3.4.9 Access for T&R services by clients below 18 years

Figure 17 reveals that younger children are seeking addiction treatment services. This finding confirms that the problem of drugs and substance abuse in our schools is a reality that can no longer be ignored. Treatment data shows that the problem of SUDs among adolescents initiates at age 14 and peaks at age 16.

Figure 17: Number of clients accessing T&R services below 18 years (n=282)

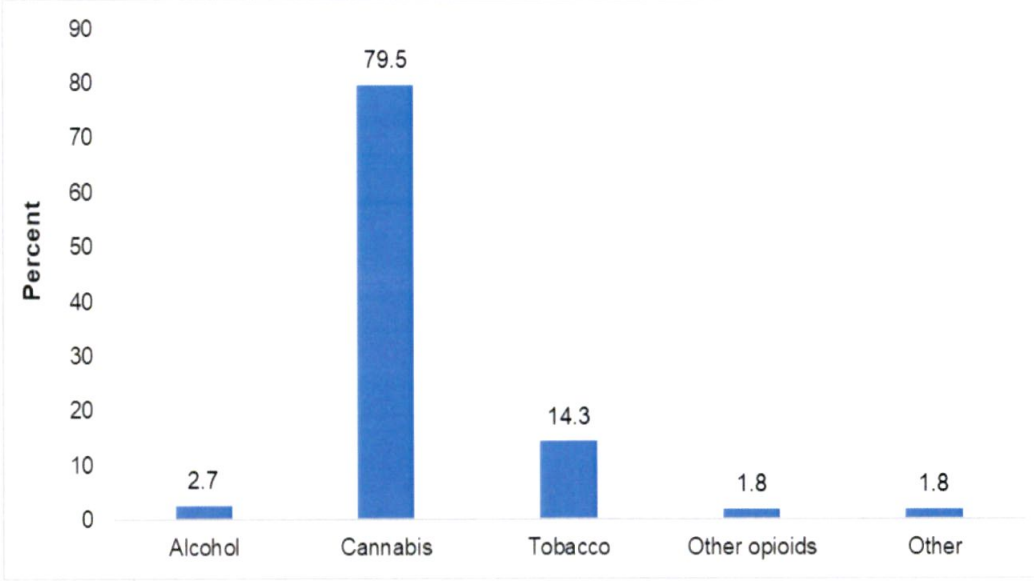


Source: Treatment data, 2025

3.4.10 Primary substance among under-age clients seeking T&R services

Figure 18 reveals that cannabis is the underlying primary substance (79.5%) among adolescents seeking addiction treatment services. This observation provides undeniable evidence that cannabis use presents an emerging challenge in our schools and the youth in general.

Figure 18: Primary substance among under-age clients seeking T&R services



Source: Treatment data, 2025

3.5 Research and knowledge management

NACADA in collaboration with the Pharmacy and Poisons Board and the Government Chemist conducted a nationwide study on "Wastewater Analysis to Assess Emerging New Psychoactive Substances and Illicit Drug Use in Kenya" in 12 sampled counties namely: Kisumu, Mombasa, Kilifi, Kwale, Uasin Gishu, Nakuru, Busia, Nairobi, Kilifi, Garissa, Isiolo, and Nyeri. The study confirmed the presence of three NPS categories: alpha-ethyltryptamine, benzofurans, and synthetic cathinones. Other emerging psychoactive substances detected included methamphetamine, MDMA (ecstasy), psilocybin, and DMT. The findings of this study point to a rapidly evolving and increasingly complex drug use landscape in Kenya.

During the reporting period, the Authority published the 14th edition of the African Journal of Alcohol and Drug Abuse (AJADA). AJADA is an open access, peer reviewed, multidisciplinary journal, committed to high quality output publications with an international audience seeking reliable, timely and current information on ADA. During the reporting period, a total of 12 journal articles were published in this edition.

The articles are as follows:

1. A scoping review of the potential for no- and low-alcoholic beverages to mitigate alcohol harm in Kenya;
2. Alcoholic beverages as a breast cancer risk factor in Nigeria;
3. An exploration of transitioning from smoked to injected nyaope use among users in Tshwane district, south Africa: A phenomenological analysis;
4. Barriers to successful treatment of substance abuse among Nigerian Youths: A systematic review;
5. Celebrity drug display on social media and its influence on youths' substance abuse in Lagos State, Nigeria;
6. Determinants of alcohol consumption among the Ghanaian youth: An examination of motivational and socio-demographic driver;
7. Exploring differences in academic motivation of secondary school students using and not using psychoactive substances in Buhweju District, Uganda;
8. Financial burden of risky behaviours: Effects of alcohol and tobacco use on household savings in Ghana;
9. Generation at risk: Findings and recommendations from the tobacco and nicotine use among adolescents DaYTA survey 2024;
10. Shisha smoking in Nigeria: Dissecting youth knowledge, awareness and perceptions (KAP) and health implications;
11. Substance use and the insidious rise of cardiovascular disease in young people in Africa: a call to action;
12. The hidden social crisis: Drug addiction in the Kashmir Valley, India;

3.6 Compliance with policies, laws, regulations and standards

Compliance with alcohol and drug control laws, regulations and standards is a major challenge in Kenya. As part of the response measures, the Ministry of Interior and National Administration has set up an inter-agency committee comprising of Government departments and lead agencies involved in drug demand reduction and supply suppression for the purposes of enhancing coordination in the development of plans of action, implementation and enforcement of laws and policies related to ADA control.

In this regard, the Authority embarked on a nationwide mapping exercise of alcoholic drink selling outlets across the country. This initiative is aligned with one of the Authority's core mandates under the Alcoholic Drinks Control Act, which requires the Authority to maintain statistics on the levels of alcohol consumption and related deaths, as well as to conduct research, documentation, and dissemination of all relevant information on alcoholic drinks. The information generated from this process informs and strengthens policy processes at the county level. A total 1,232 alcoholic drink outlets in Embu and Narok Counties were mapped during the period under review.

During the reporting period, the Authority supported county governments to conduct crackdowns on illicit brews, counterfeit alcoholic products and drugs to enforce compliance with the existing alcohol and drug control legislation. This was undertaken in the counties of Nairobi, Kakamega, Narok, Isiolo and Wajir. The enforcement operations also led to the seizure of products suspected to be cannabis. In addition, 1,781 cartons of counterfeit alcoholic drinks were also seized. The operations also led to the recovery of assorted paraphernalia suspected to be used in counterfeiting activities, including several rolls of fake Kenya Revenue Authority stamps. During this enforcement exercise, 51 persons were arrested for engaging in illegal production and distribution of alcoholic products.

CHAPTER FOUR: CHALLENGES AND WAY FORWARD

4.1 Challenges

The campaign against alcohol and drug abuse in Kenya was faced by multiple challenges during the reporting period. These are as follows:

4.1.1 Inadequate funding for alcohol and drug abuse control programmes

The national response to alcohol and drug abuse continues to face significant funding constraints. Existing allocations are insufficient to support prevention, treatment, rehabilitation, research, and enforcement programmes. This has limited nationwide scale-up of interventions targeting learning institutions, workplaces, and communities, thereby weakening overall programme impact.

4.1.2 Severe treatment and rehabilitation capacity gap

Kenya faces a critical treatment deficit, with an estimated 2,707,266 people in need of treatment services against a national capacity of less than 10,000 clients per year. This gap is compounded by high treatment costs, inadequate public facilities, shortage of trained professionals, and limited community-based and outpatient care options.

4.1.3 Growing normalization and availability of cannabis

Cannabis continues to account for the largest proportion of drug seizures, reaching record levels during the reporting period, an indication of sustained growth in both demand and supply. This trend is driven by sustained supply and distribution networks, growing demand particularly among young people, and the on-going global, regional and local legalization debates contributing to reduced perceptions of risk.

4.1.4 Rising cannabis use among school-going children

Treatment and rehabilitation data indicate a worrying trend of under-age children aged 14–16 years seeking addiction treatment services, with cannabis accounting for the primary substance of use. The trend suggests early initiation into drug use among school-going children, exposing them to adverse health, educational, social, and developmental consequences.

4.1.5 Emerging shift from traditional narcotics to synthetic drugs

Kenya is experiencing a notable transition in the illicit drug landscape, with synthetic drugs, especially methamphetamine and ketamine, increasingly overshadowing traditional narcotics such as heroin and cocaine. This shift is evidenced by rising seizures, changing trafficking patterns and growing demand. Synthetic drugs present a more complex threat owing to their high potency, ease of manufacture, adaptability of trafficking networks and severe health consequences, necessitating a recalibration of prevention, treatment, intelligence and enforcement strategies.

4.1.6 Emergence of New Psychoactive Substances (NPS)

New psychoactive substances such as benzofurans, alpha-ethyltryptamine, and synthetic cathinones have been detected in the Kenyan drug market through wastewater surveillance. Emerging NPS are designed to evade existing drug control laws, making regulation, detection, and enforcement increasingly difficult while posing unknown health risks.

4.1.7 Limited forensic and detection capacity

National capacity to detect and identify emerging substances remains constrained due to inadequate laboratory infrastructure, limited advanced analytical equipment, and insufficient specialized training for law enforcement, forensic personnel, and prosecutors.

4.1.8 Growing exploitation of air cargo systems for drug trafficking

Trafficking networks are increasingly shifting towards the use of air cargo and courier systems, enabling a more anonymous and decentralized mode of operation that obscures the involvement of key perpetrators and reduces exposure to conventional law enforcement interventions. This trend complicates intelligence gathering, investigations, and interdiction efforts.

4.1.9 Weak regional policy and enforcement cooperation

The absence of harmonized regional drug control frameworks continues to undermine efforts to address transnational drug trafficking. Differences in legal regimes and enforcement capacity across the region are being exploited by organized criminal networks.

4.2 Way forward

4.2.1 Strengthen sustainable financing for ADA control programmes

Enhance sustainable financing mechanisms to support expansion of supply suppression and demand reduction programmes through increased government funding, resource mobilization initiatives, strategic partnerships, and exploration of dedicated funding streams for alcohol and drug control interventions.

4.2.2 Expand treatment and rehabilitation capacity

Expand access to treatment and rehabilitation services through increased investment in public treatment facilities, integration of substance use disorder services into primary healthcare, development of community-based and outpatient treatment programmes, and expansion of the addiction treatment workforce.

4.2.3 Strengthen prevention and enforcement to address cannabis use and trafficking

Strengthen national prevention and enforcement efforts to address rising cannabis use and trafficking by enhancing youth-focused awareness programmes, countering misconceptions regarding the safety of cannabis, and disrupting trafficking and distribution networks.

4.2.4 Strengthen prevention and protection interventions for school-going children

Develop and implement a multi-sectoral framework bringing together the education, health, social protection, child welfare, security, and community sectors to address the underlying drivers of adolescent substance use. The framework should prioritize parental empowerment, community-based prevention initiatives, protection of children from exposure to drug markets, enhanced monitoring of emerging trends among school-going populations, and targeted interventions for vulnerable and at-risk children.

4.2.5 Enhance the national response to synthetic drugs

Strengthen the national response to the growing threat of synthetic drugs through enhanced intelligence-led operations, specialized investigations, strengthened border and port interdiction capabilities, improved forensic and early warning systems, and intensified public awareness campaigns on the risks associated with synthetic drugs.

4.2.6 Establish a National Early Warning System for NPS

Establish a National Early Warning System for New Psychoactive Substances to facilitate timely detection, monitoring, risk assessment, information sharing, and regulatory responses to emerging drug threats.

4.2.7 Strengthen forensic and laboratory capacity

Invest in modern forensic infrastructure and capacity development through acquisition of advanced laboratory equipment, specialized training, and strengthened collaboration with regional and international centres of excellence.

4.2.8 Enhance air cargo security to disrupt drug trafficking

Strengthen air cargo security and surveillance systems through enhanced risk-based profiling, deployment of advanced detection and screening technologies, improved inter-agency coordination, and strengthened collaboration with international aviation, customs, and postal enforcement authorities to detect, disrupt, and interdict illicit consignments.

4.2.9 Strengthen regional cooperation and policy harmonization

Promote regional cooperation and policy harmonization by supporting development of common regional drug control frameworks, joint enforcement operations, intelligence-sharing mechanisms, and coordinated responses to transnational organized crime and drug trafficking.

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