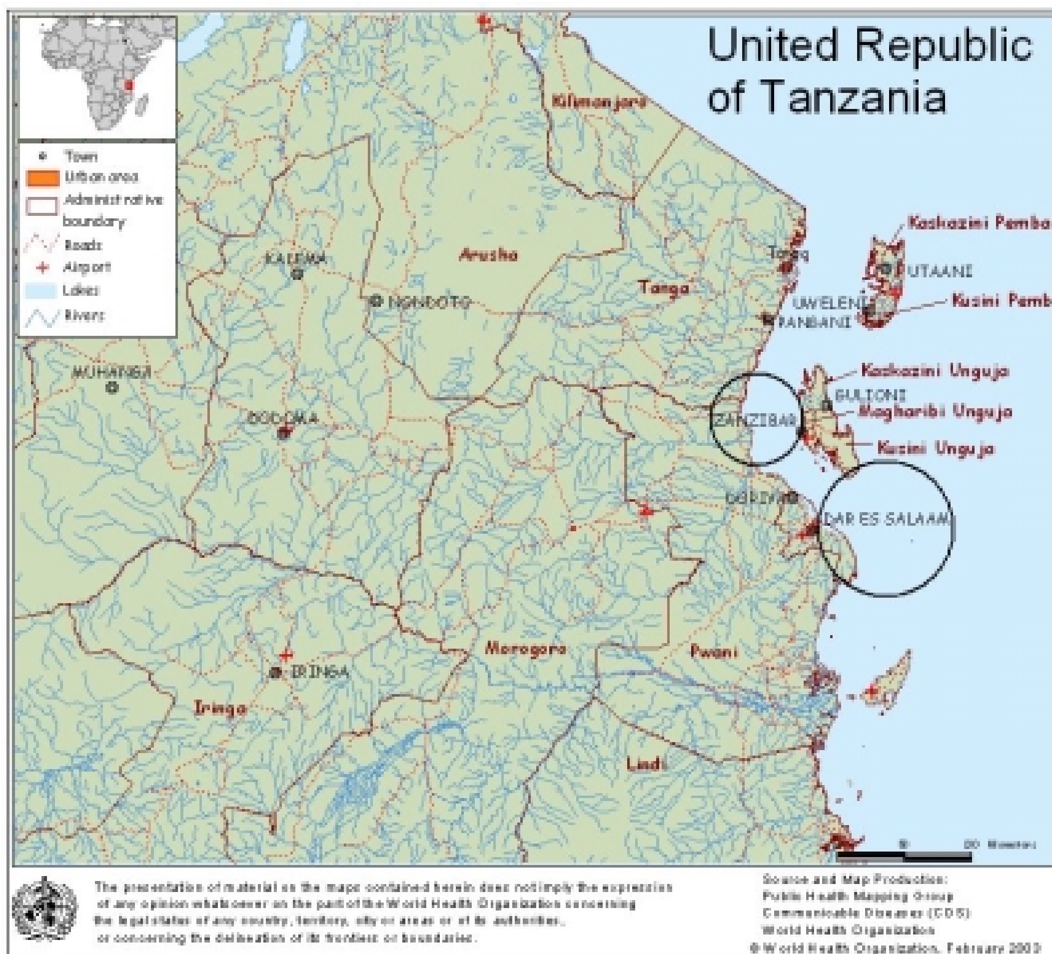
Section 3

UNITED REPUBLIC OF TANZANIA



3.1 Site description

The baseline assessment sites in the United Republic of Tanzania were two urban communities, namely Old Stone Town in Zanzibar Municipality and Kinondoni Municipality in Dar es Salaam. Although these two sites are both urban, the special location of Zanzibar (an island) as a transit point for drug trafficking further justifies the need for primary prevention of substance use. In general, the demographic features of the two sites were similar. The mean age (2000 census) was 25.4 years for Zanzibar and 26.0 years for Dar es Salaam. The general population distribution was similar, with 48% of the population of Zanzibar aged under 15 years and 47% of the population of Dar es Salaam aged under 15 years.

3.2 Demographic findings

Apart from a much higher proportion of respondents being of Muslim faith in Zanzibar, all the other demographic findings were similar for the two sites (Table 1).

Table 1: Demographic profiles of adult and youth KAP survey participants

Variable	Old Stone Town (Zanzibar)		Kinondoni (Dar es Salaam)	
	Adult (N=100)	Youth (N=299)	Adult (N=100)	Youth (N=303)
Sex distribution				
1. Male	60.8%	62.9%	59.0%	61.4%
2. Female	39.2%	37.1%	41.0%	38.6%
Mean age (years)		16.5 years		17.2 years
Religious affiliation (Muslim)	93.6%	90.3%	69.0%	68.2%
Religion considered important	84.0%	92.7%	87.2%	90.3%
Age distribution				
10-14 years	N/A	25.1%	N/A	24.4%
15-19 years		53.8%		48.8%
20-21 years		21.1%		26.7%
Employment/school attendance				
Employed/full-time student	30.2%	68.0%	17.0%	38.6%*
Unemployed	69.8%	24.7%	83.0%	11.7%*
Years of formal education				
1. 0-7 years		64.5%	65.0%	76.0%
2. 8+ years		35.5%	35.0%	24.0%

* The remaining 49.7% of the youth respondents were neither in school nor in employment

3.3 Knowledge, attitudes and practices

3.3.1 Substance use among adults

a) Patterns of substance use among adult survey participants

The pattern of substance use among the adults surveyed is presented in Figure 1. A large percentage of the adults had used tobacco over the past 30 days (24.0% for Dar es Salaam and 38.8% for Old Stone Town in Zanzibar). Of the various kinds of tobacco, cigarettes were the most popular. For alcohol, 33.7% of the adult respondents in Dar es Salaam and 19.4% in Zanzibar had consumed alcohol over the past 30 days, with beer being the most popular drink.

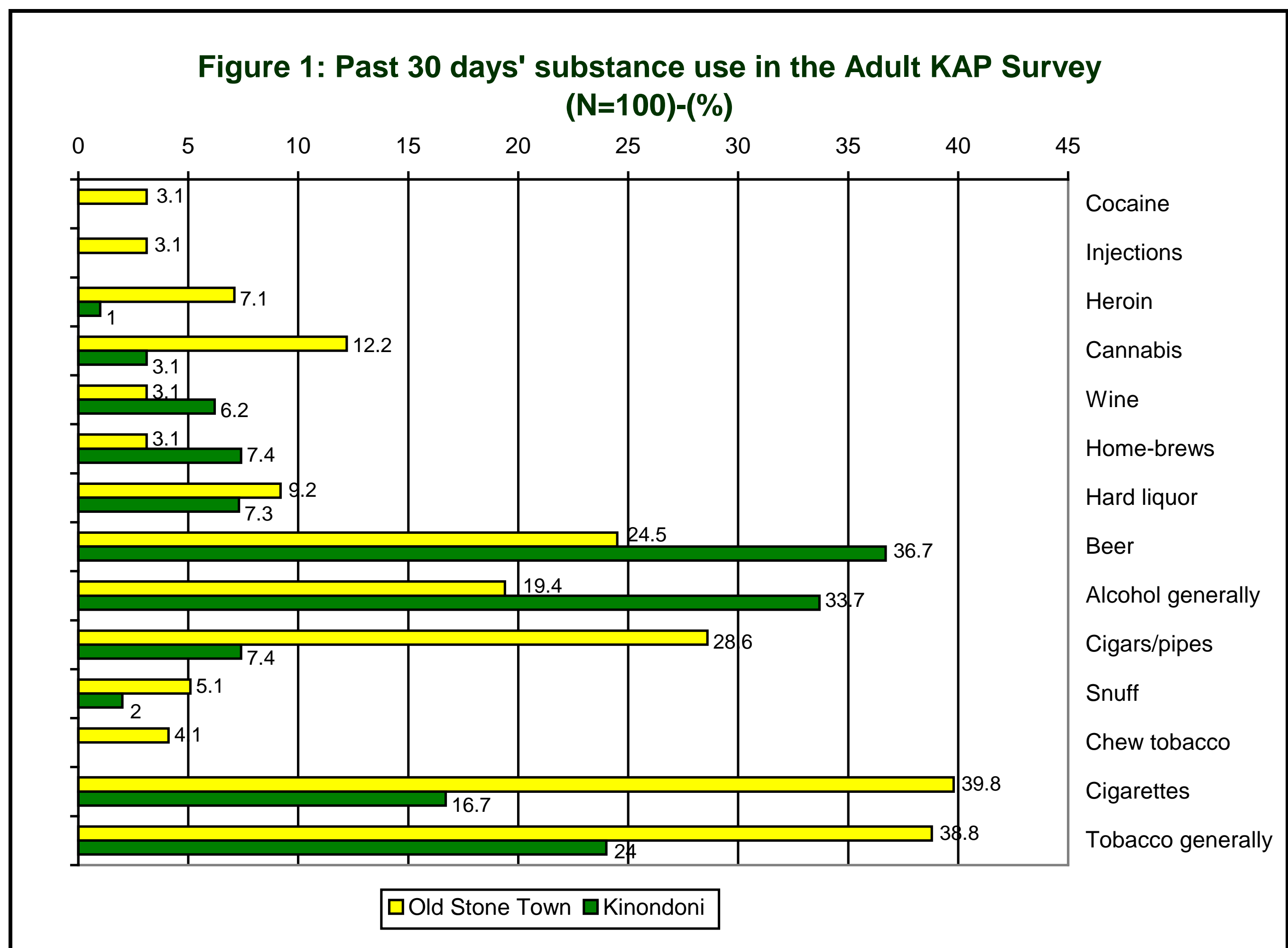


Figure 1: Past 30 days' substance use in the Adult KAP Survey (N=100)-(%)

None of the respondents had used hallucinogens, amphetamines, mandrax, or a mixture of marijuana and mandrax in either Dar es Salaam or Zanzibar. Proportions for other substances were considerably lower in comparison to that of alcohol and tobacco in both Dar es Salaam and Zanzibar. However, the figures remained higher for Zanzibar than for Dar es Salaam. For instance, the use of marijuana and heroin among the respondents over the past 30 days was 3.1% and 1% respectively for Dar es Salaam, whereas the corresponding Zanzibar figures were 12.2% and 7.1% respectively. None of the respondents had used cocaine or injected themselves with substances in Dar es Salaam over the previous 30 days, while the figures for Zanzibar were 3.1% each for these two categories.

(b) Attitudes towards substance use among adults surveyed

Between 33.8% and 42.5% of adults either approved or strongly approved of using heroin and mandrax. A higher figure (55.9% to 77.3%) approved heavy smoking of cigarettes and marijuana, using cocaine, having one or two drinks several times a week, as well as having more than five drinks once or twice each weekend. Among adults in Zanzibar, for these same substances, the figures were much higher, ranging from 64.2% for cocaine, to 88.8% for smoking more than 10 cigarettes per day. Although a lower percentage of adults in Zanzibar than in Dar es Salaam approved of mandrax (26.3% to 29.5%), it was higher for heroin (51.6% to 53.7%) in Zanzibar. Overall, Zanzibar had higher figures for approval of substances than Dar es Salaam.

(c) Perception of risks associated with substance use

Although adults commonly approved of substance use, they were more hesitant to agree that substance use entailed no or a slight risk. For example, between 64.2% and 88.8% of the Adult KAP Survey respondents (strongly) approved of smoking 10 or more cigarettes per day, using cannabis, using cocaine, having one or two drinks several times a week, or having five or more drinks once or twice each weekend. Between 26.3% and 29.5% (strongly) approved of the use of mandrax, and between 51.6% and 53.7% of heroin. Between 21.0% and 67.4% believed that substance users in general placed themselves at no or a slight risk; between 29.1% and 72.0% believed this about youth users. Substance use tended to be regarded as fun, fashionable, and stress relieving.

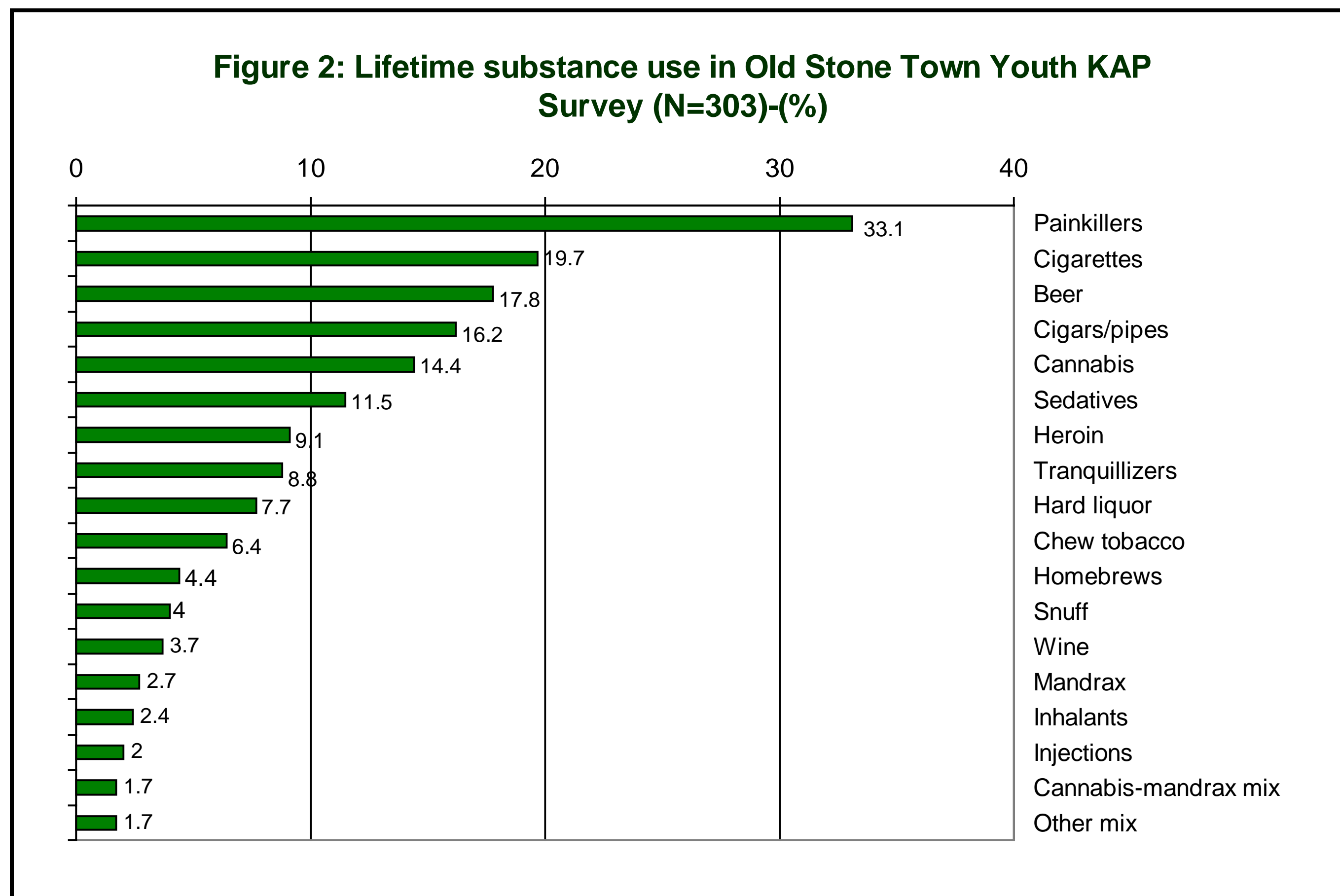
(d) Ease of access to substances

Between 37.0% and 75.0% of the adults in Dar es Salaam perceived cigarettes and other tobacco products, alcohol (including hard liquor, beer, wine and traditional brews) as well as marijuana and cocaine to be easy to obtain. Alarmingly, in Zanzibar, a larger percentage of the respondents (between 38.6% and 93.8%) viewed all the above products, as well as heroin, sedatives and tranquillizers as easy to obtain. On the other hand, heroin, sedatives and tranquillizers were perceived as being fairly difficult or impossible to obtain by a large majority of adults in Dar es Salaam.

3.3.2 Substance use among youth

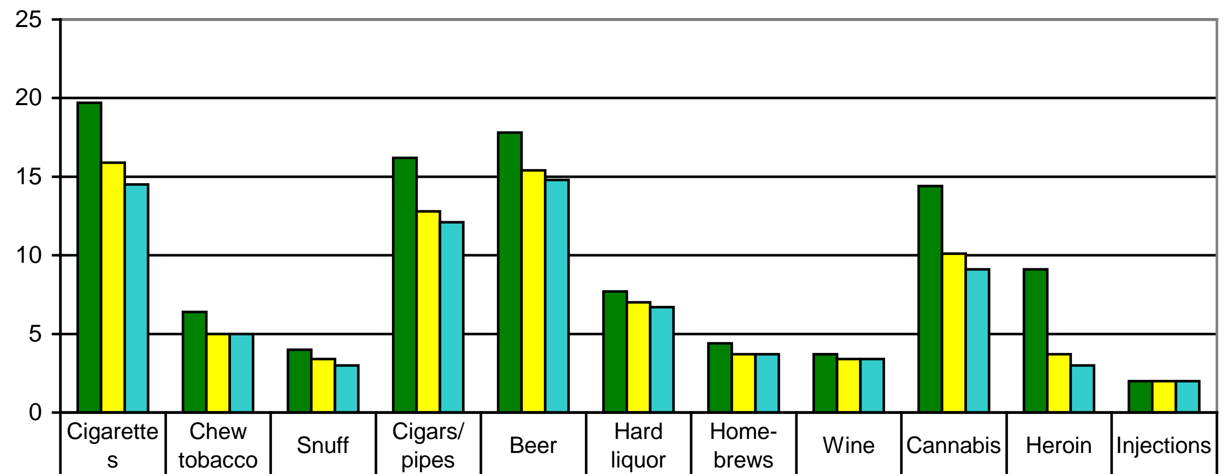
(a) Lifetime use of substances

Lifetime use of substances is illustrated in the reported data for Zanzibar in Figure 2. Painkillers were the commonest substance used (33.1%), followed by cigarettes (19.7%), alcohol (17.8%), cannabis (14.4%), sedatives (11.5%), heroin (9.1%) and tranquillizers (8.8%). Lifetime use of other substances was low.



(b) Current use of substances

Figure 3 presents all types of substance use among the youth in Zanzibar. A wide range of substances including heroin and injections was used. Past 12 months' use was 15.9% for cigarettes, 15.4% for beer, 10.1% for cannabis and 3.7% for heroin. In Dar es Salaam it was 10% for cigarettes, 11.1% for beer, 5.0% for cannabis and 0.3% for heroin. The percentage of youth currently using the same substances was similar in both sites



	Cigarettes	Chew tobacco	Snuff	Cigars/ pipes	Beer	Hard liquor	Home-brews	Wine	Cannabis	Heroin	Injections
Lifetime use	19.7	6.4	4	16.2	17.8	7.7	4.4	3.7	14.4	9.1	2
Past 12 months' use	15.9	5	3.4	12.8	15.4	7	3.7	3.4	10.1	3.7	2
Past 30 months' use	14.5	5	3	12.1	14.8	6.7	3.7	3.4	9.1	3	2

Figure 3: Use of selected substances in the Old Stone Town Youth KAP Survey (N=303)-(%)

(c) Experiences and context of substance use

Most of the youngsters knew a substance user, especially users of cigarettes, heroin, cigars/pipes, beer and cannabis (Figure 4). The context of first and past use of various substances is presented in Tables 2, 3, 4 and 5. Onset of substance use tended to be in early adolescence (Table 2). Onset typically took place within friendship/family circles, and to a lesser extent through agencies such as health care services. After onset, substance use tended to proceed within family/friendship circles, to a lesser extent under a bush or bridge and among acquaintances. Positive attitudes underpinned substance use. For example, curiosity and personal "rewards" such as social acceptance (to be fashionable) and enjoyment were generally given as reasons for the first use.

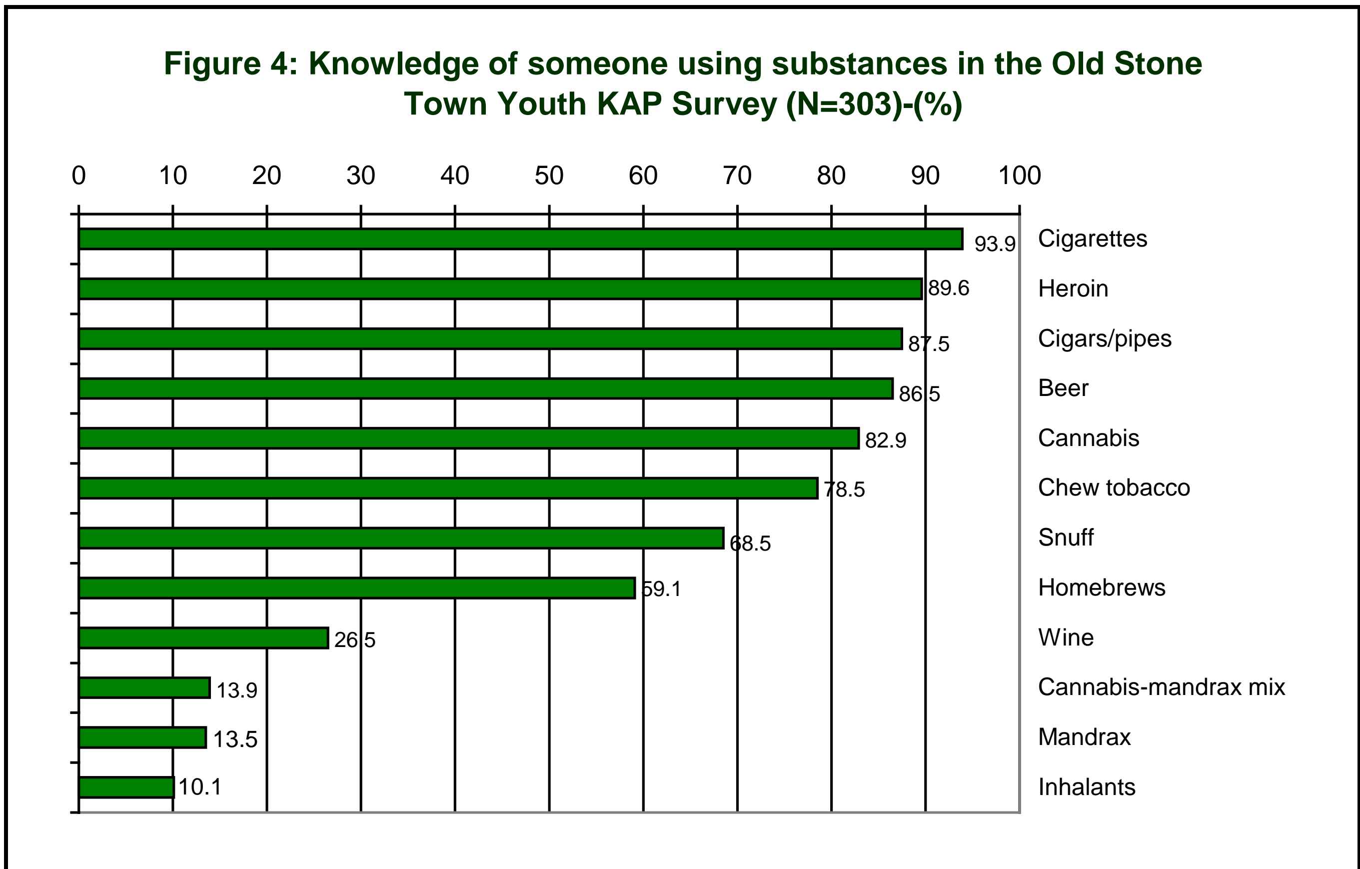


Table 2: Context of first/past 12 months' use of alcohol and tobacco and reasons for onset in the Youth KAP Survey (N=303)—Old Stone Town

	Cigarettes (%)	Chew tobacco (%)	Cigars/pipes (%)	Snuff (%)	Hard liquor (%)	Beer (%)	Wine (%)	Homebrews (%)
Age of 1st use								
Median age	14.9	13.6	13.7	12.3	15.6	17.2	12.1	12.7
≤10-12 years	3.0	1.7	5.4	2.0	1.7	2.0	1.7	1.7
13-14 years	4.7	1.0	2.0	0.3	0.7	1.7	-	0.3
15-16 years	3.1	-	3.7	0.3	2.0	3.0	0.3	0.3
17-18 years	4.1	0.7	0.3	-	1.3	4.4	0.3	0.3
≥19 years	-	0.7	-	0.3	0.3	3.0	-	0.3
Reasons for 1st use								
Acceptance	1.4	0.3	3.4	0.3	-	1.0	-	-
Curiosity	4.7	0.7	1.0	0.3	1.7	3.7	0.3	0.3
Enjoyment	2.7	-	1.7	0.3	1.3	4.4	0.3	0.7
Sociability	2.4	0.7	0.3	-	0.7	1.7	-	-
Health	-	0.7	-	-	-	0.3	-	-
Stress relief	-	-	-	-	-	0.3	-	0.3
Cold/hunger/fatigue relief	1.0	-	-	-	-	0.3	-	0.3
Religious custom	1.4	1.7	2.0	1.7	1.3	1.7	1.7	1.7
Sex boosting	1.0	-	1.7	-	0.7	0.3	-	-
Other	0.3	-	1.0	-	-	0.3	-	-
Provider of 1st substance								
Friends	2.4	-	0.3	0.3	1.7	3.4	-	0.3
Family	1.4	2.5	4.0	1.7	1.7	1.3	2.0	1.7
Acquaintance	0.7	0.7	5.7	-	1.3	0.3	-	-
Dealer	1.4	-	-	-	0.3	1.7	-	0.3
Health practitioner	6.1	0.6	-	0.7	-	5.7	-	0.6
Unknown person	2.0	-	1.6	-	1.0	1.7	0.7	0.7

Table 3: Place and company for first/past 12 months' use of alcohol and tobacco and reasons for onset in the Youth KAP Survey (N=303)—Old Stone Town

	Cigarettes (%)	Chew tobacco (%)	Cigars/pipes (%)	Snuff (%)	Hard liquor (%)	Beer (%)	Wine (%)	Homebrews (%)
Place of 1st substance use								
Friend's home	3.1	0.7	1.7	0.3	0.7	1.3	-	-
Family home	3.7	2.4	3.7	1.7	2.7	3.4	2.7	1.7
Public place	3.7	0.7	0.7	0.3	-	2.4	-	0.7
School/work	3.1	-	1.7	-	-	-	-	0.3
Open/street/bush/bridge	1.4	-	3.4	-	1.0	6.1	-	0.3
Other	-	-	0.7	-	0.3	0.7	-	-
Past 12 months: place of use								
Friend's home	2.4	1.3	3.0	0.3	-	1.3	0.3	0.3
Family home	3.4	2.0	3.4	2.3	2.4	3.0	2.3	1.7
Public place	3.4	0.3	2.7	-	0.7	3.0	-	0.3
School/work	2.4	0.3	0.7	-	-	-	-	-
Open/street/bush/bridge	2.7	-	1.4	-	2.7	5.1	-	-
Other	0.7	0.7	0.7	-	-	1.7	-	0.3
Past 12 months' use: company								
Friends	2.7	1.3	5.7	-	4.0	8.1	-	0.7
Acquaintances	8.9	2.4	5.1	2.0	2.0	5.1	1.7	2.0
Family	0.7	0.7	0.7	1.0	-	1.0	0.3	0.3
Work/school mates	1.7	-	0.3	-	-	-	0.3	-
Other/alone	0.6	-	-	-	-	-	-	-

Table 4: Context of first/past 12 months' use of other substances and reasons for onset in the Youth KAP Survey (N=303)—Old Stone Town

	Cannabis (%)	Heroin (%)	Mandrax (%)	Cannabis-mandrax(%)	Inhalants (%)	Painkillers (%)	Tranquillizers (%)	Sedatives (%)
Age of 1st use								
Median age	15.8	12.1	12.1	11.7	12.4	…	…	…
≤10-12 years	1.3	2.4	1.7	2.4	1.7	…	…	…
13-14 years	1.7	0.7	0.3	-	1.0	…	…	…
15-16 years	3.7	0.3	-	0.3	-	…	…	…
17-18 years	2.0	-	0.3	-	-	…	…	…
≥19 years	0.3	-	-	-	-	…	…	…
Reasons for 1st use								
Acceptance	0.3	-	-	0.3	0.3	1.0	0.7	0.7
Curiosity	3.4	0.7	-	-	0.3	0.3	0.3	-
Enjoyment	1.7	-	-	-	0.3	0.7	1.0	0.3
Sociability	1.0	-	0.3	0.7	-		0.7	0.3
Health	-	-	-	-	-	14.6	0.7	2.7
Stress relief	0.3	-	-	-	-	4.8	1.0	1.4
Cold/hunger/fatigue relief	0.7	0.7	-	0.7	0.3	2.4	0.7	1.4
Religious custom	1.7	1.3	0.7	1.3	0.7	1.0	0.3	1.0
Sex boosting	0.3	0.3	-	-	-	0.3	-	0.7
Other	-	-	0.3	-	-	1.0	0.7	0.6
Provider of 1st substance								
Friend	5.1	0.3	0.7	0.3	0.3	…	…	…
Family	2.0	1.3	1.7	1.0	1.0	…	…	…
Acquaintance	1.7	0.3	0.3	-	0.3	…	…	…
Dealer	-	-	-	0.3	0.3	…	…	…
Health practitioner	0.3	-	-	-	-	…	…	…
Unknown person	0.3	1.0	-	0.7	-	…	…	…

Table 5: Place and company of first/past 12 months' use of other substances and reasons for onset in the Youth KAP Survey (N=303)—Old Stone Town

	Cannabis (%)	Heroin (%)	Mandrax (%)	Cannabis-mandrax(%)	Inhalants (%)	Painkillers (%)	Tranquillizers (%)	Sedatives (%)
Place of 1st substance use								
Friend's home		*…Information not available…*						
Family home			"					
Public place			"					
School/work			"					
Open/street/bush/bridge			"					
Other			"					
Past 12 months: place of use								
Friend's home	0.7	0.3	0.3	-	0.7			
Family home	2.7	2.0	2.0	1.3	2.0			
Public place	0.7	2.0	-	0.3	0.3			
School/work	0.7	-	-	-	0.3			
Open/street/bush/bridge	2.7	0.3	-	0.3	-			
Other	2.0	-	-	-	-			
Past 12 months' use: company								
Friends	6.7	-	-	0.3	0.7			
Acquaintances	1.3	2.7	2.0	1.7	1.4			
Family	0.7	0.7	-	0.3	0.3			
Work/school mates	-	0.3	0.7	-	-			
Other/alone	-	-	-	-	-			

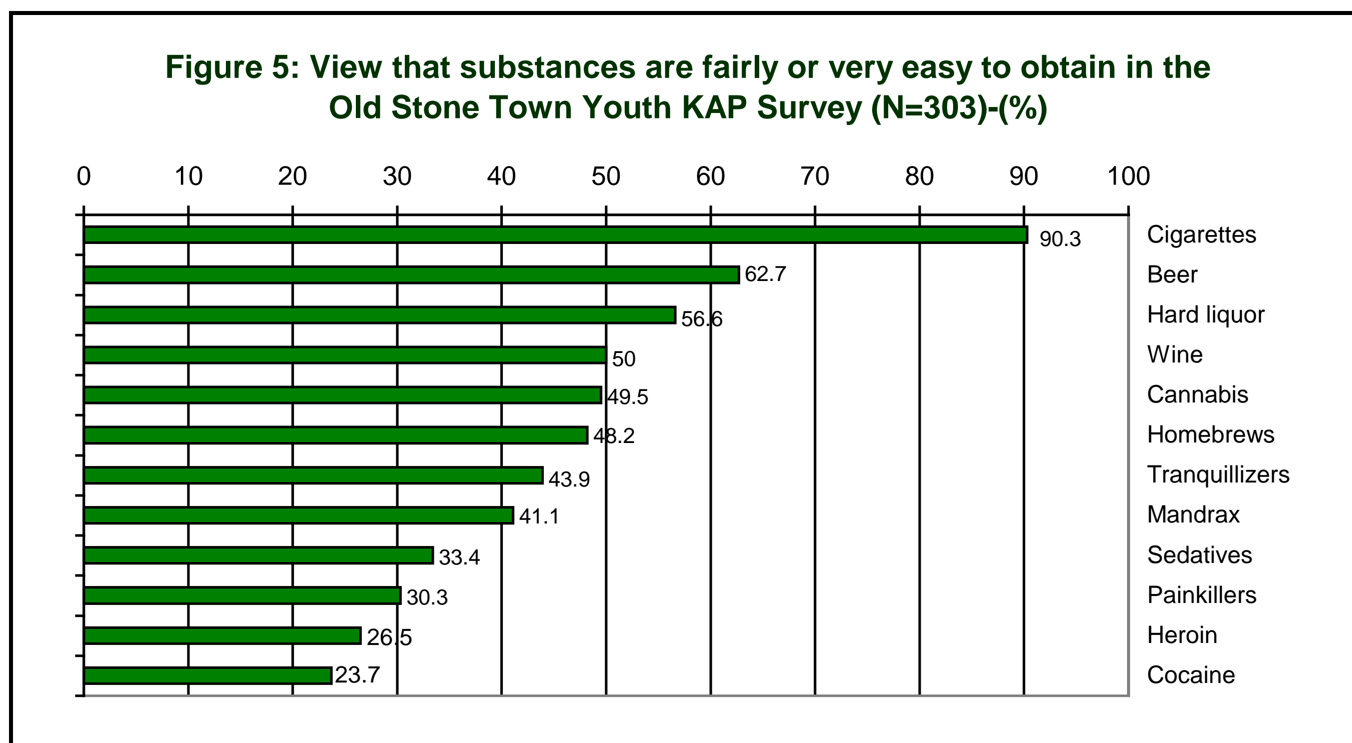
(d) Attitudes towards substance use among the youth

As regards attitudes towards substance use, over half of the respondents (ranging from 56.2% to 62.2% in Dar es Salaam) either approved or strongly approved of using 10 or more cigarettes per day, of smoking marijuana/hashish both occasionally and regularly, and of having one or two drinks several times a week. Between 40% and 48% of the Dar es Salaam youths approved or strongly approved of using cocaine either once or twice or occasionally, and of having five or more drinks once or twice each weekend. Disapproval was high only for using heroin and mandrax.

(e) Ease of the youth's access to substances

The perception of the availability of substances for Zanzibar is presented in Figure 5. Zanzibar youths perceived cigarettes and other tobacco products, as well as alcohol, including homemade brew, easy to obtain, ranging from 48.2% for homemade brew to 90.3% for cigarettes. Furthermore, 41.1% to 49.5% perceived mandrax, marijuana and tranquillizers as being easy to obtain. Cocaine/crack, heroin, painkillers and sedatives were perceived by a large majority of the Zanzibar youths as being fairly difficult, very difficult or impossible to obtain. Between 40% and 66% perceived cigarettes, tobacco and alcohol as easy to obtain. However, in Dar es Salaam all other substances including marijuana/hashish, mandrax, cocaine/crack and heroin, were perceived as being fairly difficult to impossible to obtain.

Figure 5: View that substances are fairly or very easy to obtain in the Old Stone Town Youth KAP Survey (N=303)-(%)



3.4 Community Profile 1: Organizational and cultural context

Tables 6 and 7 present organized social units' understanding of substance use. Substance use among the youth in both sites in the United Republic of Tanzania was not only common, but also started very early in life. Many children started using substances at 10 years of age or earlier. Conclusions from individual interviews and focus group discussions indicated a sense of hopelessness in the community. The rapid increase in substance use and the absence of effective control measures were alarming to leaders and parents. Parents were often unaware of their children's substance use because they did not know the symptoms of such use. Most respondents were frustrated by the lack of reliable treatment options. The local government administrative structure was well segmented from district to ward to street level. Local leaders facilitated or coordinated most of the community-based initiatives. The strongest community institution that influenced use of substances was the Muslim religion (in Zanzibar). Schools were also strict about the use of substances. However, tobacco was tolerated among adults because it did not adversely affect people's behaviour. The mass media gave conflicting messages to the public. While it gave educational information against substance use, it also featured substance use and foreign cultural habits that encouraged substance use among the youth. Television Zanzibar had a weekly 45-minute youth talk show that discussed youth issues including substance use. Some NGOs provided information and counselling but they lacked the necessary resources. Their educational activities were sporadic, without regular follow-up.

3.5 Community Profile 2: Societal structures and processes

Table 8 presents the wider societal context of substance use. The two sites participating in the study had fast-growing populations. However, the infrastructure, health status, safety/security, educational attendance/enrolment and economic conditions were deteriorating. Female-headed households were increasing. For example, in Zanzibar the infant mortality rate was high (120 per 1 000 live births in 2000); malaria was the leading cause of morbidity and mortality; and HIV/AIDS rates were increasing. The percentage of female 15-24 year olds living with HIV/AIDS at the end of 1999 was estimated to be 9.27% in the United Republic of Tanzania. In addition, between January and October 1999 the mental hospital in Zanzibar admitted 47 new substance users—27 were admitted in 1996 and 17 in 1994. Zanzibar had many informal dwellings (37.4%). Water trucks provided water to 40.0% of households and did so irregularly; only 27.3% of the inhabitants had electricity inside their dwellings; most had pit latrines; 40.0% had no kitchen; and waste removal was inconsistent. Roads were defective. Between 20.0% and 25.0% of the households in Zanzibar were unable to provide for their food, health, education and social service needs. Almost all school leavers (90.0%) in Zanzibar were without gainful employment. National figures suggested that the total number of reported crime per 100 000 of the

population in Zanzibar rose from 1 692 in 1996 to 1 714 in 1999. Possession of or dealing in illicit substances rose from 12.9 per 100 000 of the population in 1996 to 14.1 in 1999.

Table 6: Organized social units' understanding of substance use

Status, development and consequences of psychoactive substance use
Types of substances commonly used • Tobacco, alcohol, homebrews (e.g. "gongo"), sleeping pills (e.g. Valium), petrol (for sniffing), cannabis, khat, heroin and to a lesser extent cocaine, mandrax and ephedrine
Substance use patterns/trends • Indications that licit substance use as well as the use of cannabis and khat remained more or less stable, but an upsurge occurred in the use of other substances (e.g. heroin and especially injection heroin) • Substance use was overwhelmingly a male phenomenon • Female substance use mainly occurred among socially excluded women (e.g. commercial sex workers) • Substance use was mainly a youth phenomenon • The onset age tended to be early (10 years or younger) for substance use • The use of tobacco tended to precede the use of illicit substances • Commonly used substances were alcohol, tobacco, petrol, sleeping pills, local homebrew ("gongo"), cannabis, heroin • Substance use among young people tended to occur at youth-only recreation activities, celebrations, sport gatherings, cemeteries, and especially at street corners where illicit substances were exchanged and jobless persons gathered • Heavy and dependent use occurred (for example, an estimated one-third of Tanzanians aged 12 years and above regularly used tobacco)
Contributors to substance use, especially youth substance use • The mass media marketed substances (especially licit drugs) (in)directly (e.g. through advertisements and lifestyles projected in programmes) • Liberation of trade increased the availability of substances, especially licit substances, as well as promoted foreign lifestyles/cultures • Socioeconomic pressures, especially high unemployment among the youth, poverty, lack of constructive recreational activities • Participation in risky occupations, e.g. commercial sex (especially relevant in the case of women), bus driving, porterage, manual labour, criminal activities • Peer pressure (friends), substance use among significant others (e.g. relatives, lovers) • Psychosocial needs: fun, friendship, curiosity, stress • Ineffective preventive efforts on the part of government and civil society • Poor parenting
Consequences of substance use • Disintegration of social fabric (e.g. traditional values, norms, customs) Increased burden of already overtaxed health care, welfare, safety and security structures, and thus declining economic development

Table 7: Community resources for the prevention of substance use-related problems

Type of units	Main services	Primary prevention programmes/projects, objectives, targets, strategies, resources, level of commitment
Government • Ministry of Health (e.g. substance control section, and a mental hospital); substance-related care at psychiatric sections of medical facilities; general medical services at primary health care centres, dispensaries, hospitals • Ministries of Education, Immigration, Legal Affairs, Home Affairs, Youth Development and Labour, Foreign Affairs, International Cooperation, Finance, Community Development, Tourism; ministers of State and State Planning • Inter-Ministerial Commission for the National Coordination of Drug Abuse Control • Police service (Anti-Drug Unit, Marine Anti-Drug Unit) Non-government • Tanzanian Federation of Trade Unions (substance problem awareness campaigns) • Zanzibar Stone Town Youth Centre (primary prevention of substance use) • Zanzibar Association of Information Against Drug Abuse and Alcohol • Zanzibar Association for Children's Advancement • Zanzibar Women Muslim Association (substance-related education) • Zanzibar Youth Muslim Centre (youth development, prevention/treatment of substance-related problems) • Zanzibar Anglican Church as well as other churches (education, responsible citizenship) • Zanzibar Mental Health Association (SWAZA) (mental health care) • Zanzibar local government leaders/councillors • Zanzibar parent groups • Private health care facilities (general medical care) • Political parties (e.g. youth development agendas attended to substance problems) • YMCA (youth development, residential care) • DON BOSCO (family education/care) • EMAU (responsible parenthood training) • Save the Children Fund (youth development) • UMATI (reproductive health care)	Government • Control, e.g. anti-drug trafficking and policy formulation initiatives (including a national drug control master plan) • Contribution to education on substance use-related consequences (e.g. through talks, pamphlets, life skills training and training in schools) • Limited specialized substance use-related treatment services in mental hospitals and psychiatric units • Free/subsidized medical care in health centres, hospitals, dispensaries • Strong youth development programmes Non-government • Educational and awareness programmes on substance use-related consequences, e.g. by health and welfare agencies, religious organizations, the media, political parties • Youth/community development programmes • Limited free substance use-related treatment, e.g. by church bodies	Overall objectives • Awareness raising of substance use-related consequences • Mainstream substance-related harm prevention initiatives, e.g. initiating the latter as part of socioeconomic development efforts • Coordination of substance use-related prevention initiatives • Reduction of substance supply and demand Main target group General public, with special attention to young people (in as well as out of school) Main strategies • Combination of demand and supply reduction • Demand reduction mainly comprised awareness programmes on substance use consequences • Initiatives to reduce broader socioeconomic "pressures" Substance prevention projects and programmes (See section on services.) Programme resources, efficacy and sustainability **Constraints** • Limited institutional/funding capacity for quality health and educational care • Limited funding for sustained educational and awareness programmes on substance use-related consequences • Limited quality treatment facilities, notwithstanding a general increase in treatment demand • Low level of coordination of existing initiatives within/across communities • Conflicting media messages (pro/anti-substance use) • Introduction of foreign practices into community via business and tourism • Community does not expect success in countering substance use-related problems **Strengths** • Cohesive communities, with low income-inequality and strong relations between community leaders and community members • Religious agencies are against substance use • Older generation/leaders are against substance use • Comprehensive government policy

Type of units	Main services	Primary prevention programmes/projects, objectives, targets, strategies, resources, level of commitment
• Public Health Association (TPHA) • MEHATA (mental health care) • AMREF (community-based health interventions) • International bodies: WHO and UNDCP offices Networks • Inter-Ministerial Commission for the Coordination of Drug Abuse Control • Limited formal and sustained collaboration among agencies concerned with substance-related prevention, an exception being agreements between the government and other African/overseas governments and international (drug control) bodies • Periodic activism/advocacy in communities, frequently led by local community leaders engaged in drives for providing in basic needs (e.g. safe water, security, labour)		Viable preventive efforts • Concerted and sustained preventive efforts at all levels of government and community life, (a) harnessing the existing strong relations between local government leaders and community members as well as central government concern about substance use-related problems, and (b) giving attention to substance-related control as well as to education, i.e. to reducing supply and demand • Comprehensive programmes directed at the prevention of substance use-related problems and embedded in broader socioeconomic development programmes • Preventive programmes that give special attention to the very young

Table 8: Status of trade in substances

Marketing medium	Content and intensity of marketing	National, provincial, local government and non-government policy
Alcohol/tobacco • Radio, television, newspapers, billboards, magazines, cinema • Sport and drama sponsorships • Progressively more vigorous marketing of alcohol and tobacco since the introduction of a free market system in the beginning of the 1990s • Broad-based promotion of tobacco and alcohol on plastic bags, calendars, umbrellas, T-shirts • (Un)licensed production and outlets, a variety of outlets, and an increase in outlets selling traditional cheaper brews Substances other than alcohol and tobacco No information available	Alcohol/tobacco • The mass media encouraged and, to a lesser extent, discouraged alcohol/tobacco use • Government television and radio advertised tobacco but not alcohol, except at international football matches and in cinemas • Comedy/cartoon magazines (WASAA, Bantu film, SANI) promoted use • All newspapers (except those run by religious agencies) advertised • Advertisements in the public media were common, having increased over the past 10 years with the introduction of more liberal trade legislation/policy • Men and the youth, but also women, were targeted in tobacco advertisements • Advertisements portrayed achievement, toughness, attractiveness/glamour Substances other than alcohol and tobacco No information available, except the note that (a) Tanzania is a transit country in international illicit trafficking in substances (especially Zanzibar), and (b) the tourist trade facilitates illicit substance trafficking	• Inter-Ministerial Commission for the Coordination of Drug Abuse Control defined, promoted and coordinated especially illicit drug control policy • Various departments had drug control policy frameworks (eradication or reduction of illicit psychoactive substance trafficking, control of trade in and use of licit illicit substances, cooperation with international drug control agencies), e.g. Anti-Drugs Section in the Department of Health, the Anti-Narcotic Unit in the police, the Marine Police Unit, the Customs Department, Immigration Department, Pharmacy Board, Medical Stores Department • Agendas/policy related to youth substance use Political parties had agendas for youth development, attending to the countering of substance use-related problems Inter-Sectoral Trade Unions Policy Guidelines National Youth Development Policy (1977) National Employment Policy (1977) Education and Training Policy (1995) Community Development Policy (1996) Sport Development Policy (1995) Cultural Development Policy (1997) Child Development Policy (1996)

3.6 Intervention development

3.6.1 Key concerns

The baseline findings suggest the key intervention concerns listed below.

Key concerns: Community Profile 1

- The use of a wide range of substances
- Substance use among 21-30 year old males; cocaine, heroin and mandrax use among the affluent; multiple substance use among commercial sex workers and street children
- Substance use among spouses/cohabitants
- Beliefs that substance use is no or a slight risk; approval of usage; and the view that substances are easy to obtain
- Inadequate institutional resources for preventing substance use and related problems

Key concerns: Community Profile 2

- A growing youthful labour force (15-34 year olds) and few employment opportunities
- Female-headed households
- Malaria infection/deaths, HIV/AIDS and substance use-related health care demands
- Severe housing, sanitation, cooking, water, electricity and communication constraints
- Rising crime, e.g. dealing in or being in possession of illicit substances
- Weak law enforcement in respect of substances, bold media marketing of licit substances, and illicit trading through tourists, street vendors and pharmacies

Key concerns: Youth KAP Survey

- All substances, but particularly tobacco, alcohol, cannabis and heroin
- "Heavy" (five cigarettes or more per day), "regular" (daily/weekly) and dependent substance use, as well as substance use-related injury and fights/arguments
- Early onset (10-14 years) of substance use, especially for illicit substances (e.g. cannabis-mandrax mixture, mandrax, heroin), inhalants, alcohol (e.g. wine, homebrews) and tobacco (e.g. snuff)

- Starting to use substances by accepting them from family, friends or health care workers, and because of curiosity, a need to be socially accepted (to be in/fashionable, to appear modern or affluent) and have fun
- The typical places where substances are used, e.g. private homes, bushes/bridges

3.6.2 Intervention priorities

The listed concerns and the preferences expressed by community leaders suggest the following intervention priorities in which young people should participate:

- Programmes that facilitate socioeconomic development and especially employment and substance-free recreation for young people, strengthen substance-related prevention services, reduce substance availability, and increase non-approval of use,
- through mobilizing coordinated community groups within existing structures, educational campaigns and motivational peer education, and
- insist on outcomes such as
- ▪ improved infrastructure,
- ▪ improved and integrated/coordinated substance-related services with adequate funding,
- ▪ increased licit income generation activities and participation in substance-free recreation among young people,
- ▪ increased deterrence of illicit substance trading,
- ▪ reduced trade in licit substances,
- ▪ consistent anti-substance media messages, non-approval of substance use, and reduced youth substance use among especially 10-14 year olds and males.