

STUDY TITLE

AN EXPLORATION OF THE PERCEPTIONS OF AND RISK AND PROTECTIVE FACTORS FOR DRUG USE AMONG YOUNG PERSONS AGED BETWEEN 18 AND 24 YEARS IN MUFAKOSE, HARARE, ZIMBABWE.

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Abstract

Background: Drug use by young people is on the increase globally, regionally and locally, in Zimbabwe. Most of what is known about the risk and protective factors for drug use has been written from studies done in high income countries. Limited studies focused on the low to medium income countries. The available literature for Zimbabwe is a few quantitative studies, done nearly two decades ago. These might not still be relevant today because of the generational changes that have taken place in the society over time.

Methods: A qualitative study was conducted in Mufakose, one of the low income high density suburbs of Harare, Zimbabwe. The aim of the study was to find out the reasons why young people in the community were using drugs while others within the same geographical area were not using. A purposive sampling method was used to recruit 40 young people aged between 18 and 24 years who were current drug users, past users and those who had never used drugs at all in their entire lifetime. Individual in-depth interviews and focus group discussions were conducted at two community centres in the community to elicit data from the participants. Data collected from the in-depth interviews and focus group discussions were analysed using NVivo using themes that were derived from literature.

Results: Results showed that both risk and protective factors for drug use exist at three levels of human interaction: the micro, meso and macro levels. Micro level risk factors included stressors from the home or living arrangements or workplace, stress due to loss of a loved one, boredom due to unemployment and lack of activities, a lack of commitment to work, sport or school and one's beliefs. Meso level risk factors were exposure to the drug using behaviour by peers and bullying. At family level, exposure to drug use, family conflicts were reported as risk factors. At macro level, drug availability and cost and media influence were cited as risk factors for drug use among the group. For the protective factors leading to non-use, religion was the strongest protective factor at all the three levels. A commitment to work, sport or school was also protective at micro level. Non-exposure to drug using behaviour were protective at the meso level.

Conclusion: The current social environment in Zimbabwe together with a breakdown of the country's institutions such as marriage due to death, divorce or migration to other countries. The breakdown has left some children in single parent families vulnerable to a life of drug use. Early initiation into drug use was reported to be through exposure from peers, families and other members of the community as young people in Mufakose are using drugs in-order

to escape from the reality of life. Evidence based psychosocial interventions could be used to reduce the impact of drug use among this population.

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1 CHAPTER ONE: INTRODUCTION

The chapter introduces an explorative narrative study that was conducted in Mufakose, Harare, Zimbabwe in order to understand the reasons why young people use drugs. The chapter introduces why this study is important, providing a framework for the purpose, aim and specific objectives of the study. It will also give an outline of this dissertation.

1.1 Background of the study

1.1.1 Worldwide burden of mental, neurological and substance use disorders.

Mental, neurological and substance use (MNS) disorders contribute significantly to the global burden of disease. Whiteford et al. (2013) found that MNS disorders accounted for 10.4% of global disability adjusted life years (DALYs), 2.3% of global years of life lost (YLLs) and 28.5% of global years lived with a disability (YLDs), making them the leading cause of YLDs in 2010. Within the MNS, substance use disorders alone accounted for 14.7% of DALYs (Whiteford et al., 2013). In low and middle income countries (LMICs) specifically, neuropsychiatric and substance use disorders cause substantial disability and account for 25.3% and 33.5% of all years lived with a disability respectively (World Health Organization, 2013).

1.2 Risk factors for drug use

Elements in an individual's life expose or protect one from abuse of drugs. These elements affect people at the individual (micro), relational (meso) and community or societal (macro) level (Bronfenbrenner, 1994; Hawkins, Catalano, & Miller, 1992; Wallace & Muroff, 2002). Individual level factors include biological factors, attitude and commitment issues. Commitment issues are an individual's devotion towards pending school, work or other upcoming activities. These micro level factors have a direct influence on the individual's decision to use or not to use drugs and also determine the type and amount of substances used (Boys, Marsden, Fountain, Griffiths, Stillwell & Strang 1999a). Meso level factors include relations with peers, family and the school. Bahr, Hoffmann and Yang (2005) advised that relational factors have a significantly direct effect on drug use. They concluded that drug use by adolescents had more to do with social learning than with restraints imposed on the individual by the family, society or religion (Bahr, Hoffmann, & Yang, 2005). Social or community factors are macro-level factors that are also referred to as contextual factors and include drug availability in the community, laws and norms that address drug use, and neighbourhood disorganisation (Bronfenbrenner, 1994; Hawkins, Catalano & Miller, 1992;

Wallace & Muroff, 2002). Exposure to risk factors however does not necessarily predestine one for a life of substance abuse.

1.3 Protective factors for drug use

Resilience protects some individuals against the practice of substance abuse and protective factors for substance use operate at the same levels as the risk factors as outlined above (Bronfenbrenner, 1994; Hawkins, Catalano & Miller, 1992; Wallace & Muroff, 2002). Models essential in preventing illicit drug abuse are the so called ‘risk/protective’ and ‘protective/protective’ mechanisms (Brook, Brook, Gordon, Whiteman, and Cohen, 1990). Protective factors for substance use include school attendance, peer support at school, parental supervision, connectedness and bonding (Peltzer, 2009). Other factors include individual religious conventionality and association with non-using peers (Wallace & Muroff, 2002).

In order to understand drug use, one needs to be aware of the perceptions users, potential users or non-users have on the functions of the different substances. A United Kingdom based study showed that the perceived function of a substance was most influential in drug use decision making (Boys et al. 1999). The major challenge in interventions to reduce drug use is finding alternatives which fulfil the same functions as those of drugs or alcohol and making these alternatives equally attractive to young people (Boys, Marsden, & Strang, 2001). Many countries around the world face the challenges of intervening for substance misuse, and this is also evident in Zimbabwe, the site of the current study.

1.3.1 Zimbabwean situation

Zimbabwe is a low income country (World Health Organization, 2011), with a population of just under 13 million (ZimStat Agency, 2011) and a life expectancy of 42 years of age compared to that of Africa which is 53 years (World Health Organization, 2010b). Young people aged between 15 and 24 years comprise 23% of the country’s population (Ministry of Health and Child Care, 2013). In Zimbabwe, non-communicable diseases accounted for 15.1% of DALYs in 2004, of which neuropsychiatric disorders accounted for 3.8% of the total DALYs (WHO - AFRO, 2010). The latest global burden of disease studies do not have specific information on Zimbabwe.

Of the neuropsychiatric burden of disease in Zimbabwe, alcohol use disorders accounted for 0.26% and drug use disorders accounted for 0.02% in 2004 (World Health Organization, 2010).

A prevalence study of psychoactive substance use among psychiatric in-patients in Harare showed that 14.3% had used cannabis and 28.4% had used alcohol (Acuda & Sebit, 1997). Wallace & Muroff, (2002) state that most of what is known about illicit drug use among young people has been derived from studies done on populations in high income countries and the extent of generalizability of the findings on the population in low to medium income countries is unknown. There is a lack of qualitative studies that identify young people`s perceptions of drug use in Zimbabwe. Bandason and Rusakaniko (2010) advised that a qualitative study would help to gain insight into why young people expose themselves to the risks involved in the use of tobacco and other substances. This study therefore seeks to explore reasons why young people in Mufakose, Harare, use or do not use illicit drugs; and the risk and protective factors that may determine use or non-use. This understanding will enlighten mental health practitioners when conducting further research that eventually will lead to developing appropriate psychosocial interventions to address illicit drug use in Zimbabwe (Hawkins, Catalano & Miller, 1992; Brook, Morojele, Pahl, & Brook, 2006; United Nations, 2014).

1.4 Aim of the study

A broader aim of the study is to explore young people`s views on illicit drug use in Mufakose, Harare, Zimbabwe and to identify factors that expose some young people to drug use or those that help some to build resilience against the practice.

1.5 Outline of the dissertation

This dissertation is presented as follows:

- Chapter Two reviews relevant literature that provides insight into the existing knowledge on drug use. This provides the background on which this study is based.
- Chapter Three takes a look at the methodology that was used for the study.
- Chapter Four presents the findings from the analysis of the data collected for the study.
- Chapter Five discusses the study findings, comparing these against those from other international and regional studies.
- The final chapter, Chapter 6 sets out the conclusions of the study, recommendations for policy makers, mental health practice and continuing research required.

2 CHAPTER TWO: LITERATURE REVIEW

2.1 Introduction

This chapter reviews literature that is related to young people's drug use. The chapter will show the patterns of drug use in young people. The patterns include the prevalence and burden of drug use, drug use in African cultures, reasons for drug use by young people and factors that impact on young people's drug use. The structured literature review that was carried out to try and determine the current knowledge on the risk and protective factors for drug use in young people and suitable frameworks to understand these factors.

2.2 Patterns of drug use in young people

2.2.1 Prevalence and burden of drug use

The United Nations Office on Drugs and Crime (UNODC) in 2014 noted that illicit drug use continues to cause a significant toll on society and human life leading to loss of productive years (United Nations, 2013). The consequences of substance abuse on the world's population are alarming, with drug related deaths estimated to have increased to from 187 100 in 2013 (United Nations Office on Drugs and Crime, 2015) to 207 400 in 2014, corresponding with 43,5 deaths per million people in the 15 – 64-year-old age group (United Nations Office on Drugs and Crime, 2016). The 2013 world drug report highlighted that 200 million people aged between 15 and 64 years worldwide were estimated to have used illicit drugs between 2005 and 2006 (United Nations Office on Drugs and Crime, 2014). This has since increased to an estimated 1 in 20 people which translates to 247 million adults or a quarter of a billion-people having at least used one illicit drug in 2014 (United Nations Office on Drugs and Crime, 2016). Roughly 1 in every 10 drug users were problem drug users (United Nations Office on Drugs and Crime, 2015) and more than 29 million people were reported to suffer from substance use disorder or drug dependence (United Nations Office on Drugs and Crime, 2016).

Drug use among young people continues to escalate. The National Institute on Drug Abuse (NIDA), reported that 50% of American high school students used an illicit drug by the time they finished Grade 12, and 73% of them had used only cannabis as a drug of choice (National Institute on Drug Abuse, 2005). Another report on Monitoring the Future, brings to light that 68.1% of American high school seniors do not view cannabis use as harmful (National Institute on Drug Abuse (NIDA), 2015). A Brazilian study showed that 22.5% of the adolescents aged 10 – 12 years use drugs, with 12.7% of the adolescents having used a psychoactive substance

at least once in their lifetime (Lopes, Nóbrega, Del Prette, & Scivoletto, 2013). In a sample of 20 765 students aged 13 – 15 years from six African countries (Uganda, Swaziland, Zimbabwe, Zambia, Kenya and Namibia), the prevalence of illicit drug use was 10.5% and risky alcohol use was 6.6% (Peltzer, 2009).

The worldwide extent of prescription drug misuse is unknown (United Nations Office on Drugs and Crime & UNODC, 2011). Misuse among American high school seniors increased gradually with 1 in 5 (19.5%) reporting lifetime use and 13.9% (1 in 7) having used the drugs in the past 12 months (National Institute on Drug Abuse, 2005). An evaluation of the 2005 National Survey on Drug Use and Health in the USA showed a prescription drug misuse rate of 8.2% among adolescents aged between 12 and 17 years (Schepesis and Krishnan-Surin, 2008). The same authors go on to say that among these respondents, 3% were estimated to be showing symptoms of substance misuse disorder related to prescription drugs. Data from high income countries showed that in 2008, over 1% of the total population used amphetamine type stimulants for non-medical uses (United Nations Office on Drugs and Crime & UNODC, 2011).

Observance of societal laws and norms has decreased in the current climate and an erosion of the social fabric leads to increased criminal violence and a weakening of a state's essential institutions (UN, 2014). Jiloha (2009) shared that social and cultural factors are vital in the initiation, maintenance and therapeutic intervention of drug use. The use of drugs by young people continues to rise globally, both in high-income countries and low to medium income countries (Acuda, Othieno, Obondo, & Crome, 2011; National Institute on Drug Abuse (NIDA), 2015; UNODC, 2016).

The National Institute on Drug Abuse reported that in 2015, 68.1% of senior high scholars did not view cannabis use as harmful to their health (National Institute on Drug Abuse, 2015). Nearly half a million adolescents aged between 12 and 17 years in the United States were reportedly using non-medical opioid pain relievers, of which 168 000 had a documented opioid addiction (Wenner & Gigli, 2016). The burden of caring for people with mental illness, including drug abuse is significant, and the mental health budget (including the budget for the institutionalized population) in the USA, for example, far exceeded the amount of money spent on other non-communicable diseases, such as cardiac disease and cancer (Roehrig, 2016).

In India, early initiation of drug use is widespread as 50% of children who initiated smoking before the ninth grade were noted to have tried a gateway drug (Jiloha, 2009). A gateway drug is a drug that once used, will lead the person to experiment with other harder drugs. A Kenyan study showed that 19.7% of university students had used cannabis and 13% had used tranquilizers. The major concern was that the students reported early initiation into the life of drug use as 20% had started using the drugs in primary school (Acuda et al., 2011). These authors went on to show that 38 million African adults or 7.7% of the whole adult population consume cannabis, a figure that is 3.8% higher than the total world population of those aged between 15 and 64 years.

Studies done in South Africa in the early 2000s have shown a prevalence rate of 19.8% for illicit drug use among adolescents in urban Limpopo (previously Northern Province) (Madu & Matla, 2003), and an increased and widespread use of cannabis by South African adolescents (Boys, Marsden and Strang, 2001; Parry, Myers, Morojele, Flisher, Bhana, Donson & Pluddemann, 2004).

The Zimbabwean government, through the Ministry of Health and Child Welfare, admitted that there is a local increase in the use and burden of substance abuse with its associated disorders in the last decade (Ministry of Health and Child Welfare, 2009). Zimbabwe used to be a transit state for illicit substances but in the past two decades has also since become a consumer (Chimhete, 2010; The Standard, 2014). The Zimbabwe Police Drugs and Narcotics Section reported that more than 100 drug abuse cases were dealt with by their department every month (Mandizha, 2014). The high cost of drugs and the low socio-economic status of the Zimbabwean society explains why most young drug users in the country abuse cheaper and more readily available drugs such as marijuana and prescription drugs, including cough syrups with codeine (Dube, 2014; Nyazema, 2013).

2.2.2 Drug use in African cultures

The use of cannabis, alcohol and tobacco has traditionally had a place in ritualistic and spiritual culture across the globe though use was restricted to the older and respected members of the community (Aaroe, Loeb, Eide, Acuda, Khan, 1997; Jiloha, 2009). Use was also governed by strict behavioural norms (Eide and Acuda, 1997; Faeh, Viswanathan, Chioloro, Warren, & Bovet, 2006). The use of alcohol and tobacco is socially accepted in most cultures (Eide, Arne, Diallo, Thioub, Blom, 1999; Hahn, Payne and Lucas, 2011) and is used socially to enjoy each

other's company, to "chill" or to cope with social stressors (Bernstein, Graczyk, Lawrence, 2011). The use of alcohol and tobacco paves the way for experimenting with or abuse of illicit drugs by a number of young people (World Health Organization, 2001). While many young people use alcohol and tobacco socially without developing a substance use problem, others go on to misuse substances and develop substance use disorders that will require medical rehabilitation.

The cultural context has shifted with important implications for cultural practices related to drug use. The extended family system within a traditional context has broken down, thereby losing the protective effect of the family's values and legacy (Hong, 2006). The youthful generation within the family unit were considered as the future leaders who had to be imparted with knowledge and skills in order to cope with life's challenges (Dasen, 2000). The socialization process aimed at keeping the extended family intact. Orphaned children were absorbed into another family system where physical, emotional and psychological support would continue to be provided (Tanga, 2013). Absence of this family relationship has contributed significantly to the increase in lawlessness as some young people now lack a sense of moral obligation thereby resorting to drug use and crime (Shelby, 2007).

2.2.3 Reasons for drug use among young people

The transition from childhood to adolescence, then from adolescence to adulthood is demanding for the young person. Drug use might mistakenly be perceived by boys as a sign of being manly especially for those who have grown up in environments that are less likely to use praise to motivate the child (Arthur, Brown, Briney, Hawkins, Abbott, Catalano, Becker, and Langer, 2015; Morojele, Flisher, Muller, Ziervogel, Reddy, 2002)). An intrinsic desire to break away from the family fold may lead a number of adolescents into drug use as the transitional period is marked with rebelliousness in decision making (Weiss, George, & Greenfield, 2006). One needs to successfully negotiate through the challenges encountered during the stage or the results can be distressing. Leading a drug free life is a positive indicator that one has succeeded in harnessing the challenges of this stage and this leads to good mental health (American Institute for Preventive Medicine, 2004). Some young people fail to negotiate their way through the transition and end up abusing drugs.

Reasons for illicit drug use amongst young people vary and an understanding of the role played by drugs in contemporary youth culture is important in advocating against drug use (Boys,

Marsden and Strang, 2001). Boys et al (1999) advised that the perceived function of a substance determines the substance of choice. These perceived functions include sensation seeking, relief of boredom, increase in energy or confidence and facilitation of work (Boys et al., 2001). Drug misuse for pleasure was more common than misuse for self-treatment in a sample of young people above 15 years in Detroit (Boyd, Austic, Epstein-Ngo, Veliz and McCabe, 2015; Eide, Diallo, Thioub & Blom, 1999). Young females in the United Kingdom were also of the opinion that the drugs helped them lose weight and they therefore incorporated them in their weight loss programmes (Boys et al, 2001).

Drug use by young people is a growing cause for concern because of the disturbing effects on the individual, family and society (Hawkins et al, 1992; Faeh et al; 2006; Chimhete, 2010; UNODC, 2014). In a sample of 1321 secondary school students who were living in the Seychelles, those who smoked tobacco products were nine times more likely to use cannabis than those who did not smoke (Faeh et al, 2006). Furthermore, those who drank alcohol were three times more likely to use cannabis or to smoke than non-drinkers. This is supported by Rudatsikira, Maposa, Mukandavire, Muula, & Siziya (2009), who concluded that illicit drug use (cannabis and glue) among school going adolescents in Harare was positively associated with cigarette smoking, alcohol drinking and teenage sexual activity. Bandason & Rusakaniko (2010) also found a strong association between experimental smoking and drinking of alcohol, use of cannabis, sexual intercourse and physical fights among secondary school students in Harare, Zimbabwe. This study will therefore seek to find out the factors that expose young people to a life of drug use in order to mitigate and reduce the negative impact associated with the practice.

2.3 Factors that impact on young people`s drug use

2.3.1 Models of resilience

A model proposed by Brook and colleagues to explain mechanisms of protection against substance abuse describes the risk/protective and the protective/protective mechanisms (Brook, Brook, Gordon, Whiteman & Cohen, 1990). The risk/protective mechanism is important to consider for those exposed to risk. The mechanism enables protective factors to moderate the risk factors in individuals at risk for substance abuse, leading to non-indulgence. The presence of a strong bond between the parent and child or adolescent, coupled with that of the immediate and extended family, is essential to counteract the risk. The protective/protective mechanism

is when the presence of a protective factor is strengthened by another protective factor. The mechanism enables an individual who is already empowered against drug abuse to develop strong resilience against the practice. Examples include positive family support and social competence skills training, academic achievement and youth involvement in alternative programs that include comprehensive risk reduction programmes (Hawkins, Catalano & Miller, 1992).

2.3.2 Studies done in Zimbabwe on drug use

A couple of studies were also carried out in Zimbabwean schools, but none showed the school context as protective against drug use. These studies focused on the prevalence of drug use in the country's educational system (Bandason and Rusakaniko, 2010; Chivandire and January, 2016; Eide, Butau, and Acuda, 1999; Rudatsikira et al., 2009). Unpublished reports indicate that 60% of hospital readmissions at the Psychiatric Unit were due to substance use disorders between January 2010 and December 2011 (Nhunzvi, n.d.). Another recent Zimbabwean study showed that of the patients admitted at two of the country's referral psychiatric units, 39% of the clients who participated in the study self-reported having used cannabis and 22% having used cough mixtures (Rwafa, Madhombiro, Mangezi, n.d.). Given the high rate of drug use among young people, early initiation and associated burden of care, it becomes essential to understand the risk factors associated with the increase. Having reviewed what is known about drug use and its implications for young people, the question that remains is why young people use illicit drugs when other young people who live in the same environmental setting do not use the drugs.

2.4 Structured literature review of risk and protective factors for drug use

2.4.1 Search strategy

A literature review was conducted to understand the current understanding of risk and protective factors for drug use by young people at a global level. The results of the literature review are presented in sections 2.5 and 2.6. A search for related literature conducted on MEDLINE using the key search terms RISK AND PROTECTIVE FACTORS, DRUG USE OR ABUSE / SUBSTANCE USE OR ABUSE AND YOUTH, YOUNG ADULTS OR YOUNG PEOPLE from year 2000 to 2016.

i. Inclusion criteria

- Study participants were young adults, aged between 18 and 24 years.
- Risk and protective factors for drug use were explored.
- The drugs included were cannabis or prescription medications.
- Qualitative and quantitative studies.
- English language articles only.
- Only peer-reviewed articles

ii. Exclusion criteria

- Studies not written in English
- Studies where the drugs included licit drugs such as alcohol or cigarettes or illicit drugs such as cocaine, heroin etc. These studies were excluded because the study focused on illicit drugs that are used prevalently in the area.

2.4.2 Studies located

A total of 33 articles were identified. When full articles were requested, a total of 27 articles were available, and only 22 were peer reviewed articles. An English only restriction was requested for the articles and 20 articles remained. These were screened for their relevance to the topic using the headings and four articles were dropped because their focus was not on drug use but on adolescent sexual aggression, self-harm, suicide attempts and the buying and selling of sex. Two further articles were dropped as they discussed alcohol and cigarette use and injecting drug users which were not the focus of the review. After reading the full texts, two more studies were dropped because they did not focus on young people's risk and protective factors for drug use. One focused on co-morbidity between substance use disorders and mania, and the other study focused on reasons for relapsing back into drug use post release from prison.

A total of 12 studies were finally reviewed. This process is presented in figure 1.

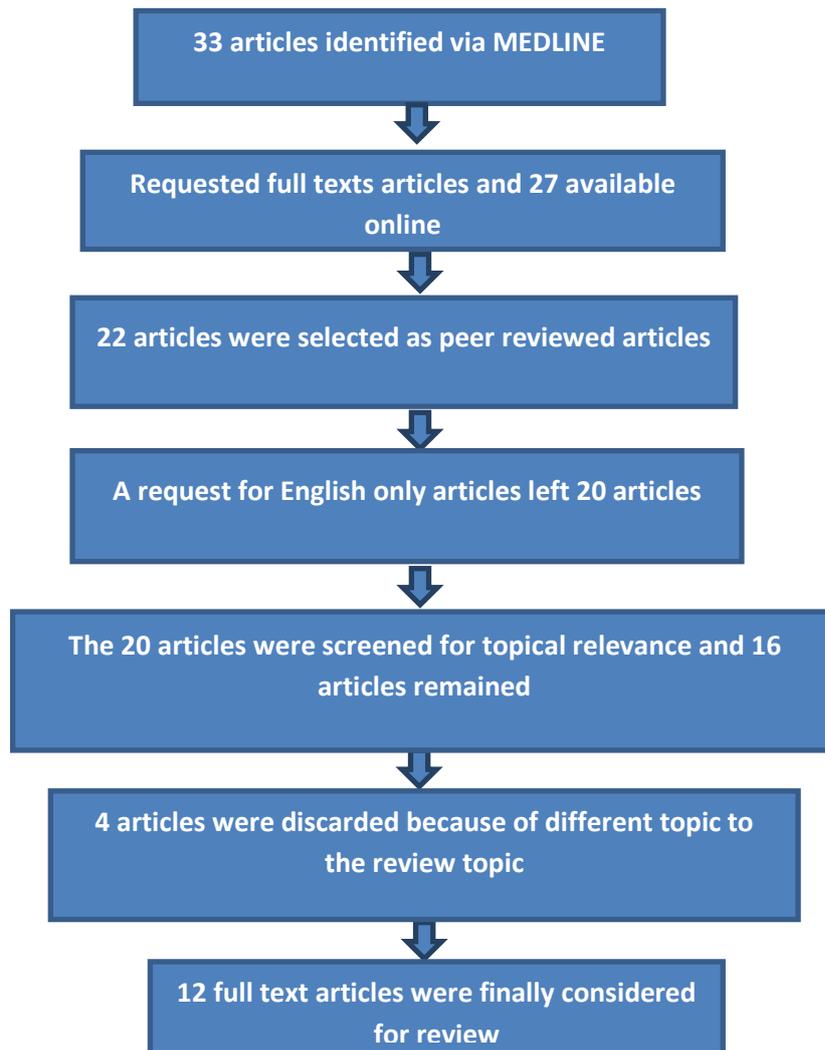


Figure 1: PRISMA diagram showing the search strategy

2.5 Risk Factors for young people's drug use

A number of investigators have studied risk factors for drug use problems and concluded that not much is known about the risk factors that are important for young people in the low to medium income countries (Wallace and Muroff, 2002; Faeh, Viswanathan, Chiolero, Warren and Bovet, 2006). This understanding may help identify prevention measures that are culturally relevant for young people (Eide & Acuda, 1997).

Factors that determine drug use have been categorised as those stemming from the individual or micro level, interpersonal relationship or meso level, and contextual or macro level factors (Bronfenbrenner, 1994; Hawkins, Catalano & Miller, 1992; Wallace & Muroff, 2002). Individual factors for drug use at the micro level include drug related expectations such as the

desired or expected effects of a drug, one's physical or psychological state (Rumpold et al., 2006) and commitments (Arthur, et al, 2002). Commitments relate to upcoming work or school assignments that one might have on their calendar and their importance to the individual. Choices made regarding the type of drugs to use are usually influenced by the negative effects experienced after use of the substance and the severity of the withdrawal symptoms (Boys et al, 1999).

The experienced outcome determines whether one will continue or stop using the drug. Stimulants arouse the nervous system and sedatives calm the system down. Amphetamines are used to improve concentration, to relieve tiredness and to suppress appetite (Boys et al, 2001; Hahn, Payne & Lucas, 2011). Boys et al. (2001) identified some of the desired physical effects as weight loss, keeping awake, relaxing or enhancing sexual feelings. A negative outcome or physical experience such as feeling sick or experiencing withdrawal symptoms may deter one from further using the drug. It is therefore important to understand the risk factors associated and their role in youth drug abuse.

Hawkins, Catalano & Miller (1992) and Wallace and Muroff (2002) agree that individual factors are inclusive of physiological factors which encompass sensation seeking, poor impulse control and a genetic predisposition. Both go on to say that academic failure, a negative attitude towards academic work and a low commitment to school also affect one's vulnerability to drug abuse and leads to truancy. A lack of personal commitment to school and academic failure influence one to initiate early into the practice of drug use (Arthur et al, 2015). Truancy was shown to be a significant predictor of initiation into illicit drug use due to the unsupervised time the young people have away from home and school (Chou, Ho, Chen, & Chen, 2006; Henry & Huizinga, 2007; Parry et al, 2004).

Relational or interpersonal factors include peer group support or pressure and the family. Association with illicit drug using peers during adolescence and early adulthood was seen as predictive of drug use (Brook, Morojele, Pahl, & Brook, 2006). This was supported by other researchers who also cautioned on the strength of the peer group (Ichael, Ric, Ohn, Ichard, & Artin, 2015; Morojele; Flisher, Muller, Ziervogel, Reddy, 2002). Boys, Marsden, Fountain, Griffiths, Stillwell & Strang (1999) however suggest that it is an individual's choice to engage in drug use and friends only provided the moral support. Association with drug using peers was seen as a strong predictor of drug use (Arthur, et al, 2002; Brook, et al, 2006). A study on the

child welfare system in the United States of America revealed that of the young people in the welfare system, 62% had got into trouble as a result of peer delinquent behaviour with 17% reporting lifetime cannabis use (Traube, James, Zhang, & Landsverk, 2012). Some young people may continue associating with delinquent peers as a means of avoiding peer rejection (Arthur et al., 2002; Wallace & Muroff, 2002; Sloboda, Glantz, & Tarter, 2012). Boys et al. (1999) maintained that most young people who use illicit drugs associate with a group of friends or peers who use the same drug as them and avoid those who use a different substance.

Family relations and the management style adopted by parents towards their children can aggravate or lessen drug use (Hong, Huang, Sabri, & Kim, 2011). Family factors predictive of substance abuse include low family bonding or parental rejection (Brook et al., 2015), high levels of family conflict, poor and inconsistent family management practice (Arthur, et al, 2015), parental attitude favourable towards drugs and antisocial behaviour (Morojele, et al, 2002), together with the parent's child rearing practice (Arthur, et al, 2002; Brook, et al, 2001; Brook, et al, 1990; Wallace & Muroff, 2002). A lack of close parental supervision was confirmed to predispose young people to substance misuse when close to 75% of young adolescents who were prescribed controlled medications inclusive of sedatives/ anxiolytics, opioid, sleeping and stimulants such as methylphenidate (Ritalin) had unsupervised access to the drugs and this led to a diversion in use (Ross-Durow, McCabe, & Boyd, 2013). Antisocial behaviour modelled by elderly family members was also seen to predispose one to a life of drug use (Arthur, et al, 2015).

Contextual factors are macro-level risk factors that affect the environment in which the young person is socialised. Societal factors for substance use can be summed up under: availability of drugs, laws and norms favourable towards drug use, neighbourhood disorganization and extreme economic deprivation (Hawkins, Catalano & Miller, 1992; Wallace and Muroff, 2002). This was supported in studies done among high school students in South Africa by Morojele et al. (2002).

Laws and norms favourable towards drug use govern the availability of drugs in the neighbourhood. According to Wallace and Muroff (2002) drug availability can be categorised into four sources. These are the physical availability which refers to the location, number and density of outlets that sell drugs to people in the community. Social responsibility refers to the extent to which the drug is promoted at the point of purchase within the community and mass media. Economic availability refers to the pricing of the drugs relative to disposable income

and the cost of other goods. Laws that govern young people`s access to drugs have been found to be effective in reducing their drug use. However, application of these laws in poor, high risk neighbourhoods is usually questionable.

Some young people are however unlikely to use drugs regardless of the extreme economic deprivation, neighbourhood disorganization and drug availability. Protective factors dampen their chances of using drugs and these young people remain resolute in their position not to use drugs.

2.6 Protective Factors leading to non-use

Protective factors for drug use empower an individual to resist the negative individual or environmental influences to drug abuse. They can also be categorised under individual or micro level, interpersonal or relational (meso) level and contextual or macro factors (Bronfenbrenner, 1994; Hawkins, Catalano & Miller, 1992; Wallace & Muroff, 2002). Meghdadpour et al. (2012) categorised protective factors into five domains which also reflect Bronfenbrenner`s model: individual, peers, school, family and community level factors. Protective factors enable one to build resilience against drug use as they tone down or control the effects of exposure to risk and inhibit drug use by those identified to be at risk (Arthur, et al, 2015). Resilience is the ability to withstand negative influences from the environment despite exposure to the causal effect (McCubbin, 2001) and is evidenced in young people who do not engage in substance abuse despite living in same risk exposed environments (Brook, et al, 2001).

Individual level factors include one`s belief in moral order (Arthur, et al, 2015), a desire to bond, engage and achieve more at school (Fleming et al., 2005; Traube et al., 2012), and religious conventionality (Brook, et al 1990; Wallace & Muroff, 2002). Self-determination, despite encountering failure along the way, also ensures high self-efficacy and provides some protection against drug use (Guerrero, Dudovitz, Chung, Dosanjh, & Wong, 2016).

Relational factors that are protective against illicit drug use include association with peers who do not use or abuse illicit drugs (Hawkins, Catalano & Miller, 1992; Wallace and Muroff, 2002). Parental attachment and supervision (Brook et al, 1990; Ross-Durow, McCabe & Boyd, 2013) were also reported to be protective of young people`s drug use. A proactive parenting style inclusive of close monitoring of the child`s activity and peer friendships make the family environment more protective against drugs and alcohol (Hong, Huang, Sabin & Kim, 2011; Wallace & Muroff, 2002). Gajewski and Malkowska-Szkutnik (2012) observed that a good relationship with one`s parents was protective against drug abuse despite association with peers

who abuse substances. Having a close relationship with the parents or caregiver (Arthur et al, 2002; Traube et al., 2012) and parental supervision (Rudatsikira et al, 2009) were protective factors for young people against drug use.

Having a peer group was reported as protective when friends do everything in their power to save a peer from drug and alcohol abuse (Buckley, Sheehan, & Chapman, 2009). Often, peers consider themselves all knowing (Meghdadpour et al, 2012) and do not easily accept correction from people outside their group. The young person continues to associate with the peer group who share the same views and opinions as them.

Religion is a contextual factor that protects against drug use (Wallace & Muroff, 2002). Parental religiosity seems to be protective of drug use in young adults (Kliwer & Murrelle, 2007). Most religions do not believe in drug use therefore they become protective of the young people who could be lured into drug use.

Jiloha (2009) put forward that caste, religion and local customs and traditions play a significant role in the choice of drugs, their consumption and their control of the mind. An active commitment to religion was seen as a protective factor against drug use by young people (Meghdadpour et al., 2012). A commitment to school work and achievements (Henry & Huizinga, 2007; Peltzer, 2009; Smit, Monshouwer, & Verdurmen, 2002), a stable family environment where the individual is accepted and shown warmth and love (Arthur, et al, 2015), and a proactive parent child relationship whereby the parent is involved in the child's life and routine activities are all deemed to be protective against drug using behaviour (Brook, Morojele, Pahl, & Brook, 2006; Brook et al., 2001; Reimuller, Shadur, & Hussong, 2011).

2.7 Zimbabwean context

Today, Zimbabwe is faced with a situation that has compounded the risk and protective factors. The current economic meltdown in Zimbabwe, has seen most parents engaging in extra income generating activities that take them away from the home or to work in the diaspora. This lack of close parental supervision could be a contributory factor to an increased use of substances by the young people in Mufakose, the setting of this study.

2.7.1 Current trends of drug use in Zimbabwe

According to the Non Communicable Disease risk factor survey conducted in Zimbabwe in 2005, alcohol use prevalence was more than 70% and tobacco use more than 33% in the adult population (Ministry of Health and Child Care, 2013). Results from the study by Bandason and

Rusakaniko (2010) mentioned above, showed that 62.6% of young people with a mean age of 16 years in Harare had drunk an alcoholic beverage, 28.8% had ever smoked a tobacco product and 9.7% had used cannabis. These authors report that the substances mostly used by Zimbabwean youth are tobacco, marijuana and alcohol. This confirms global trends (Boys, Marsden and Strang, 2001; Parry et al, 2004). In addition, abuse of prescription drugs such as tranquilizers and cough syrups has been reported in the local media (Chimhete, 2010; Chirinda, 2014; Gono, 2014; Nyazema G, 2013; The Standard, 2014). This increase is also noted in the increase in hospitalisation of young people with drug use problems (Nyoni, 2014).

Drugs are readily available in Zimbabwe and abuse is prominent among the 17 – 40 age group (Chirinda, 2014). Cannabis is locally grown or smuggled across the borders from neighbouring countries (The Standard, 2014; Gono, 2014). Cough syrups such as Histalix (locally manufactured and prescription prescribed) and Broncleer (smuggled from neighbouring countries) (Chimhete, 2010; The Standard, 2014) are abused because of their high codeine content (Chirinda, 2014; South African Electronic Package Insert, 2004).

In Zimbabwe, laws favourable towards drug use include the current classification of substances such as cannabis as a soft drug meaning the severity of punishment for cannabis possession depends on the amount in one's possession at the time of arrest. There is also on-going debate on the use of cannabis for medicinal purposes. Advocacy for the legalization of cannabis for medicinal purposes may increase its availability to the general public, including those who are protected by other factors from using it.

Neighbourhood disorganization fuels increased availability and abuse of drugs (Wallace & Muroff, 2002). The disorganization may also be associated with urbanization or the adoption of a western culture (Eide and Acuda, 1997). The adoption of western civilization and its impact on the traditional African value system has been reported in studies (Arowolo, 2010; Madukwe & Madukwe, 2010). Traditional Zimbabwean culture regards all older persons as parents and role models who are responsible for nurturing the young people into responsible members of the community or society. From personal observation and unpublished reports, these elderly persons seem to be peddling drugs as a means of income- generation for survival. One challenge regarding drug use in Zimbabwe is the paucity of documented evidence on the extent of the drug problem in the country.

The current socio-economic environment in Zimbabwe imposes a lot of stressors on the individuals, family and nation as a whole. The working age in Zimbabwe is 15 years and above and nearly seven million persons (58.4% of the country`s population) belong to this population group. Of the group, 87.3% are economically active (5.4 million are currently employed with 11% in formal employment and 84% in informal employment) (ZimStat, 2012). The remaining five percent are deemed unemployed using a strict definition of unemployment (ZimStat, 2012).

Contextual factors that are protective against substance abuse are present in Zimbabwe. Current legal restrictions include the Medicines and Allied Substances Control Act and General Regulations, Statutory Instrument 150 of 1991, which makes it an offence to cultivate, possess or abuse substances such as cannabis and also to produce or import substances high in codeine such as Broncleer (Medicine Control Authority of Zimbabwe, 2002).

Religion has become very popular in Zimbabwe, with the majority of the population having a strong association with the Pentecostal and Faith healing churches (Maxwell D, 1998). Association with religious peers is protective amongst most young people, as much of their time is spent engaging in religious activities (Beyers et al., 2004; Swadi, 1999).

The impact of the current economic situation, especially the very high rate of informal employment, on the mental status of the young people in Zimbabwe, and substance abuse prevalence has not been investigated (Ministry of Health and Child Welfare, 2009) and not much is known about individual or relationship level factors. This study aims to provide evidence on perceived risk and protective factors that will help to address this gap.

2.8 Aims and Objectives

The purpose of this study is to explore factors that expose young people in Zimbabwe to drug use and those that protect some from the same practice. The study also seeks to understand the perception young people hold on the issue of drug use. Knowledge generated from the study will help inform mental health practice as practitioners develop insight into the growing problem of drug use among young people. The study hopes to add to the current literature to enable provision of evidence based mental health services and care in a contextualised manner.

2.8.1 Objectives

- i. To explore the views on drug use of young people aged between 18 and 24 years who are living in Mufakose, Harare, Zimbabwe.
- ii. To explore young people's perceptions of the risk and protective factors associated with drug use amongst the youth.

2.9 Summary

The review of the literature has shown that young people who receive positive family support, belong to a religious community and who show commitment to school and other extramural activities fare better academically and progress well towards self-actualization. On the other hand, negative life experiences, an unstructured timeframe, excessive exposure to drugs, passive parenting skills and easy availability and low cost of the drugs were identified as risk factors for drug use. No studies have been done in Zimbabwe to identify the risk and protective factors relevant to the Zimbabwean youth and this study seeks to help fill this gap.

3 CHAPTER THREE: METHODOLOGY

3.1 Introduction

Polit and Beck (2003) refer to methodology as a set of investigating methods that are aimed at obtaining and organizing data. This chapter looks at the methodology that was used to explore the perceptions of risk and protective factors associated with drug use by young people. The chapter includes the research design, study setting, recruitment of participants, study population, sampling technique used, the research instrument, data collection and data management and analysis techniques used.

3.2 Study Design

An exploratory qualitative research study was conducted that included both in-depth one-on-one interviews and focus group discussions. Polit and Beck, (2003), highlight that qualitative research emphasises narrative information that reveals patterns. Qualitative research allows the researcher to collect data in a naturalistic setting. The naturalistic setting asserts that reality is multiple and diverse. The researcher therefore had to interact with the study participants through an interactive process which can be inductive or deductive in order to come up with the research findings (Polit and Beck, 2003). The qualitative research design allowed the researcher to gain insight into the participant`s life experiences, attitudes, behaviours, values, concerns, motivation aspirations, culture and lifestyles (Hastie and Hay, 2012; Merriam and Tisdell, 2015). Since the study explored young person`s perceptions of the risk and protective factors for drug use, the qualitative design was chosen as it allows for the collection of rich information that can help in the understanding of young people`s perceptions on drug use.

3.3 Study Setting

Mufakose is one of the oldest high density suburbs in Harare and most residents in the area are of a low socio-economic status (Parliament, 2006). The status has however not discouraged some people from the neighbourhood from excelling in different professions (Manzvanzvike, 2009). The community has also managed to contribute immensely to the country`s business, music and sporting image (Mutakati, 2013). Mufakose

Six community centres in the township offer extra-curricular activities for young people. The centres are open daily for youth activities from 08h00 to 17h00. These centres offer activities that are meant to help young persons to develop their talents, and stay healthy. A range of

indoor and outdoor sporting activities such as chess, soccer, netball, volleyball, basketball, lawn and table tennis are offered. Cultural activities include dance and drama group practice (Mutakati, 2013). Occasionally, the centres are used for film shows or music concerts by upcoming young artists. The centres are manned by social workers who attend to the young people and offer professional counselling intended to positively mentor the youth and modify their behaviour. However, despite the efforts made to keep young people occupied in the extracurricular activities, some young people use the centres to engage in illicit drug use. Two of the recreational centres (Area A and Rutendo Hall) will be used as study centres.

A study by Rwafa, Madhombiro and Mangezi (n.d) showed that the majority of patients admitted in Zimbabwe`s psychiatric units presented with drug use disorders. Local media reports also indicate that drug use is affecting the country`s young persons (Chirinda, 2014; Daily NewsLive, 2014; Nyazema G, 2013). However, as a mental health professional working in Harare, the researcher observed that despite the increase in drug use in the neighbourhood, there are some young people who have remained steadfast and are not using drugs. There are, furthermore, others who have used drugs but for varied reasons have stopped using and have remained unwavering on their decision. Mufakose thus became an ideal setting for the study so as to allow the researcher to explore the perception, the risk and the protective factors for drug use among the young people.

3.4 Study population

The study focused on young people aged between 18 and 24 years who live in Mufakose, Harare, Zimbabwe, who use, have used and stopped or have never used drugs in their lives.

3.5 Sample size and Sampling strategy

A purposive sampling strategy was used to recruit the study population. Since drug use is a criminal offence, penetrating the group would have been difficult. For this reason, a snowballing as a purposive sampling method was used to recruit the study sample. The method ensured that current drugs users would be recruited without their status being made known to other people in the community. This also safeguarded the participants from the Police authorities. Participants were recruited from two centres: Area A and Rutendo Community Centres. These centres were chosen because of their centrality and because there are activities that are ongoing at these centres that attract young people who come to socialize in different activities at the centres.

Table 1 sets out the sample size plan for the two centres by user-status groups and gender. The distribution for males was more than that of females since drug use is culturally accepted among males more than females; hence some female users were also hesitant to participate in the study.

Individual interviews: 5 participants per centre

Users: 1 male, 1 female

Non – users: 1 male, 1 female

Past users: 1male from Rutendo Hall, 1 female from Area A

Focus group discussions: 15 participants per centre

Users: 6 participants – 4 males, 2 females

Non-users: 6 participants – 4 males, 2 females

Past users: 3 participants – 2 males, 1 female

N.B. Past users from the two centres will come together to form one group of 4 males and 2 females.

Table 1: Sample plan for recruitment of participants

Centre	Centre A		Centre B	
Gender	Males	Females	Males	Females
Users	5	3	5	3
Non-users	5	3	5	3
Past users	3	1	2	2
Total	13	7	12	8
Centre total	20		20	
Study total	40 participants			

3.6 Participants

For this study, the young people were divided into three categories:

- i. Those that use drugs and alcohol.
- ii. Those that have used drugs but have stopped using them.
- iii. Those that have never used drugs in their lifetime.

3.6.1 The inclusion criteria:

- i. General inclusion criteria:
 - Male and female young adults aged between 18 and 24 years because they fall into the legal age of majority and the World Health Organization category of the definition for youth.
 - Residing in Mufakose, Harare, Zimbabwe and attending Area A or Rutendo Community Halls
 - Shona-speaking
 - Willing to give informed consent
 - Falling into one of the 3 user/non-user categories
- ii. Type of user inclusion criteria:
 - Current drug users:
 - Those who screened positive on the quick screening question for cannabis or non-medical use of prescription drugs such as sedatives, tranquilizers or broncleer as these are the most prevalent illicit drugs used in the area (ASSIST – see section 3.7 for further explanations).
 - Used the substances together with an intake of 4-5 standard units of alcohol on any given day together with tobacco. (This was used to identify poly substance users).
 - Past users: Young people who have used substances at some point in their lives but have stopped for varying reasons. They should have last used the substances more than three months prior to the date of the interview to qualify. The none-use was however based on individual self-report on the WHO ASSIST and was not verified in any other way.
 - Non-users: Never used drugs in their lifetime. Again, this was based on participant`s self-report on the WHO ASSIST and was not verified in any other way.

3.6.2 Exclusion criteria

The criteria for exclusion from the study was:

- Young people who are below the age of 18 years or over 24 years old
- Young people who do not stay in Mufakose but will be visiting the community centres as their views may not be representative of the community.
- Exclusive alcohol or tobacco abusers as these are legal drugs though some illegal alcoholic beverages are sold in the country.

3.7 Recruitment Instruments

In order to determine user status, a brief screening assessment was conducted using the WHO ASSIST. Questions 1 and 2 of the World Health Organization's Alcohol, Smoking and Substance Involvement Screening Test (ASSIST) (see Appendix A) was used as a quick screening assessment for the participants. The ASSIST screening tool was developed and adopted by the WHO to assist primary care workers in detecting psychoactive substance use and related problems. Zimbabwe is one of the countries that was selected by the WHO to pilot test the screening tool (WHO ASSIST Working Group, 2002). The results showed that the tool was reliable and valid for use in Zimbabwe.

3.8 Recruitment process

The participants were recruited from the community centres on Wednesdays and Saturdays in order to recruit those young people who visited the centres during the week or the weekend. The recruitment included both young males and females.

Two research assistants who are qualified psychiatric nurses recruited young people for the study. The principal investigator familiarised the assistants with the use of the WHO ASSIST screening tool prior to the recruitment of participants. This was done over a two-hour session. The research assistants aimed at recruiting young people who were knowledgeable and experienced on drug use or living a drug free life, with the help of the social workers. These participants provided rich sources of information that would allow for the capture and description of their life experiences (Polit and Beck, 2003).

The recruitment process started with the research assistants approaching young people attending the centres. The young people were approached as they went about their activities. The research assistants created rapport initially with the participants before asking them to take

part in the screening phase of the study. If the young people met the inclusion criteria and gave their verbal consent, they were recruited for the study.

The WHO ASSIST quick screen question together with demographic variables (gender and age) were used to recruit the 40 participants (20 from each centre) who met the inclusion criteria listed above. Additional recruitment days were to be added if the recruitment did not yield the expected number of participants within the first two weeks. Young persons who met the inclusion criteria for the study after screening and were willing to participate in the study, provided their contact details (see Appendix A).

Participants who met the inclusion criteria were notified by the researcher via telephone or in person to arrange for a convenient meeting time for the in-depth interviews and focus groups. Of the 40 participants chosen for the study, 10 were selected randomly using the fishbowl method by their user status to participate in individual interviews (five from each centre). The rest were included in the focus group discussions. The 30 remaining participants were invited to participate in five focus group discussions according to their user status categories with each group comprising of six participants. The discussion groups met at the community centres in a separate room away from the main activities.

3.9 Data Collection

Data collection for this qualitative study occurred in two phases. The initial phase included the one-on-one in-depth interviews with a selected group of the participants. The second phase included focus group discussions to validate the data collected from the in-depth interviews. These interviews and focus group discussions allowed the participants to open up and direct the flow of the conversations, to tell their own stories liberally and to select aspects of their stories that they wanted to tell, withhold or emphasize.

Since the use of drugs is illegal in Zimbabwe, in both the individual interviews and the focus groups, the researcher initially created rapport to enable the participants to open up. On commencement of the interview and discussions, the researcher read and explained the purpose, aims and objectives of the study. Written consent was obtained for the interview and voice recording (see Appendix F for the informed consent form). All participants were assured of confidentiality and anonymity concerning their involvement in the study. The researcher also assured the participants that all information given would be kept in a secure place.

The procedure for these individual interviews and the focus group discussions are described below.

3.9.1 In-depth interviews

Participants gave written consent (Appendix B) before starting the in-depth interviews. All interviews were done in Shona as this is the local language although some of the participants would use English and Shona interchangeably. The interviews were conducted in a private room at the community centres and took between 20 minutes to 45 minutes. Participants received refreshments in the form of juice and snacks for their time. This was served at the beginning of the sessions whilst obtaining consent. Participants also received US\$2 as reimbursement of their transport costs. These interviews were transcribed in Shona and translated into English before being analysed prior to conducting the focus group discussions. Data from the interviews informed the discussion guide for the focus group discussions.

3.9.2 Focus group discussions

Five focus group discussions were conducted with each group comprised of six participants. The discussions were aimed at validating the data collected in the in-depth interviews. Participants for each single group had the same user status; e.g. current users, non-users and past users. This allowed them to open up during the discussion without disclosing their user status. The groups were mixed with both males and females. The discussions were also voice recorded and took two hours. One research assistant was available to take notes during the discussions. The interviews and discussions were done in a private room at the community centres. Participants received refreshments in the form of juice and snacks for their time. This was served at the beginning of the sessions whilst obtaining consent. Participants also received US\$2 as reimbursement of their transport costs.

3.9.3 Interview Schedule

In order to fulfil the study objectives, the researcher collected data using an in-depth interview guide (See Appendix C - individual in-depth interview guide, and Appendix D – focus group discussion guide). The interview guide and the focus group discussion guide were divided into two sections: Section A collected demographic information and Section B collected information on perceptions on drug use. Demographic variables included the participant's age, religion, living arrangements, level of education and employment status. The researcher asked the question and the participants took turns to respond to the question and the responses were recorded down against the participants' study number. A number of themes based on literature

reviewed were explored including personal and peer views and experiences with use of drugs, and their perception on risk and protective factors for drug use. Section B ended with a question on the participant's recommendations to the health practitioners on drug use.

3.10 Data Management and Analysis

All the interviews and focus group discussions were conducted in the local language (Shona) to allow participants to freely express themselves although a few participants would use some English terms here and there. These were audio taped and transcribed verbatim in Shona in order to prevent data loss and preserve the meaning so that nothing important would be overlooked (Tilley & Powick, 2002). Translation into English was done verbatim in order to prevent loss of meaning by a bilingual speaker from the Linguistic Department of University of Zimbabwe. The audio recordings and transcriptions were saved on my personal laptop. A hard drive and compact disks were used as backup. No other parties had access to these transcripts and no hard copies were printed.

The framework approach (Spencer, Ritchie, Lewis, & Dillon, 2003) was used for qualitative analysis. The framework approach is a systematic and flexible approach for analysing primary qualitative data. The five steps of the framework according to Pope, Ziebland & Mays, (2011) include:

- Familiarisation – becoming immersed in the data by listening to recordings, reading and re-reading transcripts and studying notes. During this stage, a coding list will be constructed.
- Identifying a thematic framework – finding the key issues and concepts present in the data and developing themes by which to structure the findings.
- Indexing – applying the thematic framework to all the data, at the same time checking how it is related to the original aims and objectives.
- Charting – rearranging data to where it is best suited in the thematic framework.
- Mapping and interpretation – using the charts to create associations between different themes and how this relates to the objectives of the study.

The approach allows the researcher to include preconceived themes identified from existing literature. However, for an intimate association with the data, I listened to the audio recordings, read and re-read the transcripts in order to come up with the themes for analysis. As the data

were collected and analysed, more themes emerged from the discussions which the researcher added to the existing themes. The NVivo 11 software was used to analyse data that was collected for the study. The software allows for new themes to emerge from the data. It assists the researcher to save time on analysis by uncovering connections that can be difficult to do manually (Hastie and Hay, 2012; Merriam. and Tisdell, 2015). The Statistical Package for Social Science (SPSS) was used to analyse the demographic variables for the study. Basic statistics, such as frequencies and cross tabulations were calculated.

3.11 Ethical Considerations

3.11.1 Institutional Approval

Permission to conduct the research was sought and granted from the Faculty of Health Sciences Human Research Ethics Committee at the University of Cape Town (HREC 804/2015; Appendix E). Since the research involved human subjects, permission was also sought and granted from the Medical Research Council of Zimbabwe (MRCZ/B/977; Appendix F). The Director of Health Services in the City Health Department also granted his permission for the study to be conducted (Appendix G). Permission was also sought and granted from the Social Welfare Officer for Mufakose (Appendix H) and the Nurse in Charge of the local clinic gave verbal consent.

3.11.2 Informed consent

The participants were above the 18years which is the legal age of consent; therefore, consent was sought from them for their participation and for the voice recording (Appendix B). The researcher read out aloud in Shona and explained information regarding the study which was on the consent forms. The information included the scope and aims of the study. Participants were assured that no harm was expected in any form as a result of the study except minor emotional disturbances that could result from a discussion of previous stressful life events. All questions were answered before the participants signed the consent forms. The researcher also availed herself for questions and clarifications by providing her mobile number so that the participants could contact her if a need arose.

The participants signed a consent form for their participation in the study and also granted permission for audio recording. If a participant was unable to write the Social Worker was available at the centre to sign as a witness for them. Participants retained the right to refuse to disclose issues, and to participate voluntarily. The right to withdraw from the study at any stage of the research process without any negative consequences was emphasized verbally and in writing. Those who decided not to participate were not to be denied any mental health services

at the local clinic as the study was done away from the clinic. The researcher ensured that the process did not interfere with the participants' activities at the centres.

3.11.3 Confidentiality

Safeguarding confidentiality was of paramount importance since use of drugs is a legal offence in the country. The research team requested the participants in the focus groups to maintain confidentiality and anonymity concerning their participation and contributions before the discussions began. The researcher assured the participants of maintaining confidentiality and keeping all study materials in a secure place. The user status of the participants would not be disclosed to the other participants during the discussions unless they did so themselves. In cases where information was to be shared with other members of the health team, a referral note would be sealed in an envelope for assistance at Parirenyatwa Psychiatric Unit, if the participant so consented. Other protective measures for the data included use of pseudonyms or no names at all.

While significant changes to the stories could not be done as these would have altered or compromised the study findings, sufficient changes were made to protect participant's identities.

3.11.4 Privacy

The interviews were conducted in a private room at the community hall to ensure privacy. The recorded materials, consent forms, hard drive and compact disks were kept in a lockable cupboard in a private office at the Psychiatric Unit. The researcher only had access to the material and personally kept the keys. All electronic materials were kept on a password protected computer. Materials sent to my supervisors is done through secured internet lines and all names in the transcriptions were changed to pseudonyms. All data will be suitably disguised before use in public reports, especially in Mufakose where the participants come from.

3.11.5 Potential for harm and benefits

No harm was expected. Participants were informed at the beginning of the study that the discussions were likely to evoke some unwanted feelings or memories. Caution was however taken to avoid such emotions and the interviews or discussions were to be terminated if the participants had shown signs of distress. Referral for help and psychotherapy or treatment services had already been negotiated for the participants at Parirenyatwa Hospital.

3.12 Summary

The qualitative research design was well suited and applied to this study because it allows for participants to give a narrative description of their life stories. In-depth interviews and focus group discussions were planned to generate data for the study. Ethical procedures were followed and these have been documented. NVivo software was used to analyse the data collected for the study. The results of this study will be presented in Chapter Four.

4 CHAPTER FOUR: RESULTS & DISCUSSION

4.1 Introduction

Results and a discussion of these findings are presented in accordance with themes that emerged from the data. The results of the individual interviews and focus group discussions will be presented together as there were no major differences in responses. Results and discussions are divided into: (1) characteristics of participants; and (2) risk and protective factors that influence substance use, focussing on individual, family, peer group and community factors. These factors were identified from the conceptual framework by Bronfenbrenner, (1994).

4.2 Sample characteristics

Table 2 sets out the final distribution of participants recruited into the study. The final sample recruited for the study included 12 females and 28 males. There was no need to extend the recruitment beyond the planned two weeks as those who were recruited spread the word around the community and young people came in large numbers, which was impressive. This highlights the importance of providing a space to discuss these issues with these young people. However, not all were recruited for the study as some did not meet the inclusion criteria as they stay outside Mufakose and were therefore visitors to the community. Some of those who did not meet the criteria were either below or above the age range for the study.

Table 2: Participants recruited for the study

Centre	Centre A		Centre B	
Gender	Males	Females	Males	Females
Users	6	2	6	2
Non-users	6	2	6	2
Past users	2	2	2	2
Total	14	6	14	6
Centre total	20		20	
Study total	40 participants			

4.2.1 Data Collection Procedure

The 10 in-depth interviews were conducted with participants from the three user-status categories of participants randomly selected from the list of recruited participants using the fish bowl technique as a random sampling method. Refer to Chapter 3 for details. The interviews took between 20 to 35 minutes. None of the participants reported serious drug related problems or social problems, therefore no referrals to substance use services was required.

However, in the focus group discussions for users, some of the participants did come across as irritable during the discussions. These were particularly those who use tablets [non-prescribed antipsychotic medication and sedatives] as they were mocked by the other group members who use cannabis or broncleer. The researcher did attempt to successfully refocus the group by calling the participants back to order. The researcher then explained that the group consisted of young people who used different substances and encouraged the group members to accommodate each other. None of the participants showed serious drug related harm as all could follow proceedings and responded appropriately, so none were referred. The discussions were voice recorded and took one to two hours. The researcher facilitated the interviews and focus group discussions while one research assistant took notes during the focus group discussions.

4.2.2 Demographic characteristics of study participants

Of the 40-young people recruited for the study, the majority were males (n=28), unemployed (n=25) and had completed high school (n=39). The average age was 20 years (mean: 20; sd: 1.72) and most stayed with a single parent or grandparent. Just over half of the participants (n=24) visited the centre on a daily basis.

Table 3: Demographic variables for the participants

Characteristics		Characteristics	
Mean Age (sd)	20 (1.7246)		N (%)
	N (%)	Stays with	
Gender		Both parents	07 (17.5)
Females	12 (30.0)	One parent + step parent	02 (5.0)
Males	28 (70.0)	Single parent	18 (45.0)
		Grandparents	10 (25.0)
User status		Relatives	02 (5.0)
Non-users	16 (40.0)	Children only	01 (2.5)
Users	16 (40.0)	Religion	
Past users	8 (20.0)	Adventist	02 (5.0)
Educational status		Anglican	04 (10.0)
Secondary level	39 (97.5)	Apostolic	01 (2.5)
Tertiary level	01 (2.5)	Catholic	07 (17.5)
Employment status		Methodist	05 (12.5)
Formally employed	01 (2.5)	Pentecostal	17 (42.5)
Informally employed	13 (32.5)	None	04 (10.0)
Not employed	25 (62.5)	Frequency of visits to the centre	
Student	01 (2.5)	Daily	24 (60.0)
		Weekly	04 (10.0)
		Monthly	02 (5.0)
		Now and then/occasionally	10 (25.0)

Participants` recreational activities were not included in the table because of the wide variability of activities. Playing or watching soccer together and engaging in drug use as a recreational activity were the most prominent. Each was cited by 10 participants out of the 40 participants. Listening to music, playing chess, card games, and video games were the least prominent with one participant citing each as their hobby.

4.3 General views on drug use by young people in Mufakose

Reports from the in-depth interviews and focus group discussions show that all the participants agreed that there is an increase in use of drugs among the young people resident in Mufakose. Reasons behind the increase were attributed to individual, peer influence, family factors and some factors which are present in the community or nation. Without any recent studies to validate the increase in drug use in Zimbabwe, the results used were from studies done in the 1900s and 2009 (Eide & Acuda, 1996; Eide, Butau, & Acuda, 1999; Rudatsikira et al, 2009).

The nation has since gone through transitional changes and these could have led to an increase in drug use. Media reports have also highlighted the increase in drug use among young people in the country (Chimhete, 2010; Chirinda, 2014; Gono, 2014).

The view also supports regional and global reports on trends in drug use among young people. In the Southern African region, drug use is reported to be on the increase since the late 1990s with cannabis being reported as the preferred drug of choice (Flisher, Parry, Evans, Muller, & Lombard, 2003; Parry et al., 2004; Hamdulay & Mash, 2011). On a global scale, drug use is also reported to be on the increase (Lim, Hellard, Hocking, Spelman, & Aitken, 2010; Rudd, Aleshire, Zibbell, & Gladden, 2016). The World Drug Report (2016) showed that cannabis is the most widely cultivated drug crop. Though its use has been stable over the three years prior to 2016, use has increased in Northern America and Western and Eastern Europe.

Zimbabwe has not legalized the use of drugs such as cannabis and broncleer and young people`s views on the legalization of cannabis and broncleer differed across the three user status categories. Most users endorsed the legalization of cannabis both for recreational and medicinal uses. Despite the country`s position on drug use, high level government personnel have spoken publicly in support of cannabis use (Kells, 2016; NewsDay, 2011b). The reports bring conflicting and contradictory messages between the field of politics and that of medicine, leaving the young person in a state of confusion and indecision. Young people now have to search within themselves for protective factors to guide them against drug use (Nasim, Corona, Belgrave, Utsey, & Fallah, 2007).

4.4 Risk and Protective Factors That Determine Drug Use or Non-Use

Risk and protective factors for drug use were explored using the Ecological Models of Human Development by Bronfenbrenner (1994) as a conceptual framework. The framework establishes a person as composed of microsystems which help, support and guide human behaviour (Bronfenbrenner, 1994) This study identified three of the five systems described by the Ecological Model: the micro, meso and macro systems. Resilience models that can assist the young people to lead a drug free life include the Risk/ Protective mechanism and the Protective / Protective mechanism (Brook and Brook, 1990). The theory postulates that an individual might be exposed to both risk and protective factors. Others may only find protection, as protective factors compound on each other. Such individuals develop resilience against drug use. All these factors can have an impact on the young people`s decision to use or not to use drugs.

Risk and protective factors for drug use shape an individual's behaviour and lifestyle. Risk factors increase one's chance of engaging in any behaviour. Protective factors diminish one's chances of practicing the behaviour despite exposure to the causal agents by enhancing one's resilience. In this study, protective factors enable one to withstand negative influences from the environment that could have exposed one to drug use. The risk and protective factors discussed in this study are classified as those affecting the person at individual, relational and community or neighbourhood levels (Bronfenbrenner, 1994). Individual factors affect one's personal being. Relational factors include those factors that result from one's interaction with people. Community or neighbourhood factors are those that are present in one's place of residence which affect the general population as well. The transcripts were coded using these themes.

4.4.1 Individual Level Factors

These are factors that affect the individual and those close to them. Factors identified included stressors from the home, school and workplace. Stressful life events such as loss of a loved one were also highlighted. Boredom due to unemployment and lack of activity was seen as predisposing young people to drug use as well as a belief system that puts value in the use of cannabis for protection.

A number of risk and protective factors at the individual level were identified as either predisposing or protecting an individual from using illicit drugs. One risk factor that emerged strongly from the data were the high levels of stress and stressful life events that Zimbabwean young people are often faced with in their everyday lives. This includes stressors from the home or the workplace which lead some young people to engage in risky behaviours. Young people who experience such stressors reported turning to drugs as a means to cope with these life stressors. A number of stressors were identified including: the death of a loved one; stressors emanating from the living arrangements at home; and stressors in the workplace. In addition to stressors, other risk factors included: boredom due to lack of activities; lack of commitment to school, work or sport; and personal beliefs about the drug. These will be discussed below.

i. Stress due to loss of a loved one

A number of respondents discussed turning to illicit drug use as a way of coping with a death of a loved one. Grief can be debilitating, and some people may turn to alcohol or drugs in a

desperate attempt to numb the intense pain, sadness, and grief that they are experiencing. This is encapsulated by the following statement:

“What made me use drugs for the first time was the death of my father. My father died in January, on the 24th of January. He was involved in an accident on his way to our rural home ... I then decided to smoke cannabis in the hope that it would help settle my mind. But haaa, there was no difference, so I decided to stop” (Participant 002, past user, male, 24 years).

“Sometimes when you lose your parents, the people you are left to live [with] might ill treat you. One might end up abusing drugs as a way of coping with the abuse” (Participant 004 user, male, 19 years).

Despite a few of the participants agreeing that some people may turn to illicit drugs as a way to cope with stress from the death of a loved one, this concept was challenged by one participant who said:

“death has and will always be there. So, when you lose a loved one, you have to heal but you do not heal by using drugs. Because even if you use the drugs, your relative will not resurrect from the dead” (Participant 001, non-user, female, 22 years).

ii. Stressors from the home environment

Losing one`s biological parents can be a very stressful experience, but life after the loss can even have a greater negative impact if one is faced with abuse from the new caregivers in the home. This was alluded to by one participant who stated:

“Something like when one is staying with a stepmother or stepfather who will be abusing you. One will end up opting to abuse drugs so that they divert their mind from the problems. Opting to forget the ordeal that the parents are making him go through” (Participant 002, past user, male, 24 years)

A few respondents identified young women as being particularly vulnerable to stressors in the home. Examples of these stressors are being the victim of domestic violence or facing challenges as single mothers when trying to raise children. These challenges potentially contribute to their turning to drugs as a way of coping with the difficult home conditions:

“For some females, the husbands will be abusing them. So, they will be using the drugs so that they will not be able to say much or to answer back” (Participant 010, user, female, 19 years).

“Others might be single mothers, so to get rid of their stress, they resort to drugs” (Participant 030, non-use, male, 18 years).

Many of the participants agreed that it is likely that people turn to drugs to cope with these stressful home situations and environments. Yet some respondents, both users and non-users,

discussed how in reality using drugs for the purpose of stress relief is not very effective. This is encapsulated by one responded who shared:

“I will tell them the truth that broncleer does not relieve stress [stresses the point]. It does not end stress. That’s a lie.” (Participant 009, user, female, 24 years).

A few isolated cases included those where the use of cannabis was to address situations of irritations and anger resulting from interpersonal conflicts with other people. Cannabis was used as a way to calm one down after such altercations:

“My issue had to do with anger management... I use cannabis but usually when I am in conflict with people; that is when I smoke cannabis. When we exchange words with my colleagues, or mostly when there is a misunderstanding, I smoke cannabis and I calm down. Cannabis helps me to calm down after I have had a confrontation with people” (Participant 024, user, male, 22 years).

iii. Stress due to the workplace

Some forms of work demand strength and endurance, which might be above the threshold that individuals can offer. Often drugs are used as a way to enhance an individual’s capability to perform well in the work place, or to endure challenging and demanding work environments.

This was expressed in the following extracts:

“The soldiers do a difficult job, especially the six months training that they undergo. It has some painful moments such that if one is under the influence of cannabis they will have the strength to endure” (Participant 024, user, male, 22 years).

“They use the drugs to increase their work performance so that they do not tire easily. They remain strong until they finish the task” (Participant 014, non-user, male, 21 years).

“Concentration is enhanced with cannabis.” (Participant 036, user, male, 20 years).

“Once I have smoked cannabis, I respond faster.” (Participant 002, past-user, male, 22 years).

“Cannabis enlightens the brain, one starts to think fast, you see. Haaa, you will be far ahead of everyone. Cannabis strength is added strength” (Participant 004, user, male 19 years).

Participants described how drugs are often used to enhance not just work activities, but a range of everyday activities from reading a book and even household chores. These everyday activities are discussed by the participants below:

“Even if I were to take a book and read, I will understand it better. Such that if one smokes cannabis, one goes into deep meditation about what has been read, and everything is integrated into the brain and one starts to think about it and understand it better” (Participant 006, user, male, 20 years).

“It gives me energy so that I can clean the whole house thoroughly” (Participant 040, user, female, 19 years).

“But before taking the drug, I am unable to do simple chores like sweeping the house. I have to first go and buy myself some broncleer, drink it, relax a bit, then start on my chores” (Participant 009, user, female, 24 years).

Musicians, sports people and other performers were also purported by the participants to use drugs to gain confidence, enhance their talent and increase the quality of their performances.

“Among the musicians, themselves, whoever wants to write a song, is taking some broncleer and stuff, the tablets. So, that they get the lyrics” (Participant 007, non-user, male, 20 years).

“For some, that is what makes them perform, that is what makes them sing” (Participant 010, user, female, 19 years).

“I take it in the evening so that I am able to dance and sing when I am high” (Participant 037, user, male, 22 years).

“Rugby is a very aggressive game, so some players use drugs in order for them to become more aggressive during the game” (Participant 007, non-user, male, 20 years).

iv. Stress from interpersonal relations

Some use drugs to gain the confidence to approach people when settling disputes or when seeking help.

“When I drink broncleer, I am no longer shy, not that I can walk whilst I am naked, no. But that I can now say out my mind without regard for who else is there. I can say things that I am unable to say when I am sober. Even if I want to ask for something from my sister, without taking broncleer it will be difficult. But once I take the drug, I become determined, if I tell myself this is what I am going to do, I can do it” (Participant 009, user, female, 24 years).

Controlled anxiety levels are necessary when selling goods in order to maintain a good relationship with customers and ensure continued support, and in approaching others as set out in the following quotes:

“It helps me when selling my things, I can go around the neighbourhoods with lots of energy, speaking to people and selling my stuff with confidence” (Participant 026, user, male, 21 years).

“But if you get a job at a place where you will be speaking to too many people, there cannabis is needed, it qualifies” (Participant 027, user, male, 22 years).

“...where one is roasting and selling maize by the roadside, that on its own encourages one to use drugs to gain confidence so as not to be shy” (Participant 017, past-user, female, 22 years).

To summarize, stress due to loss of a loved one, stress from the living arrangements at home, stress from the workplace or stress from interpersonal relationships were all reported as factors that are perceived to predispose one to a life of drug use. Failure to manage the stressors in a

young person's life is known to contribute to their decision to find comfort in drug use (Florence and Koch, 2011) as a measure of creating a zone of comfort (Wright and Pearl, 2000). However, the differences existed in the manner in which the three user groups interpreted some of the risk factors as shown in the responses to stress due to loss of a loved one. The responses showed that turning to a life of drug use as a result of loss is a decision one has to make after encountering an unfavourable situation. The non-users suggested that one has to move on after the loss but the others verbalised challenges in moving ahead.

In addition to stress and stressful life events, boredom due to unemployment or lack of activities, lack of commitment to school, work or sport and beliefs about drugs use were described as potential risks for drug use. These risks are described below.

v. Boredom due to unemployment or lack of activities

A lack of activities for the young people to embark on at home or in the community has contributed to the increase in drug use. In this study, young people reported that they lack pastime activities to occupy their time, leaving them with lots of unstructured time to manage on their own. This was highlighted by most of the young people in the in-depth interviews and group discussions:

"Life is hard because there is nothing to do for the young people" (Participant 025, user, male, 18 years).

"Others say that there are no employment opportunities, there is nothing that keeps us active. So, to them, they opt to use drugs in order to relieve the stress of unemployment" (Participant 017, past-user, female, 22 years).

Some young people are reported to be spending the day at the street corners, drains, or behind the school security walls. These are places where the young people voiced that once they meet in these destinations, their core business is to discuss and use drugs:

"If you come across people who are just gathered by the street drains, or by the corners, then know that there is nothing else being discussed except issues to do with drugs because there is nothing else to do other than to use drugs" (Participant 025, user, male, 18 years).

"If a person spends the day in the drains, that's when they will think about getting high and spend the whole day like that" (Participant 020, past-user, male, 19 years).

"To tell the truth, we will be discussing about drugs, we do not have other stories to tell except issues to do with drug use, can I have a puff, or can I have a cigarette. Do you have a leaf; those are the stories that we talk about when we meet" (Participant 023, user, male, 19 years).

A lack of activities either at home or in the community affects the young people negatively as they are in their 'prime time' with lots of 'energy to burn'. Users and non-users use their

available time differently. The users would rather spend the day engaged in destructive activities whilst the non-users engage in productive use of time.

“One can use drugs because of lack of activities to occupy their time...one will see it fit to smoke cannabis or to drink broncleer because of boredom” (Participant 003, past-user, female, 18 years).

“If you do not have anything to do at home, you end up associating with those engaged in drugs abuse. But if one is occupied, for example by selling clothes or tomatoes, then one will not have the time to associate with such people” (Participant 008, non-user, male 18, user).

Some of the recreational facilities that are meant to be used by the young people to engage themselves in sporting activities have of late been used for purposes other than the intended.

“It is true that the recreational areas are being used for other things [such as subdivided to accommodate the building of churches, growing of vegetables and sweet potatoes]” (Participant 031, non-user, male, 21 years).

Participant 006 (User, male, 20 years) shared that they used to come to the centre for traditional dance practice, but this has been replaced by Nyau dancing. Nyau dancing is a masked traditional dance routine that is foreign in Zimbabwe as it originated from Malawi, Zambia and Mozambique. Initiation into the sect involves some form of drug use (Schoffeleers, 1976; Smith, 2001).

“That was what would keep our minds off drugs. But when construction of these structures [churches] on recreational centres started, most young people flocked to Nyau dancing because they saw it as a better option; that is how many started using drugs.”

An appeal was made by one of the participants to the authorities to preserve the recreational centres:

“The authorities should stop allocating or ploughing on the land that is not designated for that purpose. ... they should also desist from building their houses on the grounds that was set aside for recreational purposes” (Participant 005, non-user, female, 20 years).

In summary, the identification of boredom due to unemployment was highlighted as a risk factor for substance use by participants in this study. The unemployment rate in Zimbabwe is very high at 80% in 2005 and escalating to 95% in 2009 (CIA World Factbook, 2017) and the majority of employed people are in fact working in the informal sector (ZimStat, 2012). Of the participants interviewed for the study, only one participant is employed in the formal sector, 13 participants are employed in the informal sector and 25 are unemployed. Calls have been made to review the educational curriculum such that it meets the needs of the young people requiring skills to work in a predominantly informal sector economy in the country (Chingarande and Guduza., 2011). These calls seem to have made their contribution as the country`s educational system has now been reviewed (Marume, 2016).

vi. Commitment or lack of commitment to school, work or sport

A lack of commitment to school, work and sport was reported by some of the young people. A variety of reasons were given for dropping out of school with engaging in drug use as the most prominent. Some dropped out as a result of financial challenges, but others dropped or missed class at will. Exposure to drug-using peers was a contributory factor with some reporting that they started using drugs as early as in primary school. A lack of commitment to school was shown in some students:

“[Those who] will not be attending school; they will spend their school time hanging behind the school [wall]” (Participant 005, non-user, female, 20 years).

“Like one will not be attending school ... looks forward to finishing or dropping out of school so that they start engaging in drug use” (Participant 003, past-user, female, 18 years).

However, not all young people in Mufakose lacked the commitment to school, work or sport and indicated this as a protective factor. Some young people’s commitment to school, sport and work has been essential in keeping them off the streets and off the drugs, as highlighted in these excerpts:

“...if they are unable to pay [money for fees], one should find something to do” [to raise the money] (Participant 038, user, male, 19 years).

“For some of us who go to work, if we get arrested, it will be a problem” (Participant 032, non-user, male, 18 years).

“In soccer, we are not allowed to use drugs” (Participant 029, non-user, male, 18 years).

Respondents also discussed how some young Zimbabweans who are supposed to be in school and are given money to pay for school fees, divert this money and instead use it to buy drugs.

“Even when one is given money to pay for the fees, one will prefer to divert the money towards purchasing drugs as they go around the neighbourhood with the friends. That is why there is an increase in school drop outs because drugs cause young people to lose focus in life” (Participant 038, user, male, 19 years).

The long-term implications of dropping out of school were also discussed by participants. These include an increase in substance use disorders, violence and increase in crime rates as the young people do not have anything to do with their time and later on resort to drug use. They lose focus on their life as reported in the preceding quote (*Participant 038, user, male, 19 years*) and these further quotes:

“One will never think about looking for employment or going back to school once one starts using drugs” (Participant 003, past-user, female, 18 years).

“When one has a talent ... once that person engages in drug use, then one will not progress”
(Participant 008, non-user, male, 18 years).

This however is not the case with those who engage in sporting activities. Career guidance and counselling is provided for during their activities by the coaches. This helps the young people to have a sense of belonging and to be more focused in their career by not engaging in drug use.

“The coaches who train us in karate and sometimes sit us down to lecture us on the effects of drug use” (Participant 029, non-user, male, 18 years).

During the focus group discussions, some drug users disclosed that they did not receive the same encouragement and opportunities as other people in the community. Instead, they described spending most of their time engaging in drug use and sent out a cry for help saying that:

“Ever since I started using drugs, no one has ever come to me with tips on how to stop using drugs” Participant 026 (User, male, 21 years).

After a review of literature, nothing was highlighted on this theme for other young people and it is possible that the theme is specific to Zimbabwe.

vii. Beliefs

A number of themes emerged from the participants in the present study concerning the cause of drug use in Zimbabwe. First, some, believed that the reason why some young people turn to drugs is due to evil spirits. The belief is that the evil spirits would ensure that the targeted individual does not progress in life.

“It is like with evil spirits; the evil spirits may cause one to want to use drugs so that one does not reach the intended destination” (Participant 008, non-user, male, 18 years).

A popular belief in Zimbabwean culture is that if one becomes mentally ill, it is because of an evil spell that has been cast on them by their enemies. In the following quote, the participant relates how a stepmother laments over her stepson to be set free:

“She lamented that if ever there was anyone using him, [or who had put a curse on him] ... he/she should have mercy on him because he walks” (Participant 009, user, female, 24 years).

People coming from a religious background especially the Christian faith believe that there are demonic forces that rule over certain geographical areas. These spirits mislead the habitants of the area into doing evil deeds that are against their belief system. The territorial spirits were

also identified in the causation of drug use among young people in the Mufakose. These demonic forces are highlighted in the following quotes:

“I think in here in Mufakose it is a territorial spirit” (Participant 007, non-user, male, 20 years).

“We are living on a negative ground” (Participant 036, user, male, 20 years).

Cannabis use has always had a place in different religions around the world over. Some sects in African cultures believe that cannabis possesses special universal protective powers that protect one against injury to life (Parrinder, 1983). Participants also discussed how cannabis can be used in cleansing an individual’s home from evil spirits and even exposing evil deeds. The potential use of cannabis in this way is illustrated below:

“One can use cannabis to cleanse the home of evil spirits ... or even chase away demons that will be following one up” (Participant 006, user, male, 20 years).

“If you come across someone who is against cannabis, there is something wrong with that person. Cannabis exposes hidden things” (Participant 039, user, male, 21 years).

“The witch doctors, the prophets and like people dislike cannabis” (Participant 036, user, male, 20 years).

“If you burn cannabis in the home, even the robbers will not enter” (Participant 040, user, female, 19 years).

A number of respondents discussed how when people use drugs they often engage in very risky behaviour, resulting in quite serious injuries. However, it was suggested by some that these injuries were not the direct result of drug use itself, but rather were due to evil spirits forcing these individuals to engage in risky behaviour resulting in quite serious injuries:

“.... we are fighting against evil spirits. The evil spirits see that one is fit and strong, now when one is high on drugs, they will find a loose point and attack the individual, causing harm” (Participant 036, user, male, 20 years).

“Another person climbed on top of the house and threw himself down. That is the work of the evil spirits not the drugs” (Participant 038, user, male, 19 years).

“People will say that the person died because of drugs when it was the evil spirits that came and took over the person” (Participant 039, user, male, 21 years).

The medicinal use of cannabis is controversial globally as well as in Zimbabwe (Kells, 2016; Melville, 2016). Research to determine the health benefits of cannabis and the implications is ongoing. However, young people in Mufakose reported the use of cannabis in the management of some ailments. Comments reflecting this included:

“Cannabis can be used to treat a lot of ailments. Even the elderly say cannabis can be used to treat a lot of ailments” (Participant 006, user, male, 20 years).

“Cannabis is a herb... someone with asthma can be diagnosed and treated with cannabis and might not need treatment for a long period of time” (Participant 036, user, male, 20 years).

In summary, one`s beliefs about the use of drugs is determined by one`s exposure to the drug and cultural orientation. The African tradition has always had a place for cannabis use, although the use was governed by the elderly in society. A popular belief among the young people in all categories was the assertion that cannabis can be used to treat various ailments. Research is ongoing on the medical use of cannabis in modern times though its use has been since ancient times (Bostwick, 2012; Hoffman & Weber, 2010; Koppel et al., 2014). Even in Africa, where cannabis cultivation is widespread, research should be done on the health benefits.

viii. Decision making

Decisions have to be made to succumb to peer influence and engage in drug use or to lead a drug free life. This was described by one participant who said:

“What I know is that to use or not to use, to stop or not to stop, is a personal decision one has to make. Engaging in drug use is a personal decision that one has to make” (Participant 007, non-user, male, 20 years).

A decision to remain resolute emerged as a protective factor for people who do not use drugs. This is despite the prevailing challenges many people who do not use drugs face, such as peer influence and drug availability. To show that their reasons for not using drugs were personal decisions, some young people used expressions like “what the heart wants”, “it [drug using behaviour] is not in them at all”. Non-users reported that they made a choice to remain sober.

Decisions to engage in drug use can be made based on a variety of reasons. The need to experiment with drugs emerged as a popular risk factor reported by both users and non-users, male and females. Terms used to show the need to experiment included ‘trial’, ‘taste’, ‘prove’, ‘test’ and ‘get a feel of the drug’ or ‘level of high’. Comments made with regards to the need to experiment with drugs include:

“One can ask for the drugs from them just to see how it goes with him” (Participant 007, non-user, male, 20 years).

“Just wanting to have a test and you now want to find out how high the drugs can get you” (Participant 021, past-user, male, 19 years).

Using certain drugs was also reported to lead one to want to experiment further with other drugs [gateway drug]. The curiosity that one develops after exposure to drug use may lead one to experiment with other drugs. If the results are favourable, then one will have begun the journey of indulging in the practice. This is illustrated by one participant who said:

“Once you start smoking cannabis, it will lead you to want to experiment with other drugs such as mangemba [medications used in the treatment of psychiatric patients] or broncleer”
(Participant 006, user, male, 20 years).

In summary, an exploration on the role of motivation in drug use showed that intrinsic motivation or an internal drive to change should drive an individual to live a drug free life (DiClemente, 1999). Research has found that a positive self-concept is highly favoured to motivate individuals towards abstinence while extrinsic factors such as health concerns, fear of legal implications or social influence exerts lower levels of influence (Downey, Rosengren, & Donovan, 2001; McBride, Curry, Stephens, Wells, Roffman, Hawkins, 1994). In this study, participants reported all the above dimensions as protective against drug use. However, the extent of their influence on the young people reporting was not measured.

4.4.2 Relational Factors

Interpersonal factors have an impact on one`s interaction and connectedness with the outside world. If there is disharmony in this circle, termed the “meso” level by Bronfenbrenner (1994), one can be tempted to engage in drug use in order to cope with stressors within the circle. On the other hand, the same circle can be protective against drug using behaviour. The circle involves relations with the peer group, family, and school (Bronfenbrenner, 1994). Peer groups and family factors will now be discussed.

i. Peer Group Factors

Peer influence is critical during the adolescent period, because young people are starting to break away from the family, and the group becomes a major source of companionship. The peer group is therefore the most critical of all associations young people have outside the family circle. The peer group provides a zone of comfort and advice away from authority figures. If one is not careful, decisions made within this group can lead to incarceration because of violent crimes such as rape, armed robbery or murder and some end up developing depression or committing suicide (Abdul, 2016; Scales et al., 2015).

Exposure to drug use by friends and associates is a strong risk factor leading to drug use. Young people are bound to get involved in activities that occur within their circle of friends as a show of solidarity. The friends and associates the adolescent chooses to hang around with play a role in determining whether the desired behaviour will be perpetuated or not.

Terms used by participants to describe the role of the peer group in moulding their behaviour include: ‘the company that I keep’, ‘the people I spend my day with’, or ‘am still friends with’.

Current users expressed their solidarity in using drugs through the following phrases: “we use the drugs together as a group”, “most of my friends use”, “everyone else is doing it or using”, “we contribute to buy”, “we encourage each other”, or “I ended up joining them”. Some young people in Mufakose succumb to peer influence and end up engaging in a life of drug use.

Comments reflecting this include:

“I just saw my friends using and I admired it. That is how I started using drugs” (Participant 003, past-user, female, 18 years).

“One of my associates called me and asked me to have a taste of cannabis” (Participant 006, user, male, 20 years).

“He used to just come and sit and use his drugs in my presence. He offered them to me one day and I took up the offer” (Participant 009, user, female, 24 years).

Some of the reasons for engaging in drug use were simply because they wanted to feel like they are part of something, or part of the “in group” or to avoid being bullied. This way of thinking is highlighted by the following participants:

“One wants to be in the same league as the users” (Participant 023, user, male, 19 years).

“One can then seek for protection and usually it will be from the drug users” (Participant 036, user, male, 20 years).

Peer influence was also identified as a precipitating factor in a relapse. Past-users continue to face and resist the temptation from their user friends. Despite being open and disclosing to their friends that they have decided to stop using, their friends are not supportive in this decision. The influence of the peer group is discussed by a number of participants who said:

“If we just sit around, someone will show up with some cannabis such that even if one was not interested in using, one will end up using it despite having stopped” (Participant 002, past-user, male, 24 years).

“They still come looking for me, informing me that they are still waiting for me to come back to their fold” (Participant 019, past user, female, 20 years).

Not all young people who are exposed to a peer group who uses drugs engage in drug use. Personal decisions to lead a drug free life was seen as a protective factor against initiating drug use. Some young people have reported that they remain committed to their decision not to use drugs despite their association with other young people who use drugs: This is highlighted by one participant who said:

“They have tried to lure me into using cannabis, but I have said no” (Participant 007, non-user, male, 20 years).

The peer group is a very big contender when it comes to the young people`s decision making as decisions made within the group may surpass any input that might come from anyone

outside their circle. Some young people fall victim to peer influence and engage in risky behaviours that endanger their lives in order to ensure their continued stay within this social grouping. Comments reflecting this include:

“When I then used the drugs, my friends were happy because they had always wanted that”
(Participant 003, past-user, female, 18 years).

“I only use the drug when I visit my friend. The people at home do not even know that I use drugs, so when I am at home I do not use” (Participant 010, user, female, 19 years).

Past-users seemed to understand the impact of peer influence as most of them changed friends in order to cope. The change in friendship from users to non-users is protective as it helps them to sustain their sobriety. Some who have successfully gone through the transition of changing friends do not disclose the drug use experiences with their new friends. Group cohesion is essential for continued sobriety. For the past-users, group norms usually include abstaining from drug use:

“In our group, we all stopped using the drugs. So, if we catch one using the drugs, we will tell that person to leave the group because one will have chosen to get lost” (Participant 017, past-user, female, 22 years).

“The boys had stopped using drugs, now they restarted and by so doing, we no longer interact” (Participant 022, past-user, male, 20 years).

In summary, the peer group has a positive or negative influence on the young person who is transitioning through adolescence into adulthood (Rumpold et al., 2006). Consistent with previous research, peer influence was also reported by the participants to have a bearing on young people's drug use. The peer group is the young person's zone of comfort away from all authority. Drug use initiation reported by the participants showed that this usually occurs within the circle. Most young people did not disclose their drug use at home but their peers knew about the drug use. The need to fit in the group were the most prominent of the factors. The disclosure process among peers either reinforced the behaviour or deterred the individual from further drug use. All respondents reported 'strengthening' each other on their current position in regards to, drug use, either as users, non-users or past users. Some non-users, because of their position on drug use and resilience, felt they could associate with current users while maintaining their sobriety. Past users either risk being tempted back into drug use by fraternising with using peers and so have cut ties with current users or associate with them briefly and proceed with their other activities A change of friends from users to non-users was reported as beneficial by the past users.

ii. Family Factors

The family plays an important role in the socialization process and has been recognised as such in much of the literature (Bahr et al., 2005; Judith S. Brook et al., 2001; Judith S. Brook, Morojele, Pahl, & Brook, 2006b; Kopak, Chen, Haas, & Gillmore, 2012; Kostelecky, 2005; Windle, 2000). Child rearing practices, restrictions imposed on young people within the family, family use of drugs and the family's ability to provide guidance and counselling were all important themes in the participants' narratives on what can diminish or increase their drug use behaviour.

The role of the family is that of being a socializing agent whereby its offspring is guided by the norms and values enforced through the socialization process (Baumrind, 1978). Other elements found within society affect the manner in which the family raises its siblings. These factors include unemployment or loss of a job (Parke and Buriel, 2007). As a primary socializing agent, the family plays an important role in the socialization of an individual from birth till the end of life. Guidance and counselling is essential in the upbringing of the new offspring in order for them to conform to societal norms and values. Despite all efforts to ensure their offspring become role models in society, other forces, both internal and external can disrupt the functional family system and lead to deviance, conflicts and rebellion.

- Family relations /conflict / interaction patterns

Using drugs as a measure of managing family conflict was reported by many participants in both the in-depth interviews and the group discussions. Both males and females alluded to the fact that within the home setting, interpersonal conflict will always be present but has to be managed accordingly for the family's relationship to be healthy. Many of the respondents reported that many people turn to drugs as a way to cope with the stress of the conflicts in the family. Given that drug use was used as a coping mechanism to manage these interpersonal relationships, this risk factor was described under the section of individual risks.

- Child rearing practices

A number of respondents in the present study discussed how parenting or child rearing practices may influence whether an individual uses drugs or not. Many reported that the main reason why young people would turn to drug use is due to a lack of involvement of their parents or caregivers in their day to day lives. Parents seem to be too preoccupied with tasks other than

parenting their own children. The lack of close monitoring means the parents miss negative behaviours. This was shown in the following quotes:

“My father would be wherever he would be. He would just get home, greet us and get into his bedroom” (Participant 009, user, female, 24 years).

“Some parents do not have time to correct their children`s behaviour. They accept [any behaviour] until the child goes wild” (Participant 015, non-user, male, 20 years).

“Some of our parents do not even know that we use drugs” (Participant 023, user, male, 19 years).

“I would be given money by my dad and I would buy drugs” (Participant 010, user, female, 19 years).

While some parents are busy with their own careers, others take time to get involved in the life of their children. The active involvement of the parents helps the young persons to live a life free from drug use. In some cases, parents would even sit down with the children and discuss drug use as highlighted by the following participants:

“Our parents sit us down and lecture us on the effects of drug use” (Participant 029, non-user, male, 18 years).

“Parental guidance as they tell us about drug abuse and encourage us not to use drugs” (Participant 012, non-user, male, 20 years).

It was also highlighted that in Zimbabwe, many young people are raised by their grandparents. This could be a result of the children`s parents having died, some because of HIV/AIDS infection, or because they are living in other countries in a bid to fend for the family because of the lack of employment opportunities in the country. Some young people have little respect for the elderly and become misguided as discussed by the participants below:

“In cases where one is staying with grandparents who are old, one has nothing to be afraid of because one will be aware that they will not do anything to them. But if the parents were present, they will know what will happen to them if they found out [about their drug use]” (Participant 003, past-user, female, 18 years).

“For those children raised by grandparents, the challenge is that some of the grandparents are too weak and frail to control the children” (Participant 014, non-user, male, 21 years).

Other young people are however fortunate because they listen to the guidance from the elderly members of the family and have a strong bond with the elderly. The relationship on its own then becomes protective of any external forces including peer influence:

“He [my grandfather] asked me why I was using drugs and I told him everything” (Participant 017, past-user, female, 22 years).

“That touched me a lot to think that I was troubling my grandmother with my habit” (Participant 003, past-user, female, 18 years).

In addition to grandparents, some young people are also raised by other members of the extended family. Participant 009 (user, female, 24 years) said that her brother started using drugs when he went to live with the aunt after their mother passed on. The aunt is said to be permissive thus he became a spoilt child whom they are now having difficulties trying to control.

In summary, if the parent is not involved in the child's upbringing due to other commitments, the child is bound to develop behaviours which the parent might fail to pick up (Hawkins et al., 1992; Rodgers and Rose, 2002; Traube et al., 2012). Parental monitoring and involvement were reported as protective factors for drug use. Parents who were said to be loving and responsive took time to talk to their children and their children depended on them for help when faced with challenges (Crosnoe, Erickson, and Dornbusch, 2002). Parental involvement was also reported by some of the participants particularly the non-users who said that their parents sat them down and discussed with them the dangers of drug use.

- Family restrictions

Family restriction was identified as a protective factor against drug use in young people who have remained resolute in the face of exposures to drug use. Restrictions were noted in responses to the question on disclosure about drug use where most of the participants reported not having disclosed their drug use to their families. This was in fear of punishment as mentioned by the following participants:

“I was going to get myself in trouble [by disclosing about the drug use]. I would be beaten because the people at home do not like the idea, they do not allow it. The law from home carries more weight because the people at home are against the practice” (Participant 004, user, male, 19 years).

“The parents also have rules that they do not want their children to use drugs” (Participant 006, user, male, 20 years).

“The mothers are very strict when it comes to their children” (Participant 027, user, male, 22 years).

Only one participant, who is a current user reported that her family was aware of her drug use:

“As for me, my relatives have accepted that I use drugs but personally, I cannot use drugs in my father's presence. He only hears it from people that I use but he has never seen me using” (Participant 009, user, female, 24 years).

She, however, went on to lament about a negative attitude that the family shows her.

In summary, family restrictions were reported to be protective against drug use by both users and non-users. Restrictions led to none of the users and past users initiating drug use at home.

Some reported the negative effects that would have resulted, such as being beaten by their caregivers. Family restrictions were also highlighted in the literature as protective of young people's drug use as the young person seeks to identify more with the family than the peer group (Brook, Brook, Gordon, Whiteman and Cohen, 1990). The protective / protective component of the resilience model implies that young people who come from a home where the relationship with the caregiver is healthy tend to be devoted to their schoolwork and lead healthier lives (Abdul, 2016) creating a range of reinforced protective factors.

- Exposure to drug use by the family

A challenge with drug use behaviour is the behaviour portrayed by other family members in regard to drug use. Parental or sibling drug use behaviour provides a negative model for the young person and exposes them to the culture of drug use.

“My grandfather uses drugs, so should I. and females usually claim that their mother uses drugs” (Participant 039, user, male, 21 years).

“Let us say within the family, if the grandfather uses cannabis, his son used cannabis, it will be like it is our culture” (Participant 038, user, male, 19 years).

Parental drug use was also reported by many participants as a risk factor for drug use. Some of the users described that when they were growing up their family members would openly use drugs in the home, normalizing drug use behaviour:

“They might also be observing the behaviour from their parents and think it is okay to do it” (Participant 001, non-user, female, 22 years).

“From home, the parents could be using drugs as well” (Participant 005, non-user, female, 20 years).

“Because for me, my father used cannabis. We used to see it in the home and we could actually notice that it was cannabis” (Participant 039, user, male, 21 years).

Sibling drug use was reported by most participants as an encouragement to use drugs by younger siblings.

“The young people spend the day in an environment with brothers who use cannabis at home” (Participant 019, past-user, female, 20 years).

“...one will say my siblings use drugs and I don't; my brother is always high so I should also get high” (Participant 025, user, male, 18 years).

“...he never used to take drugs but his brothers did... now he uses drugs” (Participant 007, non-user, male, 20 years).

Exposure to drug use was also reported to come about when

“Parents send their children to go and buy the drugs for them and so at the end of the day, that child will start looking for money to buy the drugs for self”
(Participant 018, past-user, female, 18 years).

In some cases, grandparents are reported *“to agree to the idea of selling drugs from their homes because they know that money for upkeep comes from there”* (Participant 040, user, female, 19 years).

In summary, parent and sibling drug use was seen as a major risk factor for drug use in as much as the parents and siblings non-drug use becomes protective. Some non-users reported coming from a family of non-users that had modelled their position not to use drugs. At the same time, some users voiced exposure to drug use from the family resulting in them becoming users themselves. Studies on the role of parents and siblings in drug use behaviour have informed of the role played by the family in modelling the young person`s behaviour (Bahr et al., 2005; Jiloha, 2009; Nasim et al., 2007; Peltzer, 2009; Windle, 2000).

- A family culture of non-drug use

While some young people indicated that the family exposed them to drug use, others said the family was their source of strength as the family members lived a drug-free life. Role modelling from the elderly in the family was noted to have positively influenced the young people to live a drug free life as highlighted below:

“In my family, there is nobody that uses drugs. So, I try to copy that from them, their way of life” (participant 007, non-user, male, 20 years).

“I think my background. I have grown up in an environment where no one ever has time to think about drug use. I have never been exposed to the practice at home. So, for me to just start using drugs will be strange. Where will I have obtained the guts from?” (Participant 001, non-user, female, 22 years)

“They grew up in homes where they were never exposed to the drugs” (Participant 007, non-user, male, 20 years)

As set out above, risk behaviours portrayed by family members have the ability to influence the adolescent`s decision making and lifestyle. Exposure to drug use by parents, siblings and other family members together with family conflict were reported as major contributors to drug using behaviour by young people in this study. On the other hand, a strong family presence and positive role models provide a protective environment for young people encouraging them to avoid drug use.

4.4.3 Community Level Factors

Community level factors are macro level factors that affect the young people from the socioeconomic environment (Bronfenbrenner, 1994) . Hawkins et al (1993) and Wallace and Muroff (2002) agree that drug availability and cost, neighbourhood disorganization, laws and norms governing drug use and economic deprivation have either a positive or negative effect on young people`s view towards drug use.

i. Drug availability and cost

Zimbabwean laws prohibit the cultivation of cannabis and the manufacture of drugs such as broncleer. Cannabis that is used in the country is mainly imported from countries such as Malawi or Mozambique while broncleer is manufactured in South Africa. Access into the country is through the country`s borders. Young people lamented over the porous border system and encouraged the authorities to reform the border control laws. Terms used to describe drug availability and easy access to drugs include “sold everywhere”, “all over the streets”, “get it easily.”

Continued exposure to and the availability of drugs in the community makes access to them by young people easy thereby making them susceptible to use.

“A lot of people move around smoking cannabis in the streets as they go about their business”
(Participant 004, user, male, 19 years).

“So, for one to leave the habit it becomes very difficult because wherever one goes, one meets with people who are using the drugs” (Participant 002, past-user, male, 24 years).

“But if they are available, if we get hold of any money, we will go and buy the drugs”
(Participant 028, user, male, 20 years).

Supplying drugs in the community has become a form of employment for some young people. Some take advantage of the health delivery system to obtain the psychiatric medication destined for a mentally ill relative even if the relative has since died.

“One can take the health card for a relative to the clinic to get a resupply of the drugs, then come back and sell the drugs” (Participant 031, non-user, male, 21 years).

The low cost of the drugs is also a bait that lures young people into drug use as the cost of tablets ranges around ten cents for two tablets on the black market. This was a mockery for some participants who use the tablets to get high as those who use other substances such as broncleer felt they were of a superior class than them as they require three dollars to buy one bottle.

Drug availability and cost is a universal factor in the fight against drug use. The increased availability of drugs in the country was a major concern among the young people as they queried how the drugs were getting their way into the country and flooding the market. Wallace and Muroff (2002) write that drug availability may be categorized as physical availability (e.g. the number of outlets selling the drugs), social availability (e.g. the promotion of drug use at the point of sale) and economic availability (e.g. the price of the drug compared to income). The price of the drug and money available to buy the drug determines the drug of use by most young people. Young people in the informal sector, because of their constant handling of cash, preferred using broncleer because of a “status” they associate with the drug. Those unemployed preferred the use the tablets since they are cheap and affordable for them.

The three types of drug availability described above are present in Mufakose and are evident in the schools, families and peer groups as reported by the participants. However, to cater for the cost of the drugs, young people contribute the little money they have to enable them to buy the drugs which are more expensive (e.g. broncleer) and they share the drug. The young people also shower praises on those who have joined the drug using groups thereby promoting the social availability. While exposure to drug use might have a negative impact on someone who has witnessed the negative effects, this was reported by the non-users in the interviews or discussions as being a factor in their non-use.

Young people reported being initiated into drug use whilst still in school. School in this context refers to both the primary level and secondary school level. The age of initiation into drug use was also reported in studies done in other countries such as Kenya, South Africa, United Kingdom and America (Othieno, Ndetel, Obondo, & Kathuku, 2000; Sanders, Lankenau, & Jackson-Bloom, 2010; Sobeck, Abbey, & Clinton, 2000; Swadi, 1999; Townsend, Flisher, & King, 2007). The major worry with early initiation in drug use are detrimental effects in later life (Ashton, 2001). There is a higher probability of increased risk of harm in young people who engage early in drug use according to the World Drug Report, 2016 (UNODC, 2016). Effects reported by the UNDOC include drug dependence and risk of heavy dependency, lung problems, memory impairment, psychological developmental problems and mental health problems together with a poorer cognitive performance (UNODC, 2014). Early intervention is urgently required to reinforce protective factors (Swadi, 1999) thereby combating the escalating drug problem since more young people continue to be exposed to drug use within the community.

ii. Community disorganization

The Mufakose community is exhibiting signs of disorganization which pave the way for its young people to use drugs. These signs of disorganization include a lack of guidance for the young people, an increase in crime rates and early initiation into drug use as a result of all these behaviours. According to reports from the participants, the local drug dealers are said to be organizing soccer tournaments in the community. The drug dealers sponsor the teams with the prize money whilst selling their drugs to the public during the event. The same are said to be ploughing back into the community by helping with funeral costs for those families who cannot afford to bury their loved ones, thereby fuelling their trade.

Given this community disorganization, young people reported being initiated into drug use whilst still in school. School in this context refers to both the primary level and secondary school level. The age of initiation into drug use was also reported in studies done in other countries such as Kenya, South Africa, United Kingdom and America (Othieno et al., 2000; Sanders et al., 2010; Sobock et al., 2000; Swadi, 1999; Townsend et al., 2007). The major worry with early initiation in drug use are detrimental effects in later life (Ashton, 2001). There is a higher probability of increased risk of harm in young people who engage early in drug use according to the World Drug Report, 2016 (UNODC, 2016). Effects reported by the UNDOC include drug dependence and risk of heavy dependency, lung problems, memory impairment, psychological developmental problems and mental health problems together with a poorer cognitive performance (UNODC, 2014). Early intervention is urgently required to reinforce protective factors (Swadi, 1999) thereby combating the escalating drug problem since more young people continue to be exposed to drug use within the community.

iii. Cultural norms and practices

The Zimbabwean culture has always been restrictive of drug use in that it does not allow young people to use cannabis. This was restricted to the elderly members of the society as described by a number of participants:

“They would use cannabis but one would never come across a young person using it”
(Participant 013, non-user, male, 20 years).

“The problem is that in Zimbabwe we have lost our culture. We are just following any other culture that comes our way” (Participant 013, non-user, male, 20 years).

These sentiments were vented by one participant when insisting that young people now lack guidance on societal norms and values or take on new and negative cultural practices. This was confirmed in the following statement by another participant:

“Some young people are said to be involved in drug use as a result of their initiation as Nyau dancers” (Participant 018, past-user, female, 18 years).

iv. Laws

The Zimbabwean laws do not permit the medical or recreational use of illicit drugs. The harsh economic climate that the people of Zimbabwe see themselves living in has predisposed many to the life of drug use. The problem has however escalated to the point where even well-respected members of the society together with law enforcement agents are now involved in drug dealings.

“Some of our well-respected elders you will be surprised to see them dealing in drugs” (Participant 039, user, male, 21 years).

“We actually use the drugs together with the police officers in the streets” (Participant 023, user, male, 19 years) with Participant 026 (user, male, 21 years) completing the statement: *“the soldiers use cannabis and broncleer”*.

“One can tell that those are drugs that are being ferried by the police officer on their way home and children observe that” (Participant 012, non-user, male, 20 years).

However, the fear of breaking the law was protective for some young people who reported that it has helped them to maintain a drug free life.

“...even if you think you are in an enclosed area, you are still at risk of getting caught and if you go [to prison], you will not come back easily” (Participant 003, past-user, female, 18 years).

“This is because we do it behind their backs, in the street drains where it is hidden because we know that we can be arrested” (Participant 023, user, male, 19 years).

The current legislation appears to be inadequate in controlling drug availability especially in the high-density areas. Wallace and Muroff (2002) indicated that adherence to laws governing drug use is usually dependent on the location of the users. Currently the drugs that are used by young people in the country are smuggled in from other countries (Chimhete, 2010; Chirinda, 2014; Gono, 2014; NewsDay, 2011a; Nyoni M, 2014; The Standard, 2014). Most participants felt that the porous state of the border control system ensured the drugs continue to enter into the country.

Apart from the leakages at the borders, the law enforcement agencies are also found wanting when it comes to issues to do with drug use and control. Some participants reported using drugs

together with the police officers. Some cried foul over the seizures conducted by the police as the law enforcers end up confiscating the drugs but letting the offenders free. The participants felt that there is a need for a review of the laws governing police conduct and that there should be strict monitoring of their conduct in public.

Some young people also highlighted the need to have controls in the local health sector where some of the drugs are being sourced from, especially the antipsychotics and other prescription drugs such as Histalix. Stringent monitoring of the drug dispensing system is required as it is unethical for the health professionals to be peddling drugs. Local preparations (e.g. Betaco) is said to be an over the counter drug despite its high alcohol content. Some young people are said to be opting to use the local brands since they are legal but the impact on mental health is reported to be the same with that of the illicit brands. The dispensary system in the health sector must be strengthened in order to curb prescription drug misuse, including refresher courses on professionalism and ethical conduct for health professionals.

v. Media influence

The role of the media is to educate, entertain and inform the nation of issues that affect their day to day lives. The media can also provide negative role models for young people. In Zimbabwe, access to satellite stations is granted through pay-per-view channels. A common sentiment among the young people was that the media is influencing the young people negatively as it continues to show people who are engaging in drug use. These personalities will be celebrated on the media.

“The media is now leading in the cause because if you go to videos, you will see videos from musicians where people in the video are using drugs and all. The females in the videos will be scantily dressed” (Participant 036, user, male, 20 years).

Other participants added:

“Because young people will see them performing and think that that is the in thing, that is what is fashionable” (Participant 005, non-user, female, 20 years).

“Sorry but I have to say this that Zimdance hall music [a popular genre among Zimbabwe`s young people today] influences young people today. Some musicians for example (name withheld) sing about drugs” (Participant 007, non-user, male, 20 years).

Another participant shared the same thought:

“They should at least help us so that such things are not aired on television. ... to those who watch, it might influence them when they see the celebrities smoking and drinking [illicit substances]. Some young people will think it is the right thing to do. As for me I watch the God channels” (Participant 008, non-user, male, 18 years).

There are various forms of media available in Zimbabwe that play an important role in informing and educating the nation on issues surrounding their livelihood. However, the same can be a powerful tool in exposing young people to deviant behaviours. Young people reported videos shown on television and lyrics played on radio to be influential towards drug use behaviour. A local musical genre ‘Zimdance hall’, is popular among the young people and has contributed negatively towards their living a healthy lifestyle as described by the participants. The genre promotes all forms of deviant behaviours from drug use, violence and prostitution.

vi. Religion

Religion as a belief system and a strong commitment to it were reported as protective against drug use as it offered resources such as counselling services and activities that attract the attention of young people. Religion provides a sense of moral obligation. Societal norms and values are maintained in line with one’s belief system. Comments reflecting this include:

“What makes them to choose that way is that some of them go to church so they are governed by their church’s values” (Participant 006, user, male, 20 years).

“There are a lot of factors associated with going to church, but someone who takes time to go to attend a church service is better” (Participant 001, non-user, female, 22 years).

“They can come to church, the solution for such children [current drug users] is there, the children can be reformed but it will not be easy” (Participant 007, non-user, male, 20 years).

The increase in drug use and its adverse effects on society is now so widespread in the community. Religious leaders now include advice to young people in their sermons and have had to modify their approach to youth programs:

“If it is a Sunday service and they do not talk about it [drug abuse] then it wasn’t a service” (Participant 031, non-user, male, 21 years).

“In other churches, youth go out to the lake with their Pastors to discuss” (Participant 018, past-user, female, 18 years).

Association with religious peers was reported to be highly rewarding for those who are non-users or past users.

“Most of those whom I now spend time with go to church ... they spend their time involved in church activities” (Participant 002, past-user, male, 24 years).

“We all decided to stop using drugs and to go to church” (Participant 003, past-user, female, 18 years).

“Personally, I was brought up in a Christian life, so we were told continuously that drugs are bad” (Participant 008, non-user, male, 18 years).

In summary, religion is a form of a social institution that comes together with its accompanying beliefs, practices and symbols (Meichenbaum, 2005). The belief in a supernatural being enables one, for example, to maintain one's morality. The family's religious beliefs have been reported as a protective factor against drug use (Brook et al., 2001; Wallace & Muroff, 2002). The same effect of religion was reported by some of the participants, especially the non-users, in Mufakose as protective against drug use. However, it is not always the same, as some users also reported attending church and participating in some church activities as well. The protective aspect of religion lies in personal commitment or relationship with the supreme being in contrast to mere religious attendance (Kliwer & Murrelle, 2007; Moreira-Almeida & Francisco Lotufo Neto, 2006).

4.5 Table 4 Summary of framework coding

Level	Risk factors	Protective factors
Individual / micro level	Stress due to: loss of a loved one, the workplace or interpersonal relations. Stressors from the home environment Boredom due to unemployment or lack of activities. Lack of commitment to work, school or sport. One's belief system Decision making	Decision making Commitment to school, work or sport One's belief system
Relational / meso level	Association with a peer group that uses drug leading to exposure and experimenting in drug use behaviour. Family factors included family relations, family conflict, family interactional patterns. Child rearing practices Exposure to drug use by parents, siblings or other relatives.	Associating with a non-drug using peer group. Family factor include a family culture of non-drug use. Family restrictions
Community / macro level	Drug availability and cost Community disorganization Cultural practices, norms and values. Media influence	Religion

4.6 Chapter Summary

The narratives provided by the participants highlight a range of risk and protective factors at different levels in a young person's life. These ranged from individual factors through to broader societal factors. Risk factors however offset the protective factors leaving young people in Mufakose vulnerable to drug use.

As noted in studies from a number of other countries and regions, the major systems that have an impact on Mufakose's young people's drug use include the micro, meso or macro levels. These young people who are exposed to risk have a higher chance of using drugs than those who are protected. Risk factors identified included boredom, living in an unsupportive family, living in a community with visible drug use and availability of drugs. These together create an assemblage of mutually reinforcing risk factors. Protective factors against drug use include a family atmosphere surrounded with love, warmth and understanding, associating with peers who do not use drugs and a deep religious conviction.

5 CHAPTER FIVE: CONCLUSION

5.1 Introduction

The participants showed an awareness and wide experience with drug use as well as clear opinions of what they understood were factors that put young people at risk of using or protected them from using drugs. Agents of socialization such as the family, the peer group, the school, religion and mass media have been shown to make a great impact on the use of drugs by young people. The study showed that there are clear risk and protective factors determining drug use behaviour among young people living in Mufakose. The participants were clearly knowledgeable and willing to share their insights no matter what their drug use status. The study findings reflect similar and prevalent findings from other studies across the world.

5.2 Recommendations

Urgent measures are required to address the risk factors present in the community. Prevention measures against drug use should be aimed at strengthening the protective factors present within the individual, peer group, family, school and the environment. Interventions that may be instituted to help curb drug use by young people may be implemented at the micro, meso and macro levels. At micro or individual level, interventions may include assertiveness training and coaching clinics for one to be able to withstand pressure from the peer group. This will help to empower them to be able to resist peer influence.

Interventions at meso level include parenting classes for parents of pre-adolescent and adolescent children may go a long way in helping the community. Some parents need to be guided on how to monitor their children against drug use and need to be educated on the rewards obtained from a warm and trusting relationship with their children. These interventions might be effective in fighting the increase in drug use by young people in the community and country at large.

Macro level interventions may focus on conducting refresher courses on professionalism and ethical conduct for health professionals, especially those working with antipsychotic and addictive medicines as they were implicated by young people as suppliers of some of the drugs used. Monitoring of drug dispensary systems should also be modified to allow for transparency in issuing drugs that are prone to abuse by young people. There is also need for the health

professional to strengthen their home visits for the mentally ill patients who are reported to be unable to attend the routine out-patients' clinics at the local clinic or hospitals.

The government should review legislation concerning drug availability. The outcry by young people in this study on the continued availability of smuggled drugs should not fall on deaf ears. Stringent measures should also be instituted to monitor law enforcement agents who are involved in the drug business.

There is also need to rehabilitate the recreational centres so that young people can engage in grassroot sporting activities to help keep them off the streets and off drug use (Tambala, 2016).

5.3 Future research

As the findings and recommendations shown in this study are based on a study that was conducted on 40 young people, further research is recommended. Further studies should assess risk and protective factors for young people in other districts of Zimbabwe in order to validate the findings as relevant to young people in the country. The impact of the risk factors on young people and their bearing on decision making in the non-users also needs to be explored. Given the early age of drug use initiation, quantitative studies are recommended to ascertain the extent of age of initiation into drug use within the primary school age group and to identify the drugs that are most prevalent for use by that age group. Further qualitative studies are recommended in order to identify the risk and protective factors affecting young people in other provinces in the country in order to assist mental health professionals to intervene appropriately.

5.4 Limitations

This is the first time that the researcher has done a qualitative study. Challenges encountered along the way have enabled the researcher to grow in the field of research. The risk and protective factors identified in the study were representative of the young people in Mufakose who visited the recreational centres for a variety of activities. Young people who do not frequent these centres were not included hence their contributions were left out. Also, the language used for data collection segregated those young people who stay in Mufakose but use other dialects as their first language because of their upbringing and origin such as the Ndebele speaking youth. The study focused on young people who use broncleer, cannabis or prescription medication only or those who use these drugs together with alcohol and tobacco. Young people who use other drugs such as cocaine, heroin, amphetamines etc were not included meaning their views remain unrepresented.

From literature search, another limitation could have been the search terms used and the selection criteria as the views of young people who use drugs such as cocaine, heroin or amphetamines were not included for review as these drugs are not prevalent in the area. Young females who use drugs were not eager to be recruited for the study leading to less females being recruited for the study. This was a limitation as fewer female participants were recruited than initially intended. A further limitation is that the views and beliefs of the researcher may have impacted on the interviews and the write up of the thesis.

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7 APPENDICES

APPENDIX A: THE WHO ASSIST SCREENING TOOL

Centre Name:

Introduction (Please read to patient)

Hello to you.

My name is and if it is okay with you, I would like to ask you a few questions that will help me to have a better view of how youth view drug use. The questions relate to your experience with drugs such as marijuana, broncleer, alcohol and other drugs. Some of the substances we will talk about are prescribed by a doctor (like tranquilizers and sedative medications). But I will only record those if you have taken them for reasons or in doses other than prescribed. I will also ask you about illicit or illegal drug use—but only to better understand the practice and to help other youth who have problems with drug use. All the information that we will discuss will be kept confidential. There will be no use or mention of your identification details.

Signed..... **Participant**

Signed..... **Research Assistant**

Signed..... **Witness**

Date/...../.....

Gender: () F () M **Age**.....

Drug Use Status.....

Contact details.....

Quick Screen:

Question 1

In your lifetime, which of the following substances have you ever used? Please report non-medical use only.	Never	Once or twice	Monthly	Weekly	Daily or almost daily
Alcohol <ul style="list-style-type: none"> • Males 5 or more drinks a day • Females 4 or more drinks a day 					
Prescription drugs for non-medical reasons					
Illegal drugs such as broncleer or marijuana					
Other (Please specify)					

Participants who respond never are recruited as non-users. Those who respond with a “yes” go on to the Question 2.

In the past 3 months, how often have you used any of the following:	Never	Once or twice	Monthly	Weekly	Daily or almost daily
Alcohol <ul style="list-style-type: none"> • Males 5 or more drinks a day • Females 4 or more drinks a day 					
Prescription drugs for non-medical reasons					
Illegal drugs such as broncleer or marijuana					

N.B: For those who have used once or twice, please confirm whether they have stopped using the drug or they are still using and circle appropriately.

Continue to use / Stopped using

Response Coding

- **Current users** are those who use the substance on a daily, weekly or monthly basis
- **Past users** are those who have used the drug once or twice and have stopped using the drugs. They should not have used in the preceding three months.
- **Non-users** are those who have never used any of the drugs.

APPENDIX B: CONSENT FORM

An exploration of the perceptions of and risk and protective factors for drug use among young persons aged between 18 and 24 years in Mufakose, Harare, Zimbabwe.

Principal Investigator: Nyamadzawo Chivese

Cell number: +263773441904

Supervisors: Dr Marguerite Schneider
Dr Katherine Sorsdahl

What you should know about this research study:

- We give you this consent form so that you may read about the purpose, risks, and benefits of this research study.
- We cannot promise that this research will benefit you personally and it could have some negative effects, such as you feeling emotional.
- You have the right to refuse to take part or agree to take part now and change your mind later.
- Whatever you decide will not affect your participation in the centre's activities.
- Please review this consent form carefully. Ask any questions before you make a decision.
- Your choice to participate is voluntary.

WHAT IS THE PURPOSE OF THE STUDY?

You are being asked to take part in this study on the perceptions of and risk and protective factors for drug use among young persons aged between 18 and 24 years who stay in Mufakose Township. You will be asked questions about your views on illicit drug use and your awareness of the factors that cause youths to use or not use illicit drugs.

This study is being done as we want to see how young people in Mufakose choose to lead a life that is free from problematic drug use whilst others engage in the practice. A combination of questions will be used to assess whether you are at risk or protected from illicit drug use. You were selected to take part in this study simply because you stay in Mufakose and fall within the age range of the participants. We will talk to about **40** young people who use, have used or never used drugs in their lifetime. This will be done at Rutendo Hall and Area A community centres during the months of December 2015 through to January 2016.

PROCEDURES AND DURATION

This study will be done during one of your visits to the community centre. If you decide to take part in this study, we will ask you some questions relating to your age, marital status, family, school attendance, employment status and your experiences of and views on drug use. We will also ask you some questions on your recommendations that you may have for health professionals towards assisting young people to desist from illicit drug use.

Many of the questions that will be asked are routinely asked by some doctors or nurses. However, in this study we will talk to you in detail about your experiences of using or not using drugs and what you have seen in your community. We will also ask about things that you think cause people to use drugs, or those that prevent them from doing so. If we do find that you have symptoms of substance abuse disorder, you will be referred so that you can get treatment to improve these symptoms. I hope that you will try and give honest answers to the questions. The whole interview will take 45 minutes to 1 hour of your time.

RISKS AND DISCOMFORTS

The risks involved in this study are small. Some of the questions that will be asked may evoke sad or unpleasant memories or make you distressed or feel uncomfortable. If you are distressed, we can stop the interview immediately. We can refer you to a trained counsellor if you require someone to talk to during and after the interview.

BENEFITS AND/OR COMPENSATION

We cannot and do not promise that you will benefit directly from the study. If you do have symptoms of substance abuse, you will be referred for appropriate care. The results of this study will help us to have a basis for coming up with interventions for drug use among Zimbabwean youth. This will help the health workers to identify the risk and protective factors of drug use among young people in Zimbabwe in order to help healthcare workers to assist youth with drug related problems. As a token of appreciation for taking your time to participate in the study, you will be given some juice and snacks. The 2 US dollars is to reimburse you for your transport costs.

CONFIDENTIALITY

We will make sure that the information that you share with us will be kept confidential and your name will not appear on the interview sheet, but you will be assigned a study identity number. All the forms and recordings will be stored in a locked cupboard and only the researcher will have access to them. We will not use your real name whenever we write or talk about anything you would have told us. All this information will be kept for 3 years after publishing this study.

VOLUNTARY PARTICIPATION

You will only take part in this study if you are willing to take part. Other health professionals will not know that you have been asked to take part in this study unless if there will be need for referral. So if you agree or refuse to take part in the study, other health professionals will not know about this and it will not affect any assistance you receive from them. You are free to withdraw from the study at any time. You can refuse to take part at any time before or during the talk and it will not cause any problem for you.

ADDITIONAL COSTS

None are expected except for the transport cost which will be reimbursed.

ANY QUESTIONS YOU WANT TO ASK

Before you sign this form, please ask any questions about this study that you do not understand. You can take as long as you want to decide.

You will be given a copy of this consent form to keep. If you have any questions concerning this study or consent form beyond those answered by the investigator, including questions about the research, your rights as a research participant or research-related injuries; or if you feel that you have been treated unfairly and would like to talk to someone other than a member of the research team, please feel free to contact:

1. The Medical Research Council of Zimbabwe

On telephone 04-791792 or 04-791193.

2. University of Cape Town

Health Sciences Faculty

Research Ethics Committee

Groote Schuur Hospital

Telephone: +27 21 406 6626

Email address: lamees.emjedi@uct.ac.za

3. The Supervisor: Marguerite Schneider

Allan J. Flisher Centre for Public Mental Health

University of Cape Town

South Africa

Email: marguerite.schneider@uct.ac.za

CONSENTING TO TAKE PART IN THE STUDY

An exploration of the perceptions of and risk and protective factors for drug use among young persons aged between 18 and 24 years in Mufakose, Harare, Zimbabwe.

AUTHORIZATION

You are making a decision whether or not to take part in this study. Your signature indicates that you have read and understood the information provided above, have had all your questions answered and decided to take part in this study.

Your signature also indicates that you agree to the recording of our discussion in writing and electronically.

Name of participant (please print)

Date

Signature of participant

Time

Signature of Research Staff

Signature of the witness

Highest educational level attained

Less than primary school	[1]
Primary school	[2]
Secondary school	[3]
Tertiary education	[4]

Employment status

Unemployed	[1]
Informal employment	[2]
Formal employment	[3]

Hobbies.....

How often do you attend activities at the community centre?

Daily	[1]
Weekly	[2]
Monthly	[3]
Occasionally	[4]

SECTION B

1) Much has been said about drug use in the media for example newspapers, television and the community in general. Tell me what you think are the reasons why young people use drugs.

Prompts

- i. Let us look at why young people use drugs or why others do not use them.
- ii. Think about the effects of drug use on the individual, family, friends or community. Think about both positive and negative effects.

2) Would you like to tell me about your own experiences with any illicit drugs?

Prompts

- i. It might not be you who has used the drugs but a friend, neighbour or a relative.
- ii. If the participant gives a vague response (e.g. not that much, at some point, here and there) ask them to give examples or to explain further what they mean. What do you mean by that?

3) Tell me about the first time you used drugs (or other licit substances) if you have used any?

Prompts

- i. Can you take me through the experience? What led you to use the drugs? How did you feel soon after taking the drug, the next morning or whenever you remembered the incident?
- ii. Did you disclose to anyone about the experience?
- iii. If yes, ask why he/she chose that person. Did he/ she just tell them straight away or the person found out somehow? What circumstances led to the disclosure?
- iv. How did the other person respond? How did the respondent feel about their reaction?
- v. If no ask why he/she did not disclose?
- vi. If you have not used drugs, tell me if you have ever been tempted to use them and what made you not to.

4) Tell me about any times after that when you used drugs.

Prompts

- i. If yes, ask why he/ she repeated the experience?
- ii. What was the experience like the second time?
- iii. If not repeated, ask why he/ she did not repeat the experience?
- iv. Why didn't he/ she change to another drug type?

5) Certain life events may prompt one to use, stop using or not to use drugs. Let's discuss what these life events could be and how they affect whether young people use drugs or not.

Prompts

- i. Do you think something that happened in the past influences one's decision to use/ not use or stop using drugs?
- ii. What do you think contributes to the illicit drug use/ non use/ cessation?
- iii. What individual experiences do you think makes one continue using/ stop using or never use illicit drugs?
- iv. Which factors within the family, community or society may influence one's decision to use, stop using and not to use drugs illicitly?
- v. To what extent do these factors influence one's decision to use/ not use or stop using drugs illicitly?

6) Can you tell me your views on drug use based on your life experience and those of your friends?

Prompts

- i. Overall impression on drug use
- ii. If someone asked you whether he/she should use drugs, what will you say to them?
- iii. Some states in America have legalized marijuana for medicinal purposes; do you think that marijuana or broncleer should be legalized in Zimbabwe?
- iv. What are the benefits or losses of legalizing these drugs?

- v. Are there any particular people you think should be allowed to use drugs e.g. musicians, celebrities, sports people, the elderly, Rastafarians, military people and why?

7) Could you please tell me what your friends or associates say about drug use?

Prompts

- i. Are they for or against the practice?
- ii. What makes them decide that way?
- iii. Do you think their views on drug use influenced your personal decision to use or not to use the drugs?

8) Health workers want to learn how they can help youths with this issue of drug use. What would your message be to them?

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May I take this opportunity to thank you for sharing your experiences and feelings on drug use with me. This has helped me to have a better and clearer understanding of the views of young people regarding drug use here in Mufakose.

I hope you also had a pleasant time.

Thank you

Highest educational level

- Less than primary school []
- Primary School []
- Secondary school []
- Tertiary education: []

Employment status:

- Unemployed []
- Informal employment []
- Formally employed []

How many attend activities at the community centre?

- Daily []
- Weekly []
- Monthly []
- Occasionally []

SECTION B

N.B *The exact structure and content of the focus group discussions will depend on the findings from the individual interviews. However, the main area of discussion will follow similar areas as those covered in the in-depth interviews.*

1) Much has been said about drug use in the media for example newspapers, television and the community in general. When talking with young people in this area they suggested a number of reasons why young people use drugs illicitly. These include: [Prior to Phase 2, researcher to list a number of reasons extracted from the individual interview analysis].

Prompts

- i. Do u think these reasons are the correct ones
- ii. If not, why do you say so
- iii. What other reasons can you think of?

2) The interviews we conducted showed that people have different experiences with drugs of abuse. Some of these experiences include [Prior to Phase 2, researcher to summarise some typical examples of experiences]

Prompts

- i. Are there any similar experiences that you have heard about?
- ii. What other experiences have you heard about or do you think young people have in this area?
- iii. Do people readily disclose their drug use?

3) Some people encounter undesirable effects after using drugs but continue using them.

Prompts

- i. From your own experience, what makes one continue using the drug/s?
- ii. Do some people use alternative drugs if they experience a negative outcome with the first drug?

4) Certain life events may prompt one to use, stop using or not to use drugs illicitly. What is your take on this?

Prompts

- i. Do you think something that happened in the past influences one`s decision to use/ not use or stop using drugs illicitly?
- ii. What do you think contributes to the illicit drug use/ non-use/ cessation?
- iii. What individual experiences do you think makes one continue using/ stop using or never use drugs illicitly?
- iv. Which factors within the family, community or society may influence one`s decision to use, stop using and not to use drugs illicitly?
- v. To what extent do these factors influence one`s decision to illicitly use/ not use or stop using drugs?

5) What do young people think about the issue of drug use generally?

Prompts

- i. Overall impression on drug use
- ii. If someone asked you whether he/she should use drugs, what will you say to them?
- iii. Some states in America have legalized marijuana for medicinal purposes; do you think that use of marijuana or broncleer should be legalized in Zimbabwe?
- iv. What are the benefits/ losses of legalizing use of these drugs?
- vi. Are there any particular people you think should be allowed to use drugs e.g. musicians, celebrities, sports people, the elderly, Rastafarians, military people and why?

6) Could you please tell me what your friends or associates say about drug use?

Prompts

- i. Are they for or against the practice?
- ii. What do you think makes them decide that way?
- iii. Do you think their views on drug abuse influenced your personal decision to use or not to use drugs?

7) Health workers want to learn how they can help youths with this issue of drug use. What would your message be to them?

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May I take this opportunity to thank you all for sharing your experiences and feelings on drug use with me. This has helped me to have a better and clearer understanding of the views of young people regarding drug use here in Mufakose.

I hope you also had a pleasant time.

Thank you

APPENDIX E: APPROVAL UNIVERSITY OF CAPE TOWN HUMAN RESEARCH ETHICS COMMITTEE



UNIVERSITY OF CAPE TOWN
Faculty of Health Sciences
Human Research Ethics Committee



Room E52-24 Old Main Building
Groote Schuur Hospital
Observatory 7925
Telephone [021] 406 6338 • Facsimile [021] 406 6411
Email: learnings.enjedi@uct.ac.za
Website: www.health.uct.ac.za/fhs/research/humanethics/forms

08 December 2015

HREC REF: 604/2015

Dr M Schneider
Psychiatry & Mental health
J Block

Dear Dr Schneider

PROJECT TITLE: AN EXPLORATION OF THE PERCEPTIONS OF AND RISK AND PROTECTIVE FACTORS FOR DRUG USE AMONG YOUNG PERSONS AGED BETWEEN 18 AND 24 IN MUFAKOSE, HARARE, ZIMBABWE (MPhil candidate- Ms N Chivese)

Thank you for submitting your study to the Faculty of Health Sciences Human Research Ethics Committee.

It is a pleasure to inform you that the HREC has **formally approved** the above-mentioned study.

Approval is granted for one year until the 30th January 2017.

Please submit a progress form, using the standardised Annual Report Form if the study continues beyond the approval period. Please submit a Standard Closure form if the study is completed within the approval period.

(Forms can be found on our website: www.health.uct.ac.za/fhs/research/humanethics/forms)

We acknowledge that the following MPhil candidate Ms N Chivese will also be involved in this study.

Please quote the HREC REF in all your correspondence.

Please note that the ongoing ethical conduct of the study remains the responsibility of the principal Investigator.

Yours sincerely

Signed

PROFESSOR M BLOCKMAN
CHAIRPERSON, FHS HUMAN RESEARCH ETHICS COMMITTEE

Federal Wide Assurance Number: FWA00001637.

Institutional Review Board (IRB) number: IRB00001938

This serves to confirm that the University of Cape Town Human Research Ethics Committee complies to the Ethics Standards for Clinical Research with a new drug in patients, based on the Medical Research Council (MRC-SA), Food and Drug Administration (FDA-USA), International Convention on Harmonisation Good Clinical Practice (ICH GCP), South African Good Clinical Practice Guidelines (DoH

HREC 604/2015

APPENDIX F: APPROVAL MEDICAL RESEARCH COUNCIL OF ZIMBABWE

Telephone: 791 792/791193
Telefax: (263) - 4 - 790715
E-mail: mrcz@mrcz.org.zw
Website: <http://www.mrcz.org.zw>



Medical Research Council of Zimbabwe
Josiah Tongogara / Mazoe Street
P. O. Box CY 573
Causeway
Harare

APPROVAL

REF: MRCZ/B/977

09 February, 2016

Nyamadzawo Chivese
30 Mukarati Road
Mufakose
Harare
Zimbabwe

RE: AN EXPLORATION OF THE PERCEPTIONS OF AND RISK AND PROTECTIVE FACTORS FOR DRUG USE AMONG PERSONS AGED BETWEEN 18 AND 24 IN MUFAKOSE, HARARE, ZIMBABWE

Thank you for the application for review of Research Activity that you submitted to the Medical Research Council of Zimbabwe (MRCZ). Please be advised that the Medical Research Council of Zimbabwe has **reviewed and approved** your application to conduct the above titled study.

This approval is based on the review and approval of the following documents that were submitted to MRCZ for review:

- Study proposal
- English and Shona Informed Consent Forms
- Data Collection Tools

- **APPROVAL NUMBER** : MRCZ/B/977
The above details should be used on all correspondences, consent forms and documents as appropriate
- **TYPE OF MEETING** : Expedited
- **EFFECTIVE APPROVAL DATE** : 09 February, 2016
- **EXPIRATION DATE** : 08 February, 2017

After this date, this project may only continue upon renewal. For purposes of renewal, a progress report on a standard form obtainable from the MRCZ Offices should be submitted three months before the expiration date for continuing review.

- **SERIOUS ADVERSE EVENT REPORTING:** All serious problems having to do with subject safety must be reported to the Institutional Ethical Review Committee (IERC) as well as the MRCZ within 3 working days using standard forms obtainable from the MRCZ Offices or website.
- **MODIFICATIONS:** Prior MRCZ and IERC approval using standard forms obtainable from the MRCZ Offices is required before implementing any changes in the Protocol (including changes in the consent documents).
- **TERMINATION OF STUDY:** On termination of a study, a report has to be submitted to the MRCZ using standard forms obtainable from the MRCZ Offices or website.
- **QUESTIONS:** Please contact the MRCZ on Telephone No. (04) 791792, 791193 or by e-mail on mrcz@mrcz.org.zw

Other

- Please be reminded to send in copies of your research results for our records as well as for Health Research Database.
- You're also encouraged to submit electronic copies of your publications in peer-reviewed journals that may emanate from this study.

Yours faithfully

Signed

MRCZ SECRETARIAT
FOR CHAIRPERSON
MEDICAL RESEARCH COUNCIL OF ZIMBABWE



PROMOTING THE ETHICAL CONDUCT OF HEALTH RESEARCH

APPENDIX G: APPROVAL CITY OF HARARE HEALTH SERVICES



CITY OF HARARE

Director of Health Services

DR PROSPER CHONZI
MRDAB, MPH, MBA

21 January 2016

N Chivese
HARARE

Dear Madam

All correspondence to be addressed to the

DIRECTOR OF HEALTH SERVICES

Ref: _____

Your Ref: _____

DIRECTOR OF HEALTH SERVICES

Room: Martin Building,
City Centre,
Pennefather Avenue,
off Rotten Row,
Harare, Zimbabwe.

P.O. Box 586
Telephone: 784526
753330/1/2
Fax: (263-4) 753093

RE: REQUEST FOR PERMISSION DO A STUDY IN MUFAKOSE , HARARE

I acknowledge receipt of your letter in connection with the above.

Permission is granted for you to carry out a study entitled "*An exploration into the perception, risk and protective factors associated with illicit drug use among young persons aged between 18 and 24 years*" in Mufakose, Harare.

The specific objectives of the study will be:

- i. To explore the attitudes towards illicit drug use in young people aged between 18 and 24 years in Mufakose, Harare, Zimbabwe.
- ii. To explore young people's opinions of the risk and protective factors associated with drug use amongst the youth aged between 18 years and 24 years in Mufakose, Harare, Zimbabwe.

Yours faithfully

Signed

DIRECTOR OF HEALTH SERVICES

PC/rm

c.c. Ethics committee

APPENDIX H: Approval Welfare officer, Mufakose

0098

Mufakose Social Services
P.O Box 1996
Harare

22 February 2016

Att: Centre Heads - Area A and Ruendo Hall

Dear Sir / Madam

RE: REQUEST FOR PERMISSION TO DO A STUDY IN MUFAKOSE

May you kindly assist Mrs Chinese who would like to carry out a study entitled "An exploration into the perception, risk and protective factors associated with illicit drug use among young persons aged between 18-24 years" in Mufakose

She will explain the full details to you

Yours faithfully

M. Chimvum



Acting District Community Services Officer
Mufakose Social Services.