ECA/PHSD/SDU/95/4[5(b)(viii)]

UNITED NATIONS
ECONOMIC COMMISSION FOR AFRICA

Public Administration, Human Resources and
Social Development Division

# YOUTH, DRUGS AND HEALTH IN AFRICA: A COLLECTION OF PAPERS

An Outgrowth of the Regional Expert Group Meeting (EGM)
On Youth, Drugs and Health

Organized Jointly by
Public Administration, Human Resources and Social Development Division
of the United Nations Economic Commission for Africa
and the Commonwealth Youth Programme Africa Centre

(Lusaka - Zambia, 25 - 29 September 1995)

September 1995

# YOUTH, DRUGS AND HEALTH IN AFRICA: A COLLECTION OF PAPERS

## TABLE OF CONTENTS

# YOUTH, DRUGS AND HEALTH IN AFRICA: A COLLECTION OF PAPERS

## FOREWORD

The problems of drug and substance abuse with their inherent health hazards have reached epidemic proportions. The situation has been aggravated by the expansion of drug trafficking into many African countries, now serving as consumer, producer, and transit points. The rising rate of juvenile delinquency and crime, teen prostitution and parenthood are among the negative manifestations of this problem. Associated with the issue are Sexually-Transmitted-Diseases (STDs) which occur among the sexually active populations of 15 to 49 year old persons. Observably, the incidence is particularly high among the youth (15-25) individuals. Clinical studies have also demonstrated that adolescents (mainly males) account for well over thirty percent of STD cases in some African countries and that those addicted to various forms of drugs are particularly vulnerable. STDs are also a significant case of infertility in both men and women.

Linked to the destructive forces of drug abuse also are unwanted pregnancies among the young population of females. These pregnancies eventually result in a growing number of abortions or early child birth with significant health risks not only for the mothers but also for the children. Needless to say that the infants of teenagers suffer higher mortality rates and in many instances long-term mental and physical handicaps.

Presently, youths represent approximately 19% of the African population and this figure is expected to increase given the present rates of population growth. A youth population growth of this magnitude represents a vast potential of human resources for Africa's development which the continent cannot afford to waste through drug abuse. Despite the gravity of the problem, there is no system devised to provide, in a standardized fashion, the much needed relevant, quantifiable, reliable and verifiable data on youth, drugs and health in Africa.

Given the paucity of scientific studies on the issue, the United Nations Economic Commission for Africa, Public Administration, Human Resources and Social Development Division has put together this collection of documents for those who need information on youth, drugs and health in Africa. This collection is an outgrowth of the Expert Group Meeting on Youth, Drugs and Health held at the Commonwealth Youth Programme Africa Centre in Lusaka, Zambia, from 25-29 September, 1995. As observed in the presentations, the efforts of the authors are not backed by any systematic method of data collection, but are based on personal observation.

The aim of this publication, therefore, is to provide i) general information on African youth involvement in drugs and its effect on their health; and ii) to initiate further research on the subject. The papers are included based on a random selection of available papers at the time of compilation.

Readers are, however, reminded that the collection has not been officially edited, and that the views expressed are solely those of the authors. Neither the Economic Commission for Africa nor the Commonwealth Youth Programme Africa Centre is responsible for the inaccuracies, misrepresentations or distortion of ideas and facts that may be found in the texts.

Dr. Sadig Rasheed
Director
Public Administration, Human Resources
and Social Development Division
Economic Commission for Africa
P.O. Box 3001
Addis Ababa
Ethiopia

# YOUTH AND DRUGS: AN INTRODUCTION*

## Conceptualising Drugs

A drug is any substance that, because of its chemical content, affects the structure or function of any living being. This means that what one inhales, injects or absorbs (including medicines, illegal drugs, beverage drugs, cigarettes, food additives, even food), can be classified as drugs. All drugs have multiple effects, and these effects vary from dose level to dose level and from individual to individual. Drug effects are a function of the interaction between the drug and the person's physical, psychological and social status. All drugs are dangerous for some persons, at some dosage level and under certain circumstances. Some are more dangerous than others, and some persons are more susceptible to drugs than others. The most widely abused drugs by African youth include **Alcohol, Tobacco, Cocaine, Marijuana/Cannabis, Stimulants, Heroin, Caffeine, Tranquillizers and Opium.**

## Reaction to Youth Drug Abuse

There are four ways in which people react to youth drug abuse and each of the ways has its own bias. Each way also defines the goals of the specific attempts to influence drug use and abuse. The four ways are classified under: i) The legal-moral; ii) The disease or public health; iii) The psycho-social; and **iv) The socio-cultural.** The first two models of reaction operate from the premise that the answer to youth drug abuse problems is to keep drugs completely away from youth. In these models, drugs are classified as either **safe** or **dangerous,** dangerous including those drugs that are not legally or socially sanctioned. Drugs become the monsters from which innocent deviant youth victims have to be protected through legal control mechanisms. Thus, their cultivation, manufacture, distribution and possession of drugs have to be completely eliminated. The deterrent effects of the models lie in the **fear of harm or punishment.** In spite of the apparent similarities of the two modes of reaction to youth drug abuse, there is a major difference between the legal-moral model and the public health model. The latter dwells more on the potential harm to the abuser than on the legality of the substance.

The last two models of reaction operate from the premise that youth need to be kept away from drugs. The psychological model emphasizes the **individual** rather than the **substance** as the active agent. Here, drug use is viewed as that behaviour that persists so as to serve some purpose for the person who uses it. Thus, the distinction among different use patterns, attitudes and behaviours of youth drug abusers. The socio-cultural

---

* By Dr. Catherine M. Ade, Regional Adviser in Crime Prevention and Drug Control of the United Nations Economic Commission for Africa, Addis Ababa, Ethiopia.

model of reaction views drug use and its associated problems from the social context, emphasizing environmental and socio-economic conditions. Hence, inter-alia **poverty, inadequate housing, discrimination, differential opportunity, anomie, urbanization** and **migration** are the root causes of Substance Abuse by youth. Thus, **punishment, control, threat, reduction of need, or restructuring of the environment** become the choices of intervention.

## The Role of Motivation in Youth Drug Abuse

Most youth drug users experience an altered state of consciousness from the drugs they take, especially if they initially engage in the habit with that expectation. When the altered state is sought repeatedly, the motivation changes to include, inter alia, **"for pleasure"; "to look like my other user friends";** or **"to run away from this unfriendly world (which owes me something it is not willing to give back)".** Between the youth who experiments with drugs once and the everyday abuser, is the situation that can only be described in terms of **motivation. Motivation-based** explanations of drugs use by children cut across all categories of youth users and abusers (lower, middle and upper class youth).

## Curiosity

Some youth experiment with drugs once or twice after which they do not engage in further experimentation. Their motivation for this brief involvement is probably curiosity, for, every human being has the built-in desire to experience the unknown. This desire is especially prominent during the ages of strong peer pressure, when many a youth friends are experimenting with drugs. Just as curiosity is a short-term motivation in the majority of this population, it may well be the initial factor that exposes youth to the efforts that will meet other motivational needs. When this happens such youth will continue to take drugs, but on a more profound reason than that of mere curiosity. Thus, for the short term experimenter, rehabilitation may not be a consideration. Rather, drug abuse prevention measures aiming at addressing the impact of the curiosity factor in drug use and abuse among youth becomes the driving force behind intervention.

## Spiritual Attachment

Churches have, for several years, used mind altering chemicals to "communicate" with supernatural powers. The Catholic church, for example, uses incense and wine. But for some inexplicable reasons, there, however, exist cases of drug vulnerable victims whose motivation has gone from spiritualism to a situation reflecting deeper psychological maladjustment. These spiritual fanatics surrender themselves to drugs and become lost in a fantasy world that bears no relation to religion. Rehabilitative efforts are also often directed toward those who start off taking drugs for spiritual purposes.

**Pleasure/Boredom**

Pleasure is the antithesis of boredom. Youth abuse drugs in order to escape boredom, and to experience a different kind of awareness. Many youth have a lot of free time thrust on them without proper direction and supervision. To counter monotony, it is important for the youth to be engaged in a meaningful activity for the creative use of this time. In some cases, passive forms of entertainment and excitement are devised to fill the huge time void and this creates the misconception that fulfilment can be realised through activities not requiring input. In this case, drug use for pleasure is done once a month or twice a week. But this eventually leads to the pleasure motivation for drug taking. Pleasure motivation can therefore be viewed in terms of:

a) Drugs for pleasure, where drug use at a social event is refreshment or where the purpose of such use is meant to augment sociability. In this case, social interaction becomes the main goal and the pleasure sought, through the drug, is the means to an end.

b) Drugs as pleasure: This involves the effect of the drug being the pleasure sought and an end in itself. This is tantamount to the heightened sensitivity the youth experiences from smoking marijuana, for instance, or from taking alcohol. When the pleasure motivation form becomes compulsive it moves away from the domain of recreation.

Youth drug abusers have always chosen to experience the pleasure derived from drugs, hence, drug programmes should not attempt to eradicate all drug taking but should concentrate on drug-use patterns likely to result in drug dependence, which is the real evil.

**Social Alienation**

Alienation is used to describe two different phenomena related to motivation for drug use by youth. The one type of alienation is social. This is tied to peer pressure further explained by the theories of conformity. Peer pressure is the extent to which youth or groups of youth influence the behaviour or attitudes of others. This influence is exhibited in total compliance without consideration of private acceptance. It results in a change of attitudes in the direction of group attitude. There is an intensive feeling of estrangement and separation not only from society's values but also from life. The symptoms are manifest when a youth or a whole group of youth become alienated from the dominant society. Almost all youth attitudes towards drugs and drug taking belief patterns are derived from the influence of their peers. Consequently, in examining drug use that is a reflection of peer pressure, it must be noted that the weaker the ego of the youth the more externally motivated s/he becomes. In this case motivation will shift from social alienation to a bigger problem of self identity for which treatment is necessary.

**Psychological alienation**

This motivation occurs when the basic human needs (food, clothing and shelter) are unmet. To enable the youth to gain self-esteem and the psychological and emotional fulfilment through love and acceptance by others, the need to become competent in social, intellectual, and physical skills, the need to have power over his/her own destiny and to command respect from others becomes a priority. All this, just to attain the emotional wellbeing necessary for him/her to tell him/herself that s/he is alright. When a youth cannot look at himself/herself and confidently say that s/he is OK, personality restructuring is required and this can be the most difficult rehabilitation task.

**Identity Crisis**

Youth of today increasingly exhibit a lack of self identity amidst the rapidly changing economic, political, civil, and technological state of affairs. For, during the last few decades, agencies of positive socialization, such as the school, family, church, marriage, and the workplace have undergone so many radical changes which affect the youth adversely: The role of religion as an authoritarian moral instrument has been reduced to mere passive preaching; the family, which was a centralised unit has become decentralised; impersonal mass media and technology have replaced most face to face contacts; and a laisser-faire mode of childbearing and nurturing, together with a significant number of senseless wars have resulted to blatant disrespect for authority in the younger generations. It is, therefore, not unusual for Africa to experience a large number of identity seekers among its youth. For search of a personal identity, youth generally start taking mild depressant substances such as tobacco and alcohol leading to marijuana, on to stronger depressants like opiates, and finally to dosages meant to produce desired levels of "high" gradually lead on to lethal stages.

**Apathy**

The sense of powerlessness often arises from sex, age, race and social class discrimination which defies the meeting of the basic needs of the youth of today. Forms of discrimination against the handicapped, the poor or other minorities can lead to a state of defeat and powerlessness which accounts for **apathy.** Apathy dominates drug rehabilitation treatment efforts. It is the most difficult of drug taking motivations to treat because therapy involves the reshaping of a personality as old as the person being treated and as the adage goes, "you cannot bend an old tree".

## WHERE TO GO FROM HERE

### Policy Issues

African Governments have begun to realize their moral obligation to aggressively undertake national campaigns to curb the availability of illicit drugs. Most realize that since substance abuse has become an international problem, they are compelled to join hands in assisting other governments of producer and transit nations, so that they can all gain control over the cultivation, production and distribution of illicit drugs. One of the ways to maximize this joint effort is through international treaties. The priority item should be to stop the inter-state and inter-continental transportation of illicit drugs that are close to their territories. The diplomatic challenge is to raise international consciousness of the illicit drug problem so that acceptance of national responsibility becomes real, manifest in action taken by the Governments of producer, transit and consumer nations as their individual situations warrant. African states must collectively encourage and assist each other in crop control programmes, develop ministerial assistance treaties amongst themselves to facilitate judicial action against the drug trade (seizing assets derived from drug trafficking and preventing banking procedures that conceal illicit drug transactions). They must encourage each other to support international narcotics control programmes which include assistance linked with crop control and cooperative Law Enforcement efforts, and encourage banks, both local and international, to incorporate clauses in their loan agreements prohibiting the use of development assistance to grow illicit drugs. Governments must also curtail the diversion of pharmaceutical paraphernalia and chemicals essential to the manufacture of illicit drugs.

Finally, coast guards on the high seas, customs services and border patrol squads at ports of entry should be trained in work ethics, honesty and patriotism. To the extent possible, an international network of drug Enforcement professionals should be put in place to ensure the development of interdictory measures and participate in joint undercover assignments inside member states. Furthermore, domestic drug Law Enforcement aimed at the manufacture, distribution, sale and importation of drugs must be strengthened. This strategy requires a review of extradition treaties.

### Detoxification and Treatment

In addition to the foregoing, funds must be made available from international coffers (on a matching basis with member states) to treat drug abusers. Treatment programmes will be aimed at overcoming the physical problems of drug dependence, providing psychological and social counselling and helping the individual drug abuser get along without having to turn to drugs. In this case, it will be necessary to emphasize the establishment of new, and reinforcement of existing detoxification and treatment centres. Treatment strategies in these centres will include, inter alia: i) making visible the national network of drug treatment programmes and established referral systems; ii)

seeking less expensive, yet effective treatment alternatives other than punishment; iii) integrating drug treatment services into the general educational and health, including mental health care systems; iv) providing accessibility, acceptability and use of mental Health services, early case finding and follow-up efforts; v) encouraging religious groups, private organisations and state agencies to work together to support treatment programmes; and vi) promoting drug-free treatment programmes.

**Preventive Education**

It will also be necessary to promote preventive education. Since people who are close to the potential drug user provide the most effective prevention effort, local groups should institute approaches to substance abuse that would include peer support, confrontation, and school, family and community involvement. Private sector physicians, pharmacists and other health care officials should work with health care facilities, private organisations and the Criminal Justice Systems to find a way of reducing the dangers of inappropriate use of prescription drugs. Prevention of substance abuse among school-age children (early intervention) and the treatment of adult dependents should become a priority to fill the void that youth drug takers justify for drug abuse. Educational and counselling programmes that aim at establishing greater self esteem in students and clients are appropriate preventive and intervening strategies to fight substance abuse. An appropriate educational programme, will, therefore, be one that is holistic in approach, multi-dimensional, graded for age and ability and evaluated by empirical means so that success or failure can be noted.

**Training**

One of the most significant contributions the International community can make towards the fight against drug use and abuse is the establishment of an international training institution for the training of trainers in the "helping professions" including Criminal Justice personnel, social workers, street educators, counsellors, psychiatric nurses, youth officers, and others. The role of this unit will be exclusively to train those who train others to impart knowledge and share their experiences working directly with those affected by these social maladies: drugs, crime, unemployment, under employment, emotional maladjustment and so on.

**Research**

For there to be successful drug control in Africa, intervention strategy must support the development of new ways of gathering data through basic and applied research and the transfer of that knowledge in an understandable manner to health care workers, educators, law enforcement officials, Criminal Justice staff, and the public in general.

## CONCLUSION

The motivation for youth substance abuse presented here may have raised more questions than answers. May be youth drug abuse is a symptom of the underlying pathology with which the African region is stricken. It could also be an offshoot of a new social consciousness or backlash against depersonalised technology, or an expression of the social explanation for drug use. There is no doubt that every youth drug abuser seeks to alter his/her normal state. Society in turn is undergoing its own change, and much as we would like to think that current drug abuse problems among youth are a reflection of just a phase that would come to pass, we must learn to live with chemical substances, just like we are learning to live with technology. However, it is incumbent upon the older generation to educate young people on the proper use of chemical substances and the determining patterns of the levels of their lives brought about by the involvement with substance abuse. Drug abuse is an international problem which requires and deserves an international solution.

# THE IMPACT OF THE AFRICAN SOCIO-ECONOMIC CRISIS ON YOUTH, DRUGS AND HEALTH *

## INTRODUCTION

The socio-economic crisis afflicting the African continent has not spared the youth of Africa. Today, an overwhelming majority of them are caught in a vicious circle of ignorance, poverty, unemployment and underemployment, malnutrition and hunger, disease and ill-health and lack of shelter. Large numbers have been forced to drop out of school and take up arms and many have lost their lives in armed conflicts, apartheid, and civil strife ravaging across the continent. Several others have been pushed into various countries as refugees or joined the ranks of the displaced and disabled. Over and above this, in many countries, a crisis of governance encompassing such well-known shortcomings as the near absence of democratic structures, popular participation, political accountability and transparency, policy and institutional weaknesses, is pervasive.[1/] All these adversities have conjoined to encourage rural urban migration, dislocation, inequities, and a host of other social problems, including the breakdown of the family unit, crime, drug addiction, prostitution, homelessness, street youth, and delinquency. To make matters worse, diseases that were thought to have been controlled are resurfacing in pandemic proportions, while the new killer-disease HIV/AIDS ravages vast areas of the continent. In short, the problems afflicting the youth in Africa are wide-ranging and have been described as including the following:

> socioeconomic deprivation and disadvantage; unemployment and underemployment; malnutrition; rural/urban migration; alcohol abuse and dependence; drug abuse and dependence; smoking; accidents and risk-taking behaviour; suicide; sexual and reproductive health problems; mental disorders; and mental retardation and other handicaps.[2/]

Of the above predicaments, the problem of drug abuse and illicit trafficking and reproductive health is of serious concern for the African countries. During the last two decades and especially beginning from the 1980s, the use and illegal traffic of drugs has progressively spread throughout the African continent, in total defiance of national, economic and social boundaries, threatening all segments of society, especially young people. Today, the region is afflicted in varying degrees, as producer, user and transit point.

The health implications of drug abuse, particularly in the light of the AIDS epidemic, and more importantly, the problem of rising sexuality and fertility among the African youth population is another area of concern. Adolescent sexuality and fertility is strongly associated with early pregnancy, high rates of abortions, still birth, infant and

---

* By the Public Administration, Human Resources and Social Development Division of the United Nations Economic Commission For Africa, Addis Ababa, Ethiopia.

maternal mortality and morbidity. Research findings reveal that early childbearing poses health risks not only for the mother but for the child. Infants of teenagers tend to suffer higher mortality rates and in many instances long-term mental and physical handicaps. Furthermore, clinical studies demonstrate that youth account for well over thirty percent of STD cases in some African countries and those addicted to various forms of drugs are particulary vulnerable. The majority of those infected, particularly young persons, receive inadequate or no medical attention and thus continue to spread the infection. They are a drain on human, financial and other resources that might otherwise be used for social and economic development. Moreover, invariably, there is usually a permanent halt to education, and young persons are forced into premature marriages. Career opportunities are often interrupted thus contributing to lost productivity of the youth in Africa.

The present study thus focuses on the issue of drugs and health as they affect the youth in particular and the wider economy in general. Section I of the study provides an overview of the impact of the socio-economic crisis on youth; Section II reviews the problems of youth and drugs as well as the issue of illicit trafficking; Section III analyses youth and health with particular emphasis on HIV/AIDS and reproductive health; Section IV of the study proposes strategies and measures for prevention, control, rehabilitation and social re-integration of youth.

A limitation of this study is that the issue of drugs and reproductive health are treated as two distinct problems affecting the youth in Africa. There is growing evidence to suggest that problem behaviours cluster together. They include alcohol and drug abuse and sexual precocity as well as drugs and AIDS. Although most studies recognize the interlinkages, research in the area in the context of Africa is still in its infancy.

## The Concept of Youth

Before launching into the substance of this study, it is important to understand the concept of youth. Youth not only constitute a special target group in Africa's socio-economic development but given the numerical importance and the special vulnerability of the young generation, youth has consistently been a prime client group for much of the United Nations system's action in the social and development field. A link in the continuum of international concern for youth is the designation of 1985 as International Youth Year.

The concept of youth is overlapping, consisting of late adolescence and early adulthood. Social scientists and medical researchers, however, have found it useful when establishing age limits, to take as broad a view as possible, even to the extent of distinguishing the earlier phase of adolescence from the later, e.g., 10-14 years and 15-19 years. Some years ago, a WHO Expert Committee proposed that the age limits of 10-20 years be used to describe "adolescence", and this seems to represent the conventional wisdom on the matter.[3/] The overlapping notion of "youth", 15-24 years, has been

employed by the UN, and is in current usage because of the emphasis on 1985 as International Youth Year. "Youth" as such is also a transitional stage in human development, though it shades across the line between adolescence (15-19) and adulthood (20-24). For the purpose of this study "adolescence" is used interchangeably with "youth" and encompasses the age group 15-24.

In Africa, the operational definition of youth varies from country to country from the standard 15 to 24 years (as in Zambia) to 12 to 30 years (as in Swaziland) and 14 to 35 (in Mozambique). In most industrialized countries, the lower limit of youth is generally taken to be the legal minimum school leaving age which varies between 14 and 16. The upper age-limit is more variable by country. In some countries it includes all persons under 30 as a large proportion of first job seekers are found amongst the 20-24 and even 25-29 age groups.

Legally, the minimum age one attains the age of majority or becomes an adult varies. At common law, the age of majority - the age at which individuals are regarded as competent to handle their own affairs - was traditionally fixed at 21, although the trend is to lower the age to 18. However, 21 remains the age at which many of the trappings of legal adulthood are assumed in many countries. No consensus exists, even within countries, with respect to the legal age of majority for all purposes. Minimum ages often vary, not only by sex, but also according to the purpose of the age limit - marriage, civil majority, criminal responsibility, voting rights, military service, access to alcoholic beverages, consent to medical treatment, consent to sexual intercourse, etc.[4/]

In other words, the legal definition of adulthood has tended to operate independently of other social and biological factors. This can be seen in the fact that one may be an adolescent, but legally adult, or a youth but legally a minor, or under age.[5/]

## I. AFRICA'S SOCIO-ECONOMIC CRISIS: ITS IMPACT ON YOUTH

As is well known, the 1980s were immensely disappointing in terms of social advancement and economic growth for Africa. The cumulative result has been an increasing spread of poverty and social inequalities, leaving a large proportion of the population vulnerable to a myriad of crisis. All indicators examined in this section suggest that the social impact of the recession has been particularly devastating for the African population as a whole and the youth in particular.

### Family

A decisive factor in the healthy development of youth is its family. This fundamental unit of society provides great material and moral support to the young as well as imposing a relatively high degree of control thus preparing the youth for adulthood. The family is usually the major source of the basic necessities of life, health, adequate food, clothing and sanitation to the extent made possible by the socio-

economic, cultural and environmental conditions of a particular country. However, the stability of the African family has been seriously eroded by the socio-economic crisis and the effects of poverty have dismally affected access to their basic needs, including health, education, food and housing. The average per capita income levels and the average nutritional level intake has all declined. The number of single parent families has increased dramatically, and large numbers of young people have left their families prematurely and migrated to towns. Even where young people remain within their families, because of the socio-cultural transformation imposed by urban life, many parents feel ill-equipped to prepare their children for adulthood.

The growing phenomenon of street children and youth in urban areas cut off from their families and left to fend for themselves, is a glaring example of the disintegration of families as a result of extreme poverty, war and displacement. A survey of street children in four selected cities of Ethiopia has for example indicated that a high proportion (55%) of the children come from broken families. The findings of the survey suggest that children living under certain familial arrangements are more likely to become involved in street life. Female headed households are more vulnerable to producing street children because of higher poverty and maternal stress levels compared to two parent families. Physical abuse and psychological neglect of children in families is also a significant factor. Psychological stress mediates the links between economic hardship and dysfunctional parenting behaviour.[6/] Similar studies in Uganda, Senegal, and Zambia have identified family negligence and broken homes as factors which influence deviant behaviour.[7/] Studies in Congo, Burundi, Madagascar have all singled out family-related problems as a significant factor in the growing phenomenon of juvenile delinquency, drug abuse, prostitution and other anti-social behaviour.[8/]

Economic factors and other issues have influenced the status of women and further disrupted family life and have increased married women's participation in intermittent sex work, thereby aggravating the women's already weak socio-economic status.[9/] In Zaire, for example, economic pressures have forced many women to rely on sex for economic compensation for themselves and their families. These sexual liaisons are not without their cost for AIDS has transformed what appeared to be a survival strategy for many women into a strategy for death.[10/] In Zimbabwe, for example, land expropriation, rural poverty and male migrant labour have encouraged many women to resort to the practice of taking sexual partners outside marriage and this is "inextricably linked to economic and social survival." [11/]

Aside from the social and economic marginalization of the family, the expansion of communication, new technologies and information systems have also gradually eroded the traditional role of the African family. There is less reliance, among the youth, on traditional community solidarity and more and more on self-reliance and individualism with grave consequences such as prostitution, drug abuse, alcoholism, theft and violence and a marked negative influence on the perception of marriage and sanctions against premarital and post-marital sex among the youth.[12/]

**Education**

Formal education and training is of great importance for the formation of all young people. It is in school that literacy, numeracy and thinking skills are fostered and knowledge is acquired. Schools and teachers are a major front for fostering education and guidance about health issues and services and do also play a role in restoring the stability of youngsters who have been uprooted from their culture or whose families are unstable. However, the dramatic increase in the school-going population has outstripped the capacity of many African countries to provide adequate education and training for youth. Cuts in public spending on education, limited secondary school places, rising cost of attendance and externally-influenced factors such as debt-service obligations and fiscal restraints imposed by structural adjustment programmes have reversed what was a steady improvement in school enrolment. Less than a third of African children now attend secondary school. In Tanzania for instance, estimates for 1990 demonstrate that out of about 400, 000 primary school leavers, only 40,000 or 10% can be admitted into secondary schools and only 1% of the original cohort will ever move to the higher level.[13/] Female literacy, which is an important factor for family health and development in general, is considerably below that of men at all levels of education; with an average literacy rate for women of 36% compared to 50% for men. Obstacles to greater female participation in secondary education include shortage of female teachers for the girls to look up to and identify with, inconvenient school schedules, gender-biased teaching materials, higher drop-out and repetition rates for girls, cultural and religious barriers, and inappropriate physical facilities. Furthermore, boys are given precedence over girls when parents have to make a choice if education is not free particulary during periods of economic difficulty.[14/] Among the rural youth, even where education is available, many young women cannot attend school because of early marriage or their involvement in domestic chores at an early age. Economic pressures on young girls to drop out of school, in countries like Uganda where education is highly valued, indirectly contributes to HIV infection, since early school-leaving for girls is associated with early sexual activity.[15/] Several studies have shown that increasing levels of female education are inversely correlated with higher levels of fertility.

Similarly, enrolments in vocational and technical training have significantly declined and sufficient attention has not been given to these important areas. Furthermore, only 2 percent, on average of the relevant age group are receiving post secondary and tertiary education. At the tertiary level, women enrolments decline even more drastically. Consequently a large number of school-age going youth who cannot be absorbed by the formal educational programmes are left illiterate.

A related problem is skill deficiency which is prevalent among the youth and which the school system in many African countries has not as yet adequately addressed. The quality and relevance of the education offered in the institutions have adverse implications for skill enhancement among the youth. Course offerings which are critical to socio-economic development in Africa are paid slight attention or are neglected.[16/] As a result, increasingly more young people enter the labour market with skills and

qualifications that employers find more and more difficult to utilize. And in spite of the well-known skill shortages in the critical areas of development, increasingly large numbers of educated people cannot be fully and effectively utilized, because their education and training lack relevance and do not meet the requirements of existing job opportunities.

Another particularly disturbing feature is the harassment of students on campuses, dismissal, arrest and even imprisonment for alleged subversive activities and frequent and arbitrary closure of educational institutions which have all sparked a state of instability and lack of confidence among the youth across the continent.

**Employment**

Employment is the single most important incentive for the productive utilization and development of young people leaving school. It is often a significant indicator of the capacity for the assumption of adult roles and responsibilities, and the first experiences are crucial to the overall development of youth. While it is clear that youth can make a significant contribution to the economies of their countries, they are too frequently subject to a disproportionate burden of unemployment and underemployment which can lead to psychological stress, frustration and anti-social behaviour.

The growing preponderance of young persons (15 -24 years old) among the unemployed is a particularly disturbing feature. According to ILO/JASPA, youth constitute 60 to 65 percent of the unemployed in African countries. Within this category, women tend to experience higher rates of unemployment. The results of a survey undertaken in Kenya, Zambia, Swaziland, Mozambique, Congo, Gabon, Senegal, Mali, Egypt, and Morocco reveals that youth unemployment, especially educated unemployment, is the biggest social problem which the governments have to contend with over the years.[17/] In countries like Congo and Senegal, with the economic crisis and the related slag in labour demand, school and university graduates now face a considerably reduced chance of finding gainful employment. Lack of training and experience in skills that relates directly to an enterprise also constitutes a handicap. The problems of difficulty of access to the factors of production, which are land and credit and on-the-job-training further complicates the plight of youth entering the labour market.

Unfortunately, and quite often routine statistics fail to convey the human and social costs involved. Behind the figures lie not only the missed opportunities, but the consequent loss of confidence and bitterness, often resulting in situations of frustration leading to youth delinquency and anti-social and anti-establishment behaviours.

## Migration and Urbanization

The shift from "what is often a traditional and relatively stable rural society to urban centres that often lack an infrastructure for family support or health care" is now commonly noted to be one of the major barriers to the balanced and healthy development of young people today."[18/] As the process of migration not only weakens social norms transmitted by families, but imposes new cultural patterns and frequently leads to deviant behaviour in a particularly new and hostile environment. Current statistics indicate that deteriorating conditions in local agricultural economies, persistent drought, civil strife, diminishing incomes and general disillusionment with unacceptable living conditions in the rural areas have accelerated rural-to-urban migration, particulary among youth. Such migrations are both age- and sex-related, as a disproportionate number of migrants are young people between the ages of 15 and 24, with a somewhat larger number of males than females, who move to urban centres on permanent or temporary basis seeking employment, education, higher income or a better way of life.[19/]

The age-related nature of migration has induced fundamental changes in family structure and organization. As this is also the most sexually active sector of the population (15-49) it has "engendered dramatic changes in sexual relations and practices, often loosening traditional constraints on sexual life", thus fuelling the spread of AIDS.[20/] Moreover, poor employment prospects for migrating women creates a reliance on intermittent prostitution and return to villages brings HIV back to a rural context. In addition, this phenomenon has created a significant intergenerational gap in some communities, leaving the youngest and the oldest to be shouldered in an often worsening economic situation.[21/]

Furthermore, the influx of migrants from rural into the urban areas has resulted in the development of unplanned and uncontrolled shanty towns, slums and squatter settlements. These are often characterized by inadequate social services such as housing, education, water and sanitation, health, recreational and other facilities. Many migrants find themselves uprooted from the cultural context and exposed to radically different lifestyles. In such an alienated and abject environment, frustration and the need to survive and make ends meet can result in social disorganization.

## Health

Another major factor in the development of youth is the effectiveness of the community's infrastructure for health; policies and programmes that enhance the health of the young people; and the way these are perceived and utilized by them. Ironically, Africa's socio-economic crisis has had a particularly devastating impact on the health sector aggravated by severe budgetary cuts causing the virtual collapse of the health infrastructure in many of the countries. Essential drugs for health are in acute supply. The ratio of health personnel to population is one of the worst in the world, eg. in 1992 in sub-saharan Africa one doctor served an average of 24, 380 persons compared to 380

persons in industrialized countries.[22] Over half of the population have no access to modern health facilities and a third or more have no access to safe drinking water and proper sanitation facilities. A very high percentage of Africans continue to succumb to diseases which in other regions of the world have been overcome through improvements in public health and living conditions and the application of preventive methods.

Moreover, the health of young people has generally attracted neither concern nor attention and the health services are not attuned to the special needs of adolescents and the youth themselves tend not to utilize the modest services that are available. Little is done to give young people correct information about contraception or dispel their misunderstandings. Conventional family planning services are often inaccessible to them.

The spread of the AIDS pandemic poses a major threat. AIDS predominately affects young and middle-aged people in their prime productive years. Among African adults the highest proportions of infected people are between 16 and 29 years.[23] The World Health Organization (WHO) estimates that AIDS will add more than 40% to annual death rates for adults aged 15-49 years in sub-Saharan Africa by the mid 1990s, and will reverse the declining trends in both child and adult mortality rates.[24]

**Conflict, Civil Strife and Social Disintegration**

Several studies on youth signify that socio-economic stability is important for young people, the absence of which may lead to mental and behavioral problems. Young people in certain groups, such as refugees, who have migrated to culturally different environments and are victims of war, who lack adequate support, are more vulnerable.[25] In short, the needs, rights and interests of young people can be effectively met and fulfilled only in circumstances of peace.

Regrettably, a major obstacle to Africa's social and economic progress has been armed conflict, civil strife, apartheid and social disintegration and the displacement of people. During the period 1960 to 1993, there were more than 24 full-fledged wars in Africa while reliable data on casualties from such conflicts is hard to come by, the number of people estimated to have lost their lives between 1960 and 1970 is around 7 million. Over 20 million Africans are refugees and displaced persons.[26] Many have lost their lives in armed conflicts, apartheid destabilization and civil strife. Several others have been pushed into various countries as refugees or joined the ranks of the displaced.

Cases in point are the recent events in Burundi and Rwanda which have created extensive social upheaval, massive population displacement and widespread destruction of the country's infrastructure and services. Thousands have died and several more wounded or displaced, either within the country or in neighbouring states. Public services, schools and health services have all ground to a halt. Young people were forced to drop out of school and in many instances take up arms. The recent events had obvious negative effects on the Burundi and Rwanda economy and on the population as

a whole; but on the youth, women and children, in particular. Similar situations have taken place in Somalia, Liberia and the Sudan. Likewise, Mozambique has to contend with 100, 000 demobilized soldiers, the majority of whom are youth. It must also provide for a large number of disabled and displaced youth of both sexes, in the difficult conditions of a post-conflict economy.[27] Whatever the underpinning of these conflicts, the end result has always been staggering losses of human life, physical disablement, massive displacement of innocent victims; material destruction on a large scale, which these fragile economies can ill-afford, often resulting in famine, hunger, poverty, disease and the social disintegration of the population.

**Population growth**

Compounding the above factors is the population growth. Projections of population growth into the coming century, indicate that the category of youth in Africa will, in fact continue to grow to over 266 million in the next 25 years, given the present rates of population growth. Presently, there are approximately 122 million youths on the African continent, representing 19 per cent of the African population. According to the World Bank, there will be 512 million young people aged 15-19 in 1995 worldwide, 83 per cent of them living in developing countries.[28]

A youth population growth of this magnitude represents a vast potential of human resources for Africa's development, which the continent cannot afford to waste, particularly when viewed in light of the adverse socio-economic circumstances prevailing in the region. Moreover, the implications of this situation for the provision, by governments, of jobs, education, training, health care, housing etc. are serious.

In sum it can be said that the social and economic conditions prevailing on the continent have not only marginalised the African youth from the development process and left many people jobless or homeless, but have had the secondary effect of increasing anti-social behaviour and pushing up the levels of crime, drug-abuse, and encouraged early expressions of sexuality. If current trends continue, the magnitude of the problems pertaining to youth would become devastating.

## II. YOUTH AND THE DRUG PROBLEM

As noted in the earlier section, among the predicaments afflicting the youth, the problem of drug abuse and illicit trafficking is of serious concern for the African countries. Drug addiction, which has traditionally been seen as a problem specific to advanced industrial societies, is progressively spreading throughout the African continent, threatening all segments of society, especially young people.

**Illicit Trafficking**

Today, Africa is the producer of a number of toxic or potentially toxic substances.[29] Clandestine laboratories manufacturing psychotropic drugs or converting them for illicit purposes through thefts from pharmacies or dispensaries and through misuse of prescriptions have mushroomed all over. A number of African countries serve as trafficking points and African nationals including young people, are being used as couriers by traffickers, smuggling drugs to Western Europe and North America.

Cannabis is abused throughout the continent, and is produced in many countries. Large quantities are trafficked abroad, primarily from Morocco, which has a long tradition of cannabis growing. Morocco's pivotal location, between two seas and between Europe and America, makes it a promised land for international traffickers and tourists who "offer exorbitant prices to Moroccan cannabis producers and make their transactions from the decks of small pleasure boats".[30] Although Morocco has adopted a series of measures to tackle the drug problem, European syndicates who control the import and distribution of cannabis on illicit markets still have a strong hold over the country and have extended their activities into sub-Saharan Africa, in particular, Ghana and Nigeria.

As in Morocco, Senegal's coastal regions of the "Gnaws" and the swampy areas of the "Casamance", in the South of the country, lend themselves readily to the cultivation of cannabis or "yamba" as is known there. The financial yield from the crop is very high - a kilogram costs between $18 and $43 compared with one kilogram of groundnuts ($0.25) - and two harvests are gathered each year.[31] Apart from cannabis, increasing use is made of "datura metel" or "koubediara", a plant with disturbing and harmful effects, and of many other psychotropic substances such as psychostimulants, anxiolytics, hypnotics, neurolytics and various depressant drugs. There is also a growing tendency to make use of certain solvents such as benzine, turpentine, and to indulge in such crude practices as drinking a mixture of beer and ordinary petrol, or inhaling the fumes of empty petrol cans.[32]

Heroin, until recently virtually unknown in Africa, is now abused in Mauritius and Nigeria, which also serve as transit points for heroin originating in Asia and bound for Western Europe and North America.[33] Large quantities are also routed through Addis Ababa and Nairobi for distribution to illicit markets in other parts of the world and cities in Cameroon, Chad, the Congo and Gabon are becoming prime targets. In Egypt, heroin along with abuse of other psychotropic substances has become common.

Countries such as Cote d'Ivoire, Ghana, Nigeria, Algeria, Tunisia, Morocco are becoming transit points for cocaine from South America. Nigerian customs authorities seized 555 kg. of cocaine in 1991. In Africa as a whole, the total quantity of heroin seized in 1991 represents a six fold increase over the figure for 1990.[34]

Khat chewing exists in many countries, including Djibouti, Somalia and Ethiopia, and khat trafficking, has progressively acquired an international dimension and large quantities are being shipped to Europe. In addition, a large number of farmers are involved in cultivation of this crop for quick economic gains, primarily in Ethiopia. Proceeds from Khat sales is a major income source for farmers who produce them, usually far exceeding what could be earned from legitimate agriculture.

What is more, there is a marked increase in alcohol consumption and a shift from traditional to western commercial alcohol in several African countries particularly among school-going youth. Murphy and Gieske's survey of drinking habits in ten secondary schools involving 1,125 pupils aged 15 to 19 years revealed that 64 per cent of the boys and 26 per cent girls were drinkers.[35/] In a study done at the University of Zambia involving 1,200 students (mean age 22.1 years), it was found that 38 per cent were regular drinkers and 36 per cent were occasional drinkers. Changing drinking habits have also given rise to a number of alcohol-related problems, including alcoholism, traffic accidents, and social and economic difficulties.[36/]

Illicit drug production and trafficking in psychotropic substances -- financed and masterminded by criminal organizations with international links and accomplices in financial circles -- is substantial and increasing too. Amphetamine, Amphetamine derivatives, pemoline and ephedrine are synthetic stimulants most frequently smuggled into African countries from Europe. There are also frequent cases involving the clandestine manufacture and counterfeiting of pharmaceutical preparations containing psychotropic substances in Nigeria. The preparations are sold on local markets or are smuggled into other countries in western Africa. Large amounts of psychotropic preparations reach illicit markets after having been diverted from illicit sources and tablets containing psychotropic substances are often sold by street vendors.[37/] Togo, for example, located between Ghana and Nigeria, acts as a relay point for the drug traffic and amphetamines and antibiotics are displayed for sale in Togolese markets.[38/]

Illicit trafficking not only violates national drug laws and international conventions but also involves many other criminal activities, including racketeering, conspiracy, bribery, and corruption of public officials, tax evasion, banking law violations, illegal money transfers, import/export violations, crimes of violence and terrorism. In many regions these activities also have close ties to illegal weapons trade, subversion and international terrorism. And vast sums of narco-dollars generated by illicit trafficking are being laundered through legitimate enterprises and government officials. Traffickers can and do use millions of narco-dollars to influence votes, to buy law enforcement officers, judges or lawmakers to influence how strictly an international treaty is complied with, and to exercise power throughout entire regions of the world. Many drug trafficking networks have the power to threaten the very integrity and stability of governments.

Furthermore, illegal cultivation of drugs has serious implications on agriculture. The income received by the farmer for illicit crops is generally higher than that received for traditional food crops and may lead to increased illicit production to the complete exclusion of food crops. It may contribute to shortages in food crops in a given region, create an artificially based cash economy, and foster a close relationship between farmers and drug traffickers, placing them in an adversary position to the Government and force them to resort to criminal activity as a means of survival. In short, the whole process undermines the economic and social order, spreads violence and corruption and imperils the political stability and security of the states concerned.

Despite measures introduced in various countries, Africa continues to be the weakest link in the international drug control system with a number of countries not yet party to any international drug-control treaties. Moreover, the prevailing political, economic, social and even climatic conditions of the continent create enormous obstacles for many governments in coping with the devastating effects of abuse of drugs and illegal trafficking. The limited capacity of the law enforcement agencies, inadequate legislation, insufficient prevention programmes; limited resources, lack of appropriate training and technology; loopholes in the import controls and inadequate pharmaceutical control services as well as corruption of public officials are among the factors that have further compounded the problem.

**Drug Abuse**

A particulary disturbing feature is that the continent not only is an illicit cultivator, producer and drug trafficker, but has over the years also become a large consumer of these drugs. Some ten years ago, the prevailing view both in Africa and in the outside world was that drug dependence posed no threat to African countries, even if some of them were producers of the raw materials used in manufacturing narcotics. This view has been proven erroneous as most African countries have seen the menace of drug abuse spread with frightening speed, and frequently involving more than one drug including the use of alcohol.

The kind of drugs used by youth and the magnitude of the problem varies across the continent; however, some generalizations can be made. The profile of Smart and colleagues' of young chronic drug abusers is that they "are alienated from families, out of school, and away from home, or in situations where parental controls are relaxed and their peers are using drugs".[39/] According to Kielholz, "drug dependence [among the youth] is always related to the general human desire to prevent, correct or forget temporarily such unpleasant elements [of human experience] as conflicts, tension, anxiety, unhappiness, stressful situations, as well as the desire to repeat and intensify pleasures which have once been experienced".[40/] In other words, adolescence is a time of stress

and use of drugs, at least initially, may be an attempt to relieve that stress. "The psychological isolation of the individual stemming directly from the exodus from the countryside to town, shares some blame for the increasing problem of drug dependence in the African continent," notes another study.[41/]

Some of the more apparent internal and external contributing factors to drug abuse are: peer pressure and approval-seeking curiosity (the younger the age at which experimentation begins, the more likely it is that drug use will continue); ignorance of the dangers of illegal drug use and of the health consequences of abusing specific substances; feelings of alienation; changing social structures, including the breakdown of family unity and community life; as well as urbanization and unemployment.[42/] In other words:

> In rural areas devastated by famine and insurrection, in urban settings plagued by unemployment, in the restructuring of the economies, in refugee camps and settlements, drugs become a way out for mitigating adjustment difficulties, resulting from migration to urban areas and the loss of traditional values and support structures, and lack of training and/or skills for employment.[43/]

Moreover, when the legitimate economy offers no chance, drugs present a tempting opportunity as a means of livelihood, thus making it easy for drug trafficking networks to recruit drug dealers and carriers for activities requiring no capital or training except the ability to avoid all contact with the law and the tax authorities.

Drug abuse has invaded the home, the workplace, and educational institutions. Drug abuse causes disruption and disharmony within the family and every family member suffers. Aside from the possible criminal behaviour brought into the home by the drug user, he or she suffers both physically and psychologically. At school, drug use undermines the academic ability and performance level; school drop-out rates are high among drug users. It also brings into the school environment, the illegal activities connected to drug use including the selling of drugs to others. Many young people turn to crime, theft and prostitution to maintain their supply of drugs. While physical addiction to drugs is not a prerequisite for criminal activity, the user who supports a drug habit, often has limited funds and thus resorts to any of a wide range of illegal activities. Clearly, none of these activities are conducive to the development of a productive life among the youth.

Widespread use of drugs in the workplace generates a number of serious problems. In addition to the criminal aspects of on-the-job drug use, decreased productivity, poor performance, absenteeism, and job related accidents are a common occurrence in the drug users. Sloppy workmanship, combined with rising health-care costs and lost productivity, increase an employers cost of doing business and hinders the company's ability to compete in the market place. Moreover defective products and services pose safety and health hazards to the public.

Many health hazards also accompany the use of drugs by young people. Persistent drug use may block development. It may also promote extremely dangerous behaviour including some suicidal behaviour, debilitating accidents and injuries, and various forms of sexual behaviour. Some users remain in a psychotic state, with behaviour indistinguishable from that of chronic schizophrenics. Adolescent psychoses is common among drug users. Cannabis, for example, produces a vast array of symptoms, depending on the dosage, personality and expectations of the user. Effects of low to moderate dosage may include: loquacious euphoria; changes in perception of time and space; impaired coordination; judgement and memory. After higher dosages, illusions, delusions, depression, confusion, alienation and hallucinations may be experienced. Regular and prolonged usage lowers immunity and lowers resistance to infection. New products that are laboratory-developed have also emerged on the drug market in large quantities and pose a serious threat to the health of the user because they may contain by-products and impurities that cause illness and even death.

Furthermore, there is growing evidence to suggest that use of one drug is more likely to lead to multiple drug use. Those who smoke cigarettes are more likely to progress to cannabis; problem drinkers are more likely than others to use illicit drugs; and heavy drinking and the use of drugs aggravate antisocial behaviour including crime, theft, prostitution, and accidents at work- place, which are also a major cause of death and disability in young people.[44/]

An added risk connected with drug abuse is the new lethal health hazard of HIV infection and subsequently AIDS through the sharing of needles with infected persons. It is estimated that from 10 to 20 percent of AIDs patients are intravenous drug abusers. While intravenous drug use is virtually absent in Africa, the problem of contaminated needles may become a vehicle for HIV transmission.[45/] A much higher percentage are regular users of a variety of illicit drugs, such as marijuana and cocaine, which are known to suppress the users immune system. Research is currently underway to study and assess these potential co-factors of AIDS.[46/]

## III. YOUTH AND HEALTH

The problem of rising sexuality and fertility among the African youth and their reproductive health needs have precipitated the concern and anxiety of medical practitioners, school personnel, policy makers and parents. Research findings have shown that early child bearing is, among other things, closely associated with high rates of abortion, still birth, infant and maternal mortality and morbidity rates, and significant dropout rates among female adolescents, as well as a decrease in economic opportunity. A tragic expression of the failure to support young people in dealing with their sexuality is the high incidence of sexually-transmitted diseases including the deadly HIV/AIDs virus among the youth. Moreover, adolescent fertility and sexuality has a direct bearing on the continent's increasing population which has serious implications on the socio-economic development of Africa.

The detrimental effects of early childbirth on the health conditions of the mother, child and the immediate community are well known. Several WHO studies state that pregnancy-related deaths "are the main cause of death in 15-19 year old females.... death rates from causes related to abortion and delivery are particularly high in girls below 18 years of age".[47/] Not only do teenage women face, on average, twice the risk of dying in pregnancy or childbirth than 20-34 years old. If they survive they run a high risk of vesico-vaginal fistula or recto-vaginal fistula which, if not repaired, leaves them emotionally and physically disabled for the rest of their lives. Infants of teen mothers are more likely to die, too; mortality rates are 33 per cent higher for infants born to mothers under 20 years old than to older women. Many women who choose illegal abortions suffer health complications and thousands die each year. Poor living conditions, low nutritional levels, insufficient antenatal care and inadequate health education further aggravate the situation.

Data from studies in Nigeria, Zambia, Zaire, Kenya and Sierra Leone indicate the pattern of these diseases among the youth. In the Sierra Leone study, for instance, adolescents aged 15-24 were responsible for 38% of all the pregnancy-related complications. Another abortion study at Freetown's Princess Christian Maternity Hospital (main maternity hospital) found that 80% of all the patients with induced abortion were aged 15-24. In a study of unmarried adolescents aged 14-25 in Ibadan, Nigeria, it was found that of those who became pregnant, 90% chose abortion. Yet another study at Kenyatta National hospital in Nairobi, Kenya found that although 14-25 aged comprised about one-half of the women in the reproductive age group, they accounted for 84% of all septic abortions.[48/]

Researchers cite several reasons for the rise in teen pregnancy. Two reasons which have direct bearing on adolescent fertility are the decline in the average age at menarche in Africa and the increase in marriage age of females. These two factors have given rise to the so-called biosocial gap between the ages of marriage and menarche. In Nigeria, for example, case studies of schoolgirls in the early 60s, 70s and 80s found that the average age at menarche stood at 14, 13.85 and 12.3 years respectively. Thus an increasing proportion of sexually active adolescents, who in the past decade would have been married, are exposed to the risk of premarital pregnancy, childbirth and sexually-transmitted diseases.

The absolute growth of the adolescent population is another factor that has contributed to the increase in pregnancies. Over one-third of the continent's total fertility is accounted for by adolescents.[49/] Female adolescents numerically constitute an important component of Africa's population. In 1950 there were 21 million female adolescents aged 15-24. According to U.N. projections, the number rose to 45 million in 1980 and is expected to increase further to 84 million by the year 2,000. During the thirty year span, the percentage increased from 40.1% to 41.9%. It is expected to reach 43.6% by the end of the century. The statistics clearly demonstrate the substantial and continuing importance of adolescents to the demographic dynamics of Africa. In

addition, economic hardships or family disruption lead young girls to enter into relationships with older men. Sexual abuse of young girls, prostitution, or premature marriages are also among the factors that have contributed to the epidemic of abortions.

Perception of marriage and sanctions against premarital and post-marital sex among the youth has also contributed to increased sexual activity. In 7 out of 11 countries in sub-Saharan Africa where Demographic and Health Surveys (DHS) were carried out, over half of teenage women aged 15-19 had sexual relations at least once. In five of these countries more than half the sexually experienced women were unmarried.[50/] Another study undertaken in Kenya reported that the average age for sexual intercourse is 13.6 years among boys and 14 among girls. It is the same in neighbouring Tanzania.[51/]

Studies also show that many girls get pregnant out of ignorance. Many are ignorant of the biological nature of their bodies and how reproduction works; they know little about different kinds of sexual activity and the consequences. Very often early sexual experiences are accompanied by feelings of anxiety, shame and guilt. As a result, they may want to keep their relationships secret, for fear of adult disapproval, but often they are just ill-prepared for sexual activity.[52/] Unfortunately, little is done to give young people correct information about contraception or to dispel their misunderstandings. The traditional means of acquiring it in sub-Saharan Africa, from other members of the family, for example - have broken down and not been replaced by systematic education in and out of school. Providing young people with information on sexuality and reproductive health is a delicate subject and adults do not like to discuss sex, and too often do not want to face the fact that adolescents have sexual relationships. Many take the position that only abstinence before marriage is acceptable, even though this contradicts what is actually happening. As a result, most adolescents get their information from the media and their friends; this may be inaccurate or misleading and even encourage risky behaviour.

In Kenya, where various Family Life Education programmes have been carried out for more than 20 years, two-thirds of the young people interviewed for a recent study said they had received information on reproductive health; less than 8 per cent of these could correctly identify a woman's fertile period. A UN inquiry found that among countries acknowledging concern about adolescent fertility only 22 per cent in Africa included contraception education as part of their state school curricula.

Outside school, programmes for young people have also been constrained by the norms and values of parents, educators, religious and community leaders, family planning professionals, policy makers and politicians. Such programmes rarely offer the range of services needed. More than ignorance, as Dr. Njau points out, teenagers are left out of reproductive health programmes and discussions. They often have no knowledge of, or access to, family planning services, and are at risk of an unwanted pregnancy or acquiring a sexually transmitted disease (STD).[53/] Conventional family planning services are often inaccessible to adolescents - either because they only serve married women or couples

(for legal or other reasons), or because the adolescents themselves feel unable to use them for fear of moralizing and judgmental attitudes. Likewise, sexually-transmitted disease diagnosis and treatment services are often inaccessible to adolescents.

Whatever the factors may be, the plight of female adolescents is a wrenching one. They are "denied the right and the chance to decide on their reproductive health. They have no freedom to decide when to marry or bear children, whom to marry or under what kind of conditions. They are denied their rights as human beings".[54/] Early pregnancy simply means they must either terminate their pregnancy or drop out of school on their own volition or be officially expelled. It also usually ends their formal education, reduces their economic prospects, and restricts their social development. The problems involved in obtaining admission into another school and in caring for the child without sufficient backup support is too demanding and expensive. Many enter into premature marriages or are forced to deliver their babies out of wedlock and subsist on meagre assistance which the family might provide. Moreover, the fear of loosing future job prospects compels most adolescent to resort to criminal abortion. For females this is critical because in African countries education which is the single most important criterion to enter into the skilled job market in most African countries and vocational or secondary school certificate is vital.

Birth out of wedlock has undesirable social consequences for the child as well. His or her legal rights of inheritance may be negatively affected. These children are also threatened by the decline in the influence of the extended family system which catered to the needs of all children, despite their legitimate status. This is more pronounced in urban communities where poverty, malnutrition, diseases and other afflictions very often render these children to the streets.

## HIV/AIDS

Increased sexual activity among the youth has also given rise to an increase in the number of sexually-transmitted diseases in their age group including the new killer-disease HIV/AIDS. Available data from clinics and sample surveys demonstrates a high incidence of gonorrhoea and other STDs among the adolescents population.[55/] In some African countries, adolescents (mainly males) account for well over thirty percent of STD cases.56/ Among African youth inflicted by AIDS, the highest proportions of infected people are between 16 and 29 years.[57/] The World Health Organization (WHO) estimates that fourteen million HIV infections will occur in Africa by the end of the 1990s. It also estimates that AIDS will add more than 40% to annual death rates for youth as well as adults aged 15-49 years in sub-Saharan Africa by the mid 1990s, and will reverse the declining trends in both child and adult mortality rates.[58/] Left unchecked, HIV infection in Africa is projected to increase to over 70 million by the year 2015.[59/]

What is important here is that AIDS is being reckoned as "a disease of the young adult male and female in Africa".[61/] Most new cases are in Africa, and 60 percent of the newly HIV positive are the young people of 15 to 24.[61/] "By the year 2000, unless we manage to reduce the risks they face, nearly 5.5 million African women will be HIV-positive".[62/] UNICEF estimates that six to eleven percent of all children under the age of 15 in ten Central and East African countries will be maternal orphans by 1999.[63/]

Several HIV sero-prevalence studies conducted in Uganda,[64/] Rwanda,[65/] and Burundi,[66/] have shown higher incidence of HIV infection in women in younger age groups, compared[67/] with men of the same age. In addition to a lowering of mean age at first sexual intercourse among large proportions of both boys and girls in Africa, young girls are specially vulnerable to HIV transmission in some countries where they are sexually exploited by police, the military, teachers and employers. A nation-wide survey in Uganda revealed that 15 to 19 year old girls were twice as likely to be infected with HIV as boys of the same age. Fifty percent of 13-19 year-old females in main road trading areas were infected.[68/] Exacerbating the vulnerability of many girls is the recent practice of older men seeking even younger female sexual partners in an attempt to find partners who are as yet uninfected with HIV. Economic pressures on young girls to drop out of school, even in countries like Uganda where education is highly valued, indirectly contribute to HIV infection, since early school-leaving in girls is associated with early sexual activity.

While the basic modes of transmission in Africa are identical to those in Europe and the Americas (sexual, blood contact, perinatal), several important regional variations exist. The dominant mode of HIV transmission in Africa is sexual, involving heterosexual transmission (infected man to woman; infected woman to man) of the virus. Analysis of available data shows different distribution patterns in different countries. Some countries show a predominance of either males (e.g. Burkina Faso, Cote d'Ivoire, Niger, Togo) or females (e.g. Ghana). While in other countries (Congo, Tanzania, Zambia) the male to female ratio among AIDS cases is approximately 1:1. Most rural areas in these countries are just as affected and in certain cases the situation is more critical.

Among the wider implications of HIV/AIDs is its impact on economic and social development. As pointed out earlier, current statistics point to the fact that the disease occurs mainly among the sexually active population aged between 15 and 49 years, that is the segment of the population that is economically active and constitutes youth as well as the bulk of the country's labour force. These include the better trained labour force, the well educated, the wealthier, the military and members of the social, economic and political elite of a country engaged in various professions and occupations. The extent of illness and death caused by the epidemic, therefore will not only deplete critical components of the labour force, but also adversely affect every sector of the economy including agriculture, industry and transport. This will also adversely affect a country's gross domestic product.

Women are particularly vulnerable to the economic impact of AIDS due to their lower economic status, lower education and dependency on the husband. Death of the spouse may leave the widow without shelter or income. Furthermore, orphans will be created by the epidemic, straining traditional child support networks. Surviving children may be taken out of school to work, or because there are fewer resources to pay for education.

The AIDS epidemic will make investment in education less productive, as the young and educated persons become infected, and fail to complete their education and to contribute to the nation's output and welfare as anticipated. A further economic impact of AIDs relates to health care costs which are fast soaring with the increased demand for AIDS/HIV treatment which pushes out other, more treatable, diseases. Up to half the hospital beds in many African countries are filled with AIDS patients. Public health expenditures are overwhelmed since costs for treating AIDS patients can amount to several times GNP per capita. Ideal total treatment costs in Tanzania are estimated at US $290 for a typical HIV-positive adult. Providing ideal treatment for a child would cost US $195. The total cost to the Tanzanian health sector would be 40-50 percent of the 1991 recurrent health budget. Lifetime treatment costs of AIDS patients hospitalized in Rwanda were estimated at US $358, the total cost comes to US $600,000, or 4.6 percent of the public health budget.

Youth (15-24), as noted earlier, constitute a major proportion of Africa's population. Youth are the parents and the leaders of the future. They will determine what happens in the world of the 21st century, in sustainable development, population growth, global security - and all other matters. Their health problems are therefore a matter of great concern. Investing in their well-being must be one of the best and most important actions that can be taken today, especially action to make sure young people enter adulthood with the knowledge and information about sexual and reproductive health to look after themselves and become responsible parents in their future.[69/]

## IV. CONCLUSION AND RECOMMENDATIONS

From the foregoing narrative one can conclude that the African youth are in the midst of a deep-seated social and economic crisis. There is no doubt that the sombre outlook just outlined above would adversely affect youth more than the other population groups. The serious implications of the rapid increase in the population on economic growth and social progress and the impact of and share of the youth population in the socio-economic problems of poverty, unemployment and underemployment, rural urban migration, the inadequacy of and pressure on educational opportunities, health facilities, housing and other services, crime rate, social unrest, drugs, prostitution, HIV/AIDS call for a careful assessment of the situation of youth.

It is evidently clear from the indicators examined in the preceding sections that the measures taken so far towards solving the problems of youth in the region have been insufficient and ineffective, and have had little impact on the problems and needs of African youth. While population has been on the increase, the GDP has declined. Unemployment has drastically escalated, particularly among the youth, and jobs have become scarce. As the number of young people who leave school increases, the competition for scarce jobs becomes greater and in turn, the level of educational achievement required to secure a job becomes higher. Indeed in many countries, university graduates are seeking jobs that have traditionally been set aside for school leavers. For those without any education, especially those living in the urban areas, the informal sector, has become the only alternative. Rural youth, on the other hand, seek migration to urban areas as a solution to their economic plight and as a means of social mobility.

Paradoxically, the move to urban areas does not fulfil their aspirations as employment opportunities are scarce. Most of these young urban dwellers become separated from their traditional support systems and social control mechanisms. Greater personal freedom from family and community pressures and access to a wide range of social contacts and sources of information, subjects them to an entirely new youth sub-culture: a sub-culture where feelings and frustrations are translated into early expressions of sexuality and responsibility-free sexual relations, drugs, prostitution, and the AIDs pandemic.

In the wake of the AIDS epidemic, young people, the most sexually active group, are increasingly becoming HIV infected. This has long-term adverse implications for Africa particularly if the most productive component of its society is allowed to be ravaged by AIDS. Evidence suggests that young Africans are not receiving the necessary information or practical assistance to help them cope with the problems and trauma associated with early parenthood, sexually-transmitted diseases, AIDS and drug abuse.

In short, the looming problems of young people cannot be ignored as the future economies of Africa will depend on its burgeoning young population. The main challenge, however, lies with the individual countries where the political will and commitment of government resources to youth ministries and departments are urgently required.

It is important to emphasize that the problems of drugs and health present a daunting challenge and cannot be dealt with in isolation. The issues and problems involved are so inextricably interwoven that one cannot afford to overlook the social, economic, medical, cultural and psychological factors that impinge, in one way or another, on the development of youth. Moreover, efforts made by a single entity will not effect long-term success. This requires that all concerned policy making bodies at the inter-ministerial level (e.g Ministries of education, health, youth, sports, social development and labour) consolidate their efforts at national, regional, and international levels to embark upon integrated and multisectoral programmes.

In accordance with the **"African Common Position on Human and Social Development"** the following interrelated areas require concerted action at national, regional and international levels.[20/]

- putting the welfare of people, and youth in particular, at the centre of all development initiatives, policies and programmes especially in such areas as education, health, social services and promotion of food self-sufficiency and security;

- ensuring the effective implementation of the recommendations of the Dakar/NGOR Declaration on Population, Family, and sustainable development;

- providing viable opportunities for the productive utilization and development of youth;

- enhancing participatory democracy and mobilization of the youth to realize youth to realize their needs in social development and to achieve self-reliance; and

- establishing legislative and structural institutions for the implementation of social development programmes.

Without the above innovative strategies, as spelled out in the "African Common Position on Human and Social Development", the problems of youth, drugs and health will persist. Youth constitute an important human resource in every country. They are the future. The development of their socio-economic potential is the cornerstone to sustainable development.

In addition, the following actions need to be taken at the national, regional and international levels:

1. <u>Actions at the National Level</u>

- Governments should enhance the scope of drug control agencies established under the provisions of existing United Nations conventions to monitor the distribution of addictive drugs;

- Governments should enact legislation as well as establish law enforcement agencies to control the production, sale or use of certain specific dependence-producing drugs - medical and non-medical;

- Governments must abide by the international treaties regulating drug cultivation, production, manufacture, trade and use of these drugs;

- Governments should develop, with educational institutions, an integrated curricula on STDs/AIDS/Drugs as well as appropriate family-life education at all levels;

- Governments should formulate a national youth policy aimed at protecting the youth from any form of abuse, economic exploitation as well as other policies aimed at curbing drug abuse and alcoholism and strengthening MCH and FP services;

- Governments should remove institutional and policy biases against women and introduce special measures to integrate them in productive and remunerative activities;

- Governments should promote and upgrade existing family welfare services and programmes to enable it to fulfil its traditional functions of social integration and security and ensure legal protection of children;

- Governments should institute comprehensive prevention and control programmes for drugs, HIV/AIDS, and sexually transmitted diseases which should be incorporated into primary health care and community based programmes; and

- Governments should develop legislative measures to discourage early marriage and childbearing, access to alcoholic beverages and drugs.

## 2. Action at the Local level

Health education, guidance and counselling programmes for young people should be planned and organized in cooperation with relevant departments of health, education, welfare, labour and social affairs, youth associations and the nongovernmental organizations aimed at:

- sensitizing the public, and in particular those most vulnerable, to the adverse consequences of drug abuse/STDS/AIDS/ early pregnancy, family and sex education;

- creating a body of public opinion that not only supports the notion of a drug-free/ aids-free society but is also ready to seek and support human rehabilitative programmes for those who do abuse drugs or are afflicted by AIDS;

- enhancing and reinforcing individual restrain in matters of drug use, sexual activity through a variety of mechanisms ranging from personal awareness to criminal law;

- developing treatment and rehabilitation measures in collaboration with local government and NGOs in the fight to control drug abuse and for the protection of the health of HIV/AIDS positive;

- providing access to family planning services and counselling for sexually active teenagers;

- providing maternal and child health programmes for youth;

- making available educational and employment alternatives to women to deter early marriage and child bearing;

- launching education and awareness campaigns through the mass media on the dangers of HIV/AIDS/DRUGS/SEX in order to raise awareness among the general public. Radio and T.V. campaigns combined with other initiatives are an effective means of promoting behaviour change.

- utilizing community based interventions such as person to person communication through peer educators and outreach workers, and non-governmental organizations. Communities should be supported by other sectors, such as families, churches, traditional non-governmental organizations, women's groups, and employers among others. National and International agencies should build on community responses thereby strengthening them.

- The private sector can also be involved and play a key role in reducing job-related risk behaviour through launching AIDS/DRUGS prevention programs targeted at employees.

## 3. Action at the Regional Level

Regional, subregional and international actions which are supportive of national policies and actions should likewise be developed.

- Regional organizations and research and training institutions including African universities should be encouraged to undertake research aimed at the following:

- Prevention and intervention measures, if they are to have the desired effect, must be aimed at the age group at greatest risk of becoming drug users. One way to determine age of greatest vulnerability is to look at statistics showing the age of first use. As this varies from country to country, and from drug to drug, each region needs do its own research prior to alerting the young to the undesirable effects of drug use;

- In many countries there is a lack of sufficient reliable facts about the nature and extent of drug problems/HIV/AIDS. This hinders, to a considerable extent, any attempts to deal with the subject at the public policy level, principally because the information on which an assessment of needs could be based is vague and unreliable. Therefore, integrated research that will feed into policy must also be undertaken at the regional level;

- All U.N. specialized bodies, the UNECA, OAU and ADB, intergovernmental and nongovernmental agencies need to join hands and coordinate their efforts on various fronts.

## 4. Action at the International level

African efforts at achieving this stupendous task must be supported by complementary actions by international development agencies, bilateral partners and NGOs. An integral part of such a commitment will require development partners to put new emphasis on policies aimed at long-term development in Africa. In addition to providing a favourable external environment, a substantial increase in resource flows is required by all development partners.

The international community can assist by:

- providing training and technical assistance to health personnel, law enforcement officers, as well as personnel involved in drug control legislation and demand reduction, including treatment and rehabilitation of drug addicts/AIDS patients;

- providing technical equipment (vehicles, radios and other security-related equipment) to the police and customs authorities;

- providing testing equipment for HIV/AIDS;

- strengthening existing drug control institutions through equipment, fellowships and consultancy services;

- providing financial assistance to governments to launch communication campaigns, organize national seminars on drug control/AIDS policy and planning;
  preventive health education programmes, etc;

- providing at low cost vital drugs for health; family control devices; and other essential medical supplies.

Lastly, agencies responsible for youth issues should consider reviewing their medium-term plans to include programme elements of direct interest to young people. They might also consider devoting resources from their programme budgets to activities in support of the World Youth Programme of Action.

Notes

1. UNECA, *African Common Position on Human and Social Development in Africa,* As adopted by the First meeting of the Conference of African Ministers Responsible for Human Development (Africa Hall, Addis Ababa, Ethiopia 20-21, January 1994).

2. WHO Technical Report Series, No. 583, 1975 (Pregnancy and Abortion in Adolescence: Report of a WHO meeting) p.9 cited in J.M. Paxman and R.J. Zuckerman, *Laws and Policies Affecting Adolescent Health,* WHO, Geneva, 1987, p.1.

3. WHO Technical Report Series, No. 308, 1965. (Health Problems of Adolescence: Report of a WHO Expert Committee).

4. J.M. Paxman and R.J. Zuckerman, *Laws and Policies Affecting Adolescent Health,* WHO, Geneva, 1987, p.1.

5. Paxman, J.M., Law, *Policy and Adolescent Fertility: An International Overview,* IPPF, London, 1982.

6. Ministry of Labour and Social Affairs and UNICEF, Ethiopia; *Study on Street Children in Four Selected Towns in Ethiopia*, Addis Ababa, Ethiopia, 1993, pp. 10-14.

7. UNECA, Ibid., p.19.

8. UNECA, *The Impact of Crime on the Economic and Social Development of African Countries,* November 1991, ECA/PHSD/SDU/91/2[2.2(c)], p.19.

9. African Development Bank Group, *The HIV/AIDs Epidemic in Africa: An Overview,* Annual Meeting Symposium, Abidjan, May 1993, p.7.

10. B.G. Schoepf, Political Economy, Sex, and Cultural Logics: A view from Zaire. *African Urban Quarterly*, No.6, 1991, pp.1-2.

11. Bassett M.T., Mhloyi M: Women and AIDS in Zimbabwe: The Making of an Epidemic, *International Journal of Health Service*, 1991, No. 21, pp.143-156.

12. UNECA, *Socio-Cultural Changes and Impact on the Family*, 1993, ECA/OAU/PHSD/SDU/EGM/WD3, p.5.

13. UNESCO, *Priority: Africa* - Programme of Action Proposed by the Director General, Final Report on the Seminar on Distance Education, Arusha, Tanzania, 24-28 September 1990, pp.39-40.

14 Irene Tinker & Michele B. Bramsen (eds.), *Women and World Development,* American Association for the Advancement of Science (AAAS), Overseas Development Council, 1976, pp.161-2.

15. V. Kristiansen, *AIDS Education Research: Current Status in Uganda,* Uganda, Kampala, UNICEF, May 1991.

16. Lydia Makhubu, *Science and Technology in the Solution of Africa's Long-Term Development Problems*, Paper presented at the AAU/ECA Third Conference of Vice-Chancellors, Presidents and Rectors of the Institutions of Higher Learning in Africa, Harare, Zimbabwe, 19-20 January 1987. See also *CASTAFRICA II: Science, Technology, and Endogenous Development in Africa: Trends, Problems and Prospects,* UNESCO, Paris, 1987.

17. UNECA, *The African Fund for Youth A Pre-Feasibility Study Report* ECA/MRAG/93/23.

18. WHO, *The Health of Youth,* May 1989, p.7.

19. Ibid., p.7.

20. African Development Bank Group, *The HIV/AIDs Epidemic in Africa: An Overview,* Annual Meeting Symposium, Abidjan, May 1993, p.5.

21. Ibid.

22. UNDP *Human Development Report 1993*, New York: Oxford University Press, 1993), p.215.

23. The World Bank, *Sub-Saharan Africa From Crisis to Sustainable Growth,* 1989, p. 66.

24. WHO: *Projecting the Demographic Impact of the HIV/AIDS Pandemic. Sixth Meeting of the Management Committee;* GPA/GMC(1) 91.8. Geneva: GPA/WHO, April 1991.

25. Ibid., pp.6-7.

26. ECA, *Report on the African Social Situation in 1993*, E/ECA/CM.19/CRP.1, 1993), p.13.

27. UNECA, Ibid., (ECA/MRAG/93/23).

28. World Bank, *World Population Projections,* 1992-93.

29. Pape Marcel Sene, Africa and the Drug Threat, *World Health*, WHO, December 1981, p.11.

30. Ibid., p.11.

31. Ibid., p.12.

32. Ibid., pp.12-13.

33. *International Conference on Drug Abuse and Illicit Trafficking*, Vienna, Austria, 17 to 26 June, 1987 p. xi.

34. Ibid.

35 Cited in Muyunda Mwanalushi, The African Experience, *World Health,* WHO, December 1981, p.14.

36. Ibid., p. 15, See also Oliver Jeanneret, Alcohol and Youth, *World Health,* WHO, August 1981.

37. United Nations, *Report of the International Narcotics Control Board for 1992,* New York, 1992, p.19.

38. Ibid., *World Health*, p.11.

39. Ibid., *World Health*, p.11.

40. Kielholz, P. *New aspects of Drug Dependence in Western Europe.* in: Zarafonetis, C.J.D., ed., *Drug Abuse: Proceedings of the International Conference,* Philadelphia, Lea and Febiger, 1972, p.365.

41. Pape Marcel, Ibid., p.12.

42. Ibid., *International Conference on Drug Abuse and Illicit Trafficking,* 1987, p. xvi.

43. United Nations, *Update of the United Nations System-wide Action Plan on Drug Abuse Control*, A/48/178, E/1993/70, 3 June 1993.

44. Ibid., *Youth and Health*, p.19.

45. Jonathan M. Mann, *The Global AIDS Situation, World Health*, WHO, June 1987, p.7.

46. *The United Nations and Drug Abuse Control*, United Nations International Drug Control Programme, 1992, p.19.

47. WHO, *Traditional Practices Affecting the Health of Women and Children*, Report of a Seminar, Khartoum, Sudan, Feb.10-15, 1979.

48. Benjamin Gyepi-Garbrah,*Adolescent Fertility in Sub-Saharan Africa: An Overview*, The Path Finder Fund, Nairobi, Kenya, 1985, pp.11-14.

49. Ibid., p.5.

50. *Understanding Adolescents*, An IPPF Report on Young People's Sexual and Reproductive health Needs, IPPF, 1994, p.4.

51. Elizabeth Lee and Patricia Made, Sex and the Teenage Girl, *POPULI*, UNFPA, Vol.21, No. 3, March, 1994, p.8.

52. Ibid., p.9.

53. Ibid., p.9.

54. Ibid., pp.8-10.

55. Population Report, *Adolescent Fertility - Risks and Consequences*, Series J-10, 1976.

56. Benjamin Gyepi-Garbrah, *Adolescent Fertility in Nigeria: Health and Social Implications*, The Pathfinder Fund, Nairobi, Kenya.

57. The World Bank, *Sub-Saharan Africa From Crisis to Sustainable Growth*, 1989, p. 66.

58. WHO: *Projecting the Demographic Impact of the HIV/AIDS Pandemic*. Sixth meeting of the Management Committee; GPA/GMC(1) 91.8. Geneva: GPA/WHO, April 1991.

59. P. Way and K. Stanecki, *The Demographic Impact of an AIDS Epidemic on African Country: Application of the IWGAIDS Model,* February 1991.

60. WHO/AFRO, *Health and the family with Emphasis on HIV/AIDS Pandemic,* Ad-hoc Expert Group Meeting on the Impact of Economic and Social changes on the African Family, p.9.

61. Preventive Education: *A Stich in Time,* UNESCO Sources, April 1994, No. 57.

62. Ibid.

63. UNICEF, *The State of the World Children 1994,* New York, UNICEF, 1993.

64. Berkley S., Naamara W., Okware S., et al: *AIDS and HIV Infection in Uganda - Are More Women Infected Than Men?,* AIDS 1990, 4:1237-1242.

65. *Rwanda HIV Seroprevalence Study Group: Nation-wide Community-based Serological Survey of HIV-1 and other Human Retrovirus Infections in a Central African Country* (Lancet 1989, 941-943) cited in Elizabeth A. Premble and Joseph Foumbi, *The African family and AIDS: a current look at the epidemic,* AIDS 1991 5, AIDS Prevention programme, UNICEF, New York, USA.

66. Aubry P, Bigirimana F, Ndabaneze E, et al: *The current picture of adult AIDS in Bujumbura, Burundi. A review of 300 cases seen over 2 years* (1987-1989). Medical African Noire 1990, 37:568-572) cited in Preble and Foumbi, Ibid.

67. Carael M, Carballo M, Ferry B, Mehryar A, Slutkin G: *Prevalence of high-risk behaviours in some African countries: evidenced from recent surveys.* VII International Conference on AIDS. Florence, June 1991[abstract MD4109]), cited in Premble and Foumbi, Ibid.

68. *Understanding Adolescents,* An IPPF Report on young people's sexual and reproductive health needs. International Planned Parenthood Federation, p.15.

69. Ibid.

70. Ibid., African Common Position, pp.16-18.

# AN ALIENATED AND DISILLUSIONED YOUTH: THE PLIGHT OF YOUNG PEOPLE IN AFRICA*

## INTRODUCTION

This paper is a survey of some of the pertinent issues affecting the well being of the youth of African countries on the eve of the 21st century. The youth of the region are threatened by growing danger from a wide range of problems. These include unemployment, the rapid spread of the AIDS pandemic, alarming rates of environmental degradation, persistent gender inequalities, displacement through ethnic violence and the phenomenon of street children/youths. Governments, Non Governmental Organisations (NGOs), and international organisations working in the region have already began addressing some of these problems. The intensity and scale of some of these problems are set to increase unless novel approaches which rely on the empowerment and participation of the youth themselves are found.

### The Socio-Economic Context of Youth in Africa

The emerging picture of the development experiences of Sub-Saharan countries over the past three decades is rather abysmal. Not only are the countries of the region going through an unprecedented economic crisis, but they are also going through a period of redefinition of their political destiny. Multi-party democracy is taking shape in a number of countries, amidst economic ruins.

In a number of countries a decade of concerted economic policy reforms, supported by the international donor community, has failed to bring any respite. In Sub-Saharan countries as a whole per capita incomes fell by over a quarter in the 1980s. If account is taken of the deterioration of the terms of trade the drop was about 30 per cent. The brunt of the crisis was borne by the urban population: real wages in the formal sector declined by 30 per cent during 1980-85 with at least parallel fall in informal sector earnings (CYP, 1995).

In many countries in the Sub-Saharan region, there were cut backs on essential social services and subsidies throughout the 1980s and 1990s. The primary health care system, for instance, was and continues to be curtailed. In Zambia, for instance, the real value of the drugs budget in 1986 was one quarter of its 1993 value. Real expenditure per head on education fell in the majority of the countries (Chinery Hesse, et al 1989). In Zimbabwe the real expenditure on health fell by almost 30 percent from US$3.60 to US$2.10 between the 1990/1991 and 1992/1993 finance years (SAPEM, 1994).

---

* By Professor Richard Mkandawire, Regional Director of the Commonwealth Youth Programme Africa, Centre, Lusaka, Zambia.

For many countries in the region there is evidence of deterioration in the human condition. Throughout the 1980s to the 1990s, for instance, with the onslaught of draught plus wars in Mozambique and Angola, malnutrition among many families especially among those under five years of age has continued to soar. Poor endowed resource households in the urban sector have been hit the hardest. Most urban households have grossly inadequate incomes to meet even minimum dietary needs. (Clark J and D Keen 1988). (Table 1 below shows the social and economic indicators for selected Commonwealth countries in Africa).

Table 1: Social and Economic Indicators in Selected African Commonwealth Countries

| Country | Real GDP per capita (US$) 1991 | GNP per capita (US$) 1991 | Life expectancy at birth (years) 1992 | People in absolute poverty | | | Adult literacy rate (%) 1992 | Public expenditure on | |
|---|---|---|---|---|---|---|---|---|---|
| | | | | Total (%) 1980-90 | Rural (%) 1980-90 | Urban (%) 1980-90 | | Education (as % of GNP) 1990 | Health (as % of GNP) 1990 |
| Botswana | 4,690 | 2,580 | 60.3 | 43 | 55 | 30 | 75.0 | 8.4 | 3.2 |
| Kenya | 1,350 | 340 | 58.6 | 52 | 55 | 10 | 70.5 | 6.8 | 2.7 |
| Lesotho | - | 570 | 59.8 | 54 | 55 | 50 | 78.0 | 3.8 | 1.2 |
| Malawi | 800 | 230 | 44.6 | 82 | 90 | 25 | 45.0 | 3.4 | 2.9 |
| Mauritius | 7,178 | 2,380 | 69.6 | 8 | 12 | - | 79.9 | 3.7 | 2.0 |
| Nigeria | 1,360 | 350 | 51.9 | 40 | 51 | 21 | 52.0 | - | 1.2 |
| Zambia | 0,010 | 420 | 45.5 | 64 | 80 | 47 | 74.8 | 2.9 | 2.2 |
| Zimbabwe | 2,160 | 670 | 56.1 | - | 60 | - | 68.6 | 10.6 | 3.2 |

Source: Human Development Report, 1994.

Young people in Africa have borne the brunt of the economic crisis. They have been particularly affected in the area of employment, including their working conditions, health as well as housing. The majority of them, especially school leavers with limited or no experience, are less likely to procure a job in the formal sector. Unable to procure a job, young people further become prey to other social and behaviourial rooted problems. Some end up in the informal sector as petty criminals. Within the informal sector many are exposed to serious deprivation, personal health hazards, including exposure to drug, substance and alcohol abuse as well as the risk of HIV infection. Many are exposed to extreme forms of exploitation including acting as pimps, drug couriers, or working as prostitutes (Mtonga, et al 1993).

The youth in Africa are, as a consequence, caught up in a double crisis. The crisis of growing up in a "detribalized" or de Africanized environment (see for example Gluckman 1977, Marwick 1965). They no longer subscribe to the values and norms of their parent's ethnic groups. Through the influence of western media radio, television as well as the print media, the youth of the region are part of a global culture, a culture that is radically different from that experienced by their parents at independence nearly three decades ago. At the root of all these changes is the changing role of the family, which is now far less important in the individual development of young people. The parents are finding it increasingly difficult to fulfil their role of providing advice and nurturing the young into society. The absolute nature of their authority is attenuated by the authority of other institutions including the media.

Secondly, the youth of the region are caught up in a crisis of growing up in economies that are in a crisis. Economies that are not able to sustain and fulfil their expectations. These are young people living in a culture of poverty. This paper explores some of the fundamental questions relating to this double crisis the youth of the region are caught up in, and examines further policy interventions that governments of the region can put in place to cushion the mounting crisis. Given the character of the post colonial state in Africa, the options of escaping from this crisis by the majority of the young people remain dismal.

## The Demographic Trends

The population of Africa is very young by global standards. About 80 per cent of the regions's population is below 30 years (Polson 1994). Population growth rates in most Commonwealth African countries remain consistently high. This is not surprising in view of the high fertility rates in most of these countries. The average fertility rate of the African continent as a whole has been estimated at 6.2 births per family (UN, 1977). This is partly due to the low rate of contraceptive prevalence in the region, estimates being 16 per cent of the eligible mothers (UN 1991).

Unless something is urgently done, the region's population is set to double by the year 2015 (UN 1994). This will bring enormous pressure to bear on the capacities of governments to provide social services to society.

In addition, although Africa's population is largely rural, the region's rates of urbanisation of about 5 per cent per annum means that there will be many more people living in the cities by the year 2000 than is the case (Polson 1994). This implies that urban youth problems are poised to increase enormously from their present scale and governments will need to commit more resources to ameliorate them. Table 11 provides demographic indicators for selected Commonwealth Countries.

**Table 2: Population Growth Rates for Selected Commonwealth Counties**

| COUNTRY | ANNUAL POPULATION (Millions) 1980-85 | GROWTH RATES (%) 1985-93 |
|---|---|---|
| Gambia | 3.8 | 3.7 |
| Ghana | 2.3 | 2.9 |
| Kenya | 3.5 | 3.7 |
| Lesotho | 2.0 | 2.1 |
| Malawi | 3.2 | 3.3 |
| Nigeria | 3.2 | 2.9 |

Source : World Bank, 1994

## Who Are The Youth In Africa

A useful starting point in looking at the crisis of the youth in the Africa Subregion is to define and identify who the youth are. Sociologically, youth denotes an interface between childhood and adulthood. Many organisations consider the ages between 0 to 6 as early childhood, with the child category falling between 6 and 14. The youth on the other hand, are viewed as those between 15 and 24. The United Nations, for instance, has adopted the definition age category between 15 and 24 as youth. Other international organisations such as the Commonwealth Youth Programme define youth as the age category between 15 and 30. Individual countries also have varied definitions of youth. Many countries in Africa stretch their youth definition from 15 to as far as 40 years age limit.

These definitions of youth among organisations and among countries have been changing constantly in both spatial and temporal terms. This is due to many varied factors, such as the cultural context, physical development of the individual, social upheavals, etc. Take, for instance, a 13 year old Yao girl in Malawi getting married soon after puberty: is she a child, youth, or an adult? What of a forty year old man among the Nyakyusa of Tanzania who although married, may still be dependant on his father for most of the decisions related to his welfare and that of his immediate family? What about a 12 year old refugee who, in the process of running away from war torn Angola, has lost all parents and is alone in one of the camps in Zambia, receiving rations as an individual and as a household in his own right. Is this person a child, youth, or an adult?

The definition of youth in terms of chronological age is clearly problematic in many countries in Africa. Children are taught various traditional skills and begin to help out in the family at an age which many cultures in the West would find unacceptable. For instance, at the age of between 10 and 14 many young girls in many African communities are able to assist their parents in a wide range of tasks, such as house building, repairing, trapping animals, hunting, etc.

In the wake of wars in the region, many young people in countries such as Mozambique and Angola were able to use the gun at such an early age as 10. They get killed and they kill. Many young people at that age are roaming the streets of the burgeoning African cities, sourcing a livelihood entirely on their own. These individuals cannot be ignored in our categorisation of youth. They cannot be ignored in any intervention programmes earmarked for youth.

In many African communities, therefore, such individuals, by virtue of their participation in adult roles and their level of autonomy from parental control, can effectively be considered as youth even in circumstances where they may not have reached their adolescent period.

A major distinction that is worth considering in detail, which also contrasts sharply with the youth from the West relates to locality of the youth. Whilst in the West the majority of the youth are urban based, in Africa they are rural based. This paper will consequently attempt to consider and contrast the peculiarities of the rural and urban youth in the region. In addition, it will also in the process attempt to look into the specific problems faced by female youth.

## Youth Organisations in the post-Independence period

At the attainment of independence most states in Africa were fully aware of the potential role the youth could play in national development. At the same time they were also aware of the role the youth could play in mobilising the population to achieve the ruling class's political goals. The period soon after independence, therefore, saw the establishment of a wide range of youth movements and programmes as offshoots of the

ruling political parties. Youth movements such as Boy Scouts, Boys Brigades, Girl Guides, Young Men's Christian Association, etc., were retained by most countries because they were perceived as providing some useful service to the young people and were generally perceived as harmless. These youth organisations, however, tended to be elitist; they tended to cater mainly for the urban literate youth and they seldom penetrated the rural areas. They were consequently not national in scope nor nationalistic in ambition (Tandon 1987). Overall these youth movements tended to be Eurocentric in their patterns of operation.

The post-independence youth organisations that were established were consequently intended to be both nationalistic and non elitist. Infact such youth movements as the Malawi Young Pioneers, the Zambia National Youth Service, the Boys Brigades of Botswana and the Ghana Young Pioneers were in the early period of their formation dominated by young people from a rural background, the majority of whom were unlikely to qualify for university entrance. One of the key characteristics of the post-independence youth organisations was that they were politically driven; they were part of the ruling political party machinery. They were used by the ruling party functionaries to coerce the population to follow the ruling party's perceived brand of political ideology. Youth organisations in such countries as Zambia, Tanzania and Malawi were more often than not used as instruments of political control and as purveyors of the ruling party's ideologies.

In Malawi, for instance, the Youth Pioneers were fiercely resented by the general population for their sometimes ruthless and coercive manner in mobilising local communities for development goals and support of the ruling party. They were particularly renown in the country for their blind appeals to the population (through a combination of paternalism and sanctimonious exhortations) for "Unity, Obedience, Loyalty and discipline" (Malawi congress Party's four corner stones), as a means for creation of rural stability for the intensification of commodity production (Mkandawire 1984). Those who failed to follow these exhortations, such as the Jehovah's witness, received not only physical punishment from the Pioneers, but they also risked being imprisoned with the tacit support of the ruling political party.

In the wake of plural politics and multi-party democracy these original post-independence youth organisations have lost both their credibility and legitimacy as instruments of development. In some countries they have been disbanded or they have been adapted to the changing political environment.

## The Dual Character Of African Youth

In looking at the circumstances of young people in Africa, one cannot help, but look at the dualistic character of African economies. Most of the African economies are characterized by a large agriculture and basically rural economy and a small urban sector. The youth of Africa themselves, have a dual character in terms of where they are

located. The majority of the youth in Africa are located in rural areas, while a smaller proportion are located in urban areas. However, the life of the rural youth usually oscillates between the rural and urban areas. This paper therefore intends to review the peculiarities of problems faced by youth in both rural as well as in urban areas.

**Rural Youth: Education And Employment Opportunities**

It is estimated that approximately 64 per cent of the youth in Africa reside in rural areas, while in Asia and Latin America the figure is put at 30 to 40 per cent respectively. For the majority of the countries in Africa, the rural youth could constitute as much as 75 to 80 per cent. The only exception to this would be countries such as Zambia and South Africa. In Africa it is the rural youth that have been most seriously affected by the current economic crisis which has been fuelled by SAP.

The vast majority of young people in rural areas are either unemployed or underemployed in agriculture or in various rural development activities which are perceived as relatively less lucrative than what can be offered in an urban environment. In the wake of Structural Adjustment Programmes basic social services and amenities, such as recreational facilities, medical, education and other services have been severely curtailed. The evidence of cuts in expenditure are particularly evident in education in the countryside where poorly maintained school buildings, shortages of teachers, teaching aids and equipment (including chalk, pencils, exercise books) are abound. There are many schools in Africa where children sit on mud floors or under trees for their lessons, where teachers are paid sporadically and then only pittance. These signs are much common in rural areas than in urban areas.

With increased pressures for parents to make a contribution towards their children's education, through payment of school fees, and school uniforms, parental burdens have increased considerably in recent years. Among some poorer households this has intensified pressures not to send their children to school, or to withdraw them early. Where there is a choice in not sending a male or female child to school generally most parents are opting not to send their female children to school.

The emerging picture in rural areas, therefore, is one of not only increased illiteracy among young people, but also increased under and unemployment. The increasing numbers of young people who drop out of school are thrown into economies that are unable to accommodate them, a situation that has further been compounded by the quality of education that many young people go through. Due to lack of equipment and basic facilities, education at both primary and secondary school levels remains theoretical and textbook based, a type of education that is orientated towards white collar jobs, rather than one that has a bearing on the practical system that prepares young people in skills that would help them and absorb them in rural based employment, including self-employment.

Not surprisingly, therefore, in most countries of the region, the young people who are already affected by poverty or deprivation in rural areas have their minds set against rural based occupations, by virtue of the nature of education they are exposed to and the attitudes of the teachers who themselves have misconceived ideas about what is possible from earning a living in rural areas. Many of these teachers are themselves in rural schools, not out of choice, because they are unable to compete successfully for places in urban areas.

The circumstances for the female student in a rural setting are even worse. She is usually under pressure, not only from the home, where parents make demands on her labour in reproductive work for the household, but also from the teachers as well who themselves having been unable to attain any appreciable technical qualification, besides teaching, are not the best role models to motivate female youth to aspire for higher academic qualifications, or for that matter to provide technical skills that could lead towards self-employment for young women. If anything teachers in many schools would rather prepare young females for motherhood, hence in some schools in Africa female pupils continue to be taught separately "Home Economics" or "Domestic Science" courses.

Throughout the region evidence indicates that female youth tend to have relatively limited opportunities compared to male youth to proceed on with their education at both primary and secondary school levels, let alone post-secondary school level. Table 111 shows the status of women in Africa.

Because of the relatively limited educational opportunities, the majority of the women tend to be employed in traditionally women associated professions such as nursing, teaching, housekeeping, food and beverage processing, etc.

What seems apparent also is that even for the few that manage to get some education, this does not necessarily widen their opportunities to enter into employment as it does of the young men. Most young men, even with very minimal education such as primary school leaving certificate, are easily able to go into the productive sector as tradesmen, drivers, mine workers, plant operators, etc (Mfune, et al 1994).

Education of women is rarely perceived as a necessity by both parents and government. For the parents, there is usually the assumption that the school girl who might inevitably leave the household once married is unlikely to contribute to the future welfare of the household. And for the government, the school girls continue to be perceived in a patriarchal context, which views their ultimate contribution to society only in terms of the male defined roles. Yet as evidence shows from a number of studies, women's education is very closely linked to the well being of children in the family and society at large. For instance, in Zambia it was reported that the total fertility rate of mothers without education was 7.1 and that of mothers with secondary education was 4.0 and 6.8 for mothers with primary school education.

The under 5 mortality rate among children of mothers with no education was reported to be 204.4, those with primary 181.7 and those with secondary school education 134.8 (V.Seshamani 1992). It would seem only rational for governments therefore, to put more resources on the education of girls which has a definite high rate of return to society.

## Agriculture As A Source Of Employment For Rural Youth In Africa

The lack of appropriate, particularly technical education among school going rural youth is the greatest single handicap to the development of self-employment in rural settings. Until this deficiency is recognised by governments and corrected, it is unlikely that self-employment and the exploitation of rural resources will materialise to make rural areas adequately attractive as a base for a livelihood. Rather than start with the misguided assumption that a good life is not possible from the resources of the rural areas and set up horizons based on urban life, the educational programmes at both primary and secondary levels should set about training the minds of students to be aware of their rural environment and what it can offer and how best to use available rural resources.

One area where young people could seriously consider entering into is in the areas of agriculture. Sone countries are already making and effort to create rural employment in agriculture for the young people. Efforts in such countries as Botswana, Malawi, in Zimbabwe, Zambia and Swaziland have, for instance, been put in place to establish Young Farmers Clubs. The Young Farmers Clubs in these countries usually operate as mini or quasi cooperatives, whereby local agricultural extension officers train the youth in modern agricultural practices and innovations with the assumption that the youth will in turn train their parents, or adopt the imparted practices and innovations as farmers in their own right. However, one of the critical bottlenecks faced by young farmers clubs is that they are usually not supported with the requisite financial resources to enable them adopt the modern farming practices and innovations that are promoted.

Additionally, many young people tend to have limited access to land. Titles for land in many African countries are vested in either the family head's name, or even in the name of individuals outside the community. Not surprisingly, therefore, many rural illiterate youth find it even easier to simply work as farm or plantation labourers, rather then as farmers in their own right.

Young women in this instance are even more disadvantaged than young men. To start with it is assumed that there is no point in offering land to a young woman who is likely to be married and perhaps leave the lineage. Equally important, it is erroneously assumed that farming is an activity exclusively for men. Indeed as evidence shows in a number of countries of the region, where title deeds are offered, they are almost aptly observed to male farmers (Mkandawire 1984). Perhaps this is most aptly observed in the case of Malawi where former President Banda at one of his political rallies commented

that he was pleased that women were actively involved in farming having been informed by the Tobacco Association Chairman that 500 of them had title deeds and were growing tobacco. What the Chairman of the Tobacco Association did not tell Banda at the time is that of the 16,000 etc. of the 16,000 title deed holders only 500 were women. Clearly, there is need for a radical land reform to ensure that young people, both male and female have equal access to land.

Agriculture per se, however, will not meet young people's expectations for a better life. Fundamental changes have to take place, not only in such areas as availability of marketing, credit facilities, improved pricing policies, and various rural services, but equally important, the governments's commitment to introduce land reform in such a way that the youth will have title to land and they will be encouraged to participate in the growing of high value cash crops.

In many parts of Africa, young people's access to land and to growing high value cash crops, for traditional and political reasons, is limited. Unless young people are able to own land, either as individuals or as groups, and are given adequate incentives to participate in thef growing of high value crops, the call for promoting young people's participation in agriculture will come to nought.

## The "Detribalised" Youth: The Urban Youth in the Informal Sector

The rural youth in Africa is a transient youth. In many countries in Africa, rural areas do not provide the same challenges, opportunities and expectations as the urban areas. Many young people in Africa especially the illiterates, semi-illiterates and school drop outs, see migration as a solution to their economic plight, and as a means for social mobility. In many societies in Africa migration into urban areas has become a rite of passage. Most young people make it a point before they marry to migrate to urban areas in search of new opportunities, to raise money for bride price, to purchase a suit for their wedding, and to simply prove that they too "have been to town".

Consequently, the majority of African cities and towns are witnessing the influx of young people. For many young people, unfortunately, the urban areas are not able to fulfil their dreams. There is simply not enough employment available to absorb them.

The bulk of the youth in urban areas, therefore, become part of the unorganised or informal sector, living in the squatter, slum or shanty areas, or so called "compounds". Many of these youth have turned into "wandering street youth".

Many young people have resorted to working on the streets and making a living out of it. Some of these young people live in make-shift homes (made from such materials as cardboard boxes, plastic papers, rammed earth houses, abandoned buildings,

etc.). Some of these are from families that are in the process of breaking up or from those that have done so already. The over-riding characteristic of the vast majority of the street youth that are driven on the street, is poverty.

In some cases some of the street youth have virtually divorced themselves from their parents, earning their livelihood by a set of ingenious variation of petty trading, casual work, borrowing, stealing, pick pocketing and other illegal activities. A number of such street youth are on alcohol, most of them illicit alcohol such as Kachasu, others are on drugs, such as marijuana (Dagga), Valium, and Mandrax. Glue and petrol sniffing is also on the increase (Mtonga, et al 1993).

Most youth in urban areas, as a consequence, have turned out as agents of their own socialisation in the street where they spend most of their time. The language they use in the streets and their patterns of dressing reflect their phases of experiences which are very different from that of their parents or the wider society. The words they use are more concrete than conventional words, often revealing subtle ridicule towards the dignity and conventionality inherent in the common usage.

These are youth who have effectively escaped from the norms of their society as a consequence, they tend to be aggressive and quick thinking as a way of survival. Such youth are, therefore, less inclined to be involved in begging, because begging assumes an inferior position. They would rather steal or pick pocket in the street than beg, for begging is perceived as less aggressive and less fun.

The youth trading in the streets are not stupid, they are not obtuse either, they know their trade, they know how to survive on the pavement of the street. They are knowledgeable in retail trading as well as accounting. They have also the ability to bank together and keeping one in check against abuses. The younger members of the street are carefully indoctrinated into street life, including a mastery of street language. In the street they have a well defined leadership social structure which operates along quasi cooperative lines. New recruits into the street are assisted with not only capital, but also with new territory for their operations as well as protection from law enforcement agents. Usually they tend to be implicitly antagonistic towards the ruling regime, since they usually perceive themselves as outside the mainstream of society. A limited number of lucky street youth are able to escape from the street to take up peripheral and informal sector jobs as "garden boys", Waiters, "car washers," nannies, etc. However, since most of these jobs are in the informal sector, they are difficult to regulate, as a consequence wages paid are low, conditions and terms of employment are poor. For many youth the autonomy of self-employment in the streets, in spite of the risks involved, is a powerful attraction.

Female street youth who are less visible than male youth are particularly vulnerable. Although not much research has been carried out in Africa on the situation of female street youth, anecdotal evidence seems to suggest that among female youth prostitution is widespread. The trade seems not to be organised, rather young females

are engaged in what is commonly known as "free lancing" that is, they live normally in their homes and in some cases with their parents, but operate at night in street corners, bars, streets near hotels, etc. The risks of these "sex workers", not only relate to health, especially STDs including HIV/AIDS infection, but also moral degradation as well as exposure to drug and substance abuse, including alcohol. This is an important area that service providers and policy makers need to address, especially in circumstances where the age of sex workers is getting younger.

The problem of street youth in most countries in the region has been exacerbated by the rapid pace of urbanisation and the deterioration of the physical environment, especially the quality of housing in "Compounds" where the majority of the people live. Many of the youth in compounds, not only sleep in the same house as their parents, but among the poorest, sleep in the same room which is usually simply demarcated by a curtain. This naturally creates latent conflicts between the children, especially older children and the parents. Therefore, day break and an escape into the streets from a crammed housing environment provides some considerable relief for the children.

It is not only the so called street youth in urban areas that are facing the current of the unemployment problems. There are young people from what may be described as the middle class who are also increasingly unable to procure employment. This has arisen because job prospects for many young people are increasingly on the decline. As the number of young people who leave school with qualifications increase, so does the competition for scarce jobs becomes. In turn, the level of educational achievement required to secure a job becomes higher. Indeed in many countries in Africa even University Graduates are increasingly seeking jobs that were traditionally for school leavers, such as Bank Clerk, Policeman, Military personnel positions, etc. Unemployment for the educated youth creates considerable frustrations and despair not only for the individual unemployed young person, but also for the parents and families who have invested in school fees, their often desperately hard earned capital. A situation has now arisen where even the educated youth are entering into the informal sector. Some of these young people are those who have either been squeezed out of the formal sector employment, or those who are trying to supplement rapidly dwindling formal sector wages. Falling real incomes in the formal sector have also reduced the purchasing power of urban consumers for informal sector goods and services.

Within the informal sector itself young women have not fared well as the young men. Young men tend to dominate in the more lucrative trades and businesses such as electrical and mechanical repairs, tin smiting, carpentry and related trades, grocery stores, tailoring and other small manufacturing enterprises, while young female operators tend to concentrate in petty marketing, mainly in food and related items. Their products are normally highly perishable.

Most of the unemployed young people living in urban areas tend to be separated from their traditional support structures. Greater personal freedom from family and community pressures and access to a wider range of social contacts and sources of

information create an entirely new youth. In countries such as Zambia some of the youth in urban areas are a third generation who have never known any other place beside the city compound where they live. Many of the values and norms of the African society among the youth are changing and as a consequence the gap between the young and their parents in understanding and communication may worsen problems already caused by conflicting expectations and aspirations.

**Health and Welfare of Youth in Africa**

Current problems of unemployment among young men and women are very closely linked to their health and welfare, not only due to cutbacks in health expenditure per capita, but also due to the very serious socio-psychological consequences arising from lack of a job. This is reflected among the unemployed in the development of a sense of frustration, guilt of identity, and social rejection which in some instances has driven young people towards self-ruination (as manifested in increased substance and alcohol use).

In both rural and urban areas in Africa there is evidence of the deterioration of the health services being provided. Not only are drugs not available, but even health structures are almost in a state of ruin (broken hospital windows, doors, patients being taken to hospitals on wheelbarrows, or oxcart instead of ambulances, etc.) child immunization programmes are in disarray and infant mortality rates are on the increase, and doctors are not returning to their countries after completion of their training abroad. When they do they leave shortly for lucrative and better paying jobs in other countries.

Young people's health and welfare conditions have in this regard deteriorated considerably over the past decade. Not only do they have limited access to increasingly scarce health resources and services, but also are increasingly getting exposed to a wide range of health and behaviourial problems. For instance, the very fact that they are autonomous from parental control has entailed that they are able to mix relatively more freely with peers of the opposite sex than many of their parents were able to when they were at a similar age. In many instances, as a result, many young people find themselves in social environments which put them at greater risks than their parents and elders experienced when they were at the same age. Not surprisingly, therefore, in many countries in the region premarital sex and teenage pregnancies as well as abortions are on the increase. Given the sensitivity of this whole area, no accurate estimates of the extent of the problem are known in most countries.

In the past decade health problems of young people have been compounded by the appearance on the scene of the HIV/AIDS pandemic. Evidence shows that the majority of those infected by HIV are young adults in the age category of between 15 and 40 years, the most economically productive group. This can be clearly seen from Table IV below which shows the age and sex distribution of AIDS cases in Zambia.

**Table 3: Age and Sex Distribution - Cumulative Aids Cases in Zambia Reported 1984-1992**

| Age Group | Male | Female | Not Stated | Total |
|---|---|---|---|---|
| 0-4 | 246 | 22 | 5 | 473 |
| 5-14 | 19 | 26 | 0 | 45 |
| 15-19 | 47 | 296 | 1 | 344 |
| 20-29 | 767 | 1,437 | 1 | 2,205 |
| 30-39 | 1,358 | 1,175 | 4 | 2,537 |
| 40-49 | 606 | 265 | 2 | 873 |
| 50-59 | 144 | 47 | 0 | 191 |
| 60+ | 36 | 12 | 0 | 48 |
| Not Stated | 185 | 220 | 3 | 408 |
| Total | 3,408 | 3,700 | 16 | 7,124 |

Source: GTZ, Bulletin of health Statistics, 1994

## Cultural and Social Development Dimensions of HIV/AIDS

As a number of writers have observed, the HIV/AIDS pandemic is more than simply a health related problem. It is also a developmental issue. Furthermore, the economic impact of AIDS on the already poverty stricken nations of sub-Saharan Africa is incommensurable. As the epidemic takes hold, the costs spread from being mainly the cost of medical care and treatment to the long-term cost of falling productivity and loss of skilled labour, first at the community and then at the national level. Any delay in combating the spread of the disease significantly increases the demographic, economic and social consequences of the epidemic.

As more youth, many of whom are young parents, die, the social consequences of AIDS are equally devastating. Grandparents, already advanced in age, usually weak, are forced to assume the responsibility of looking after their grandchildren. According to WHO projections, if the current trend continues, 10-15 million children world wide will have lost one or both parents by the year 2000. In one Ugandan village, a woman in her sixties had to take care of 25 grandchildren after her own six children died of AIDS.

The HIV/AIDS epidemic has also raised the socio-cultural issues that had hitherto not come to the fore in African academic discourse in the areas of health. In the wake of the HIV pandemic many scholars and social activists are, for instance, questioning the sanctity of certain African traditions and customs that are perceived as catalytic in the spread of the HIV. For instance, the tradition of encouraging young girls

who have reached puberty to marry and start having children, or worse still in some societies in Africa, the tradition of allowing certain "respectable" elders of the community to have sexual intercourse with young girls who have become of age. These are among several customs and traditions that could fuel the spread of HIV, and are increasingly being questioned by many people.

Other socio-cultural issues that equally deserve examination in the wake of the HIV/AIDS in Africa revolve around the area of interpersonal relationships between husbands and wives. Wives in most marriages in Africa continue to assume a subservient role in their interpersonal relationships with their male partners. Many married women assume that to assert themselves is to go against their tradition, and indeed in many societies in Africa such women risk being divorced with the tacit support of society and the male dominated judiciary system. A good example of this scenario is provided in a recent court ruling in Zambia where a women who had been uncomfortable to have sex in the same house where other co-wives lived had her case thrown out in favour of the husband.

According to the Times of Zambia:

> **Presiding justice Mr Christopher Kalowa ordered Dorothy Hamungwima, 29 of Sitambo village to allow her husband Dickson Sikezela 54, married to 24 other women, to have sexual intercourse with her. Sikwela had told the local court that despite being married to him and having five children, Ms Hmungwima has been denying him sex for the past five years, and submitted only after a good beating.**
>
> **But Ms Hamungwima contended that he wanted to make love to her in the presence of other women, and that since her house was destroyed by heavy rains in 1989, he had not built her another own (Times of Zambia September 8, 1993).**

Such rulings only go on to reinforce the women's powerless position in African communities and can only lead towards the perpetuation of customs and traditions that are retrogressive and detrimental to women's reproductive and human rights. As Macfadden (1993) observes, African terms of sexuality are "fundamentally oppressive to women, because they restrict and control sexuality as a free from. When people are allowed to express their sexuality in their own terms and determined by their specific needs, it becomes a source of strength and empowerment". Unfortunately, in many African societies, the nature of sexual relationships between men and women continue to deny women this source of strength and empowerment.

Most of the African traditions and customs are clearly counter-productive to the fight against AIDS. One of the problems in Africa is that many people are uncomfortable to discuss openly customs and practices related to sexuality among themselves, let alone with their children. The various forms of marriages that are commonly practised in Africa, as well as various sexual practices ought to be discussed openly in the family as well as in communities at large.

Failure to discuss these issues and to take appropriate steps in relation to what is an appropriate preventive measure may annihilate the very same culture, the custodians of that culture are purporting to preserve.

Every society enacts rules, norms and values, bad these rules, norms and values are subject to change with the passing of time. There are hundreds of customs, norms and values in Africa that are no longer practiced today because they have either outlived their usefulness, or they have been perceived as detrimental to society at large. For instance, the custom whereby, in certain bellicose societies, a young man was expected to kill someone from another ethnic group as proof of his maturity and valour, and to win the status of adulthood and hence to be entitled to take a wife is no longer practised. The other custom whereby the families of a dead person kept vigil days over the body without regard to the contagious disease or epidemic that might have caused death is also no longer common amongst most ethnic groups in Africa (UNESCO), 1979). Or again such practices as the excision and infibulation of genitals of young girls, supposedly intended to enhance the man's sexual satisfaction has been challenged and in many societies in Africa this practice is no longer practised. The issue for consideration here, therefore, is that the young people who are still in the process of assimilating their cultures, traditions and customs should not be socialised into believing that all their customs and traditions are sacred and hence beyond questioning.

The problem of rapid urbanisation and youth streetism in Africa has also worsened the HIV/AIDS pandemic in Africa. For most young people living in urban areas, entertainment revolves around beer drinking and casual sex and in the wake of the HIV pandemic, such young people are extremely vulnerable to HIV infection. When such young people return to their rural homes, either on holiday or to marry, having encountered unprotected sexual encounter, often among "compound based sex workers, they risk infecting their prospective spouses and other young women in the rural areas. Indeed, in many countries in Africa, the HIV/AIDS pandemic is making inroads into rural areas. With the increased deterioration of the health sector in rural areas and the continued deterioration of the agricultural sector which is a major source of rural incomes, the growing of rural poverty will most likely fuel the spread of the HIV/AIDS in many countries in Africa.

Because of its poverty, Africa in 1992 spent only 2.8 percent of the global expenditure on AIDS as compared to 91.8 percent in North America and Western Europe, according to the Harvard University - based Global Aids policy Coalition. Yet Africa has 254,000 patients while the two continents combined had only 112,000.

(Gonçalves, 1994). It should, therefore, be noted that any delay in taking preventive measures to contain the spread of HIV/AIDS, particularly among the youth, will significantly increase the demographic and social consequences of the epidemic.

## CONCLUSION

After almost three decades of independence there are signs in most African countries that progress and improvements in the welfare of the majority of the region's inhabitants has begun to falter. The most adversely affected are women, children and the young people. Evidence points out that throughout the 1980s and 90s, the economic and social conditions of these social groups deteriorated considerably.

The focus of this paper has been particularly on young people, who constitute over 60 percent of the population of most countries of the region. Young people in Africa have been particularly affected in the area of employment. Many are unable to procure jobs, either in rural or urban areas, a situation that has been exacerbated by the continued squeeze on the external flow of resources to Africa as a whole. Many young people have sought refugee status in the informal sector making a living as vendors in the streets. The majority of these are exposed to serious personal health hazards, not only in terms of the housing conditions under which they live, but also their exposure to substance abuse, including drugs and alcohol, as well as the risk of exposure to HIV infection. The youth of Africa can not only be described as caught in a crisis, but also can be described as alienated and disillusioned. Alienated because they are a deAfrianised or detribalised youth, who through the influence of western media both electronic and print, are now part of a global culture, a culture that is sharply different from that of their parents.

They are disillusioned because, the post-independence period has not been able to fulfil their expectations and dreams. While they are exposed to the influence of the west through the media as well as being exposed to the conspicuous consumption patterns, and trumplings of wealth of the emerging African property owning middle class, they are themselves totally out of reach of these western derived material possessions and means of livelihood. This has created latent and real frustrations that, in some instances has forced many young people to seek unorthodox means to accumulate wealth, and earn a living. Despite radical socio-economic and political changes associated with the democratisation process and liberalisation of the national economies of most countries of the region, future prospects for improved economic and social conditions of young people in the region remain abysmal. Unless the youth are transformed into development assets, resources and properly utilised, they will remain liabilities to society and clog the limited development gains African nations have so far achieved.

## *REFERENCES*

1. *Alison, Evans (1991) "Implications of Economic Reforms for Women in Zambia. The cause of the Economic Reform Programme 1983-87" in Women and Structural Adjustment, Commonwealth papers No. 22, October 1991, Commonwealth Secretariat.*

2. *Chinery-Hesse et al (1989) Engendering adjustment for the 1990s London; Commonwealth Secretariat.*

3. *Clarke J and Keen D. (1988) Debt and Poverty. A case study of Zambia.*

4. *Commonwealth Youth Programme Africa Centre (1995) "Investing in Tomorrow's Commonwealth: Youth Towards the Year 2000"*

5. *Commonwealth Youth Programme Africa Centre (1994), Minutes of the Regional Advisory Board Meeting 22-24 November 1993, Windhoek: Commonwealth Secretariat.*

6. *Goncalves, Fernando (1994) " The scourge of HIV and AIDS in Africa", SAPEM, vol.7, No.9, 1994.*

7. *Macfadden, Patricia (1993) "Sex, Sexuality and problems of AIDS in Africa" in Ruth Meema (ed.) Gender in Africa: Conceptual and Theoretical Issues, Harare: SAPES.*

8. *Marwick, M G (1965) Sorcery in its Social Setting: A Study of Northern Rhodesia Chewa Manchester: Manchester University Press.*

9. *Mfune P O and Mwansa L K (1994) Women and Men in Zambian Work Organizations Gaborone: M and M.*

10. *Mkandawire, R M (1984) " Agrarian Change and Rural Development Strategy in Malawi: A Case Study of the Chewa Peasantry in the Linlongwe Rural Development Project" Ph.D Thesis, University of East Anglia, Norwich, UK.*

11. *Mtonga, Ruth, et al (1993) Street Children Substance Abuse in Zambia 13. Lusaka: CYPAC*

12. *Polson, R (1994) "Youth in Commonwealth: Towards 2000" Commonwealth Youth Minister' Meeting, London, Commonwealth Secretariat, 1994.*

13. *Seshamani, Venkatesh, (1992) " The Economic Policies of Zambia in the 1980s: Towards Structural Transformation with a Human Focus?" in Giovanni Andrea Cornia, et al (eds) Africa's Recovery in the 1990s: From Stagnation and Adjustment to Human Development (London: Macmillan, 1992) 116-134.*

14. *Times of Zambia, September 8, 1993*

15. *United Nations Development Programme (1994) Human Development Report.*

16. *United Nations (1991) "World Population Monitoring 1991" Population Studies No. 126*

17. *UNESCO (1979)' Youth Tradition and Development in Africa' Regional Meeting on Youth in Africa, held in Nairobi, Kenya, 17 December 1979.*

18. *Vandermoortele, Jan (1970) " The African Employment crisis", in Crispin Grey-Johnson (ed.) The Employment crisis in Africa (SAPES: Harare, 1970) pp27-39.*

# YOUTH, DRUGS AND HEALTH: INTERLINKAGES*

## INTRODUCTION

This paper is divided into five parts. The main sections deal with the three main topics - Youth and HIV/AIDS - Economic and Social Implications; Youth and Reproductive Health; and Youth, Drugs and Health - interlinkages. The first section must set the others in context and the last provides an overall commentary, bringing various themes together. In writing the paper I have taken account of the fact that related topics will be dealt with in other presentations but there will, of necessity, be some overlap. Although the paper is lengthy, it must be appreciated that the topics are so broad in scope that, in some cases only a very superficial treatment can be given.

### Defining the Population

The questi on of how to define youth may well be dealt with by others. But this does not lessen the need to discuss the definition here. It is defined generally as the period including the ages 15 and 24; in some countries the upper limit has been extended to 35, and in one case to 45. This period overlaps with that of adolescence - 10 to 19 and of childhood (which is taken by UNICEF to embrace all ages up to 18). The term "young person" is often taken to cover the age range 10 to 24 and I will tend to use this expression with that meaning. But reading about papers on "youth" I tend to find myself imagining an adolescent and I suspect strongly that the writers of many of the papers I have read have also had this age-range in mind without being explicit about it - certainly they do not appear to be describing those of 25 to 30 or more. However we are going to be discussing the use of some drugs where harmful behaviour tends to occur most commonly round about the age of 30, or in slightly older persons; and we shall have to get round this problem by seeing earlier drug use as pre-disposing to later harmful effects. This point does help underline one conceptual issue - that we are at all times dealing with a continuum and also with a range of characteristics and behaviours; a youngster of 14 may well have many characteristics and behaviours found in someone five years older. Although we may have to talk about statistics, we finally have to remember that we are discussing individuals.

On a world scale, young people are said to comprise one third of the world's population, with 80% to be found in the developing world. It has been stated (UNICEF/WHO, 1992) that the rate of increase of young people is much greater than that of the world population generally (66% versus 46% in the period 1960-80) but I do not know the source of this statistic, which in my view would need explanation before

---

* By Professor Alan Haworth, Psychiatrist, National Mental Health Centre, Lusaka, Zambia.

being accepted at face value. What is important is that young people make up a very substantial group of persons in any country, or community. Although the period of pubescence is often looked upon as a "transition" period it is important to recognize it for one in its own right - it is not simply an in-between period which is better traversed and forgotten as quickly as possible. Looking at the expression "young person" a period of 15 years (10-24) in a country where the life expectancy at birth is only 55 makes up almost a quarter of an individual's life.

Besides defining our population by age there is some advantage in thinking in terms of other groups. A natural division is into males and females, living in urban or rural environments. The question of division by gender is not simply a matter of physical and psychological differences - we shall see that women and girls in particular are subject to many disadvantages because of their gender, and we must take them into account. Even in the richer countries with much greater educational and job opportunities, many young people have a tough time. These differences are accentuated by place of residence - most rural areas are highly disadvantaged. At the same time, the young person who is marginalized by the normal social networks and support systems in a city or town is especially vulnerable.

But the situation in the developing world and in sub-saharan Africa in particular is not simply a reflection of greater wealth, or poverty. Some of the problems are specific to a particular country or group of countries e.g. the effects of drought, or military unrest or even civil war while the populations of other countries have been subject to prolonged stress, during the process of effecting change (e.g. South Africa) and most of these have deeply affected young people. Whatever the problems, many of them appear to be worsening. In one sense, rapid growth of population is the foremost and root problem. The average rate of increase for most countries in Africa lies at just above 3.2% per annum which means that the population of Africa may be expected to double within the next thirty years. But this has not been accompanied by equivalent economic development. The whole of a person's adolescence, spent in increasing poverty may take place while a country waits to fully feel the benefits of a structural adjustment programme; and the most vulnerable elements in the population - rural women who are already poor and have little education are the most seriously affected.

Because of the dire economic situation, the education sector in most countries is receiving insufficient funding so that not only do pupils fail to gain places or to progress from primary to secondary education, but teachers are demoralized and unable to inspire their students with an appreciation of the quality of life. Thus, in Zambia the progression rate from primary to secondary school is only 32% and from lower to senior secondary school 40%. But there is a high drop-out rate for girls, even at the primary level (11%) and at the secondary level the enrollment of eligible boys is twice that for girls. Formal sector employment, even in towns is becoming increasingly difficult to

obtain and even boys who have been able to complete their lower, or higher secondary schooling may have difficulty in finding a job. Many of the pupils who cannot progress become an increasing burden upon their families, and find themselves forced out onto the streets.

In terms of nomenclature, the problem of street children overlaps with that of street adolescents, and youth. The fact that, in many African countries there are far fewer children of the street than children on the street does not necessarily greatly diminish the problems they present. This is but one of the paradoxes of this group. From the point of view of health-related problems we shall see both examples of those encountered in all youth, and an exaggeration of other problems - e.g. due to the marginalization of street children, and their lack of access to services, as well as due to some special hazards such as solvent abuse. While they are an especially vulnerable group, while on the street it has to be recognized that often their presence there reflects greater turmoil and distress within the home (Chapakwenda et al, 1994). For instance, in a study of street children attending a Drop-in Centre in Lusaka, 43% described frequent fights in the home and 46% being frequently beaten. Perhaps one of a street child's greatest problems, and one which we must avoid, is that of being stereotyped and branded as essentially anti-social and unworthy of help.

It also becomes necessary to keep in mind another group of young persons who are at special risk. These are the children of "those who are on top" (to use a translation of a Zambian expression) - generally the rich and influential. Although their number may be comparatively small, their activities attract much attention and because of their parents' prominence - and the attendant publicity it sometimes seems to be assumed by both the general public and the "authorities" that the problems they experience or more usually present to society, particularly of substance abuse, are the most important to the nation, city or community. Thus while alcohol and solvent abuse are causing severe and possibly permanent physical damage to hundreds of street children, the press may be preoccupied with a "three hundred percent increase" over the baseline ten or fifteen youngsters known to have been able to afford the high price of drugs such as heroin and cocaine.

## The Health of Young People

Before looking at HIV/AIDS, it seems sensible to look at the health problems of youth generally and to look specifically at reproductive health. It will then be possible to place the new epidemic in context. Adolescence is generally looked upon as one of the healthiest periods in a person's life. Both the young child and the older person are very vulnerable, the young adult is beyond the age for many childhood infections and is far from the age when degenerative diseases will wreak their toll of ill health. Of course, there are relatively minor ailments such as acne in the male and oral hygiene may be a problem while the sensitive youth may have some difficulty in coping with the development of secondary sexual characteristics.

**Adolescent Sexuality and Health**

We currently know little of adolescent sexuality because it was alleged to be a difficult area in which to research and we cannot draw upon our own personal experience, which is likely to be too limited and shows too much unrecognized variability at the individual level for generalizations to be made - it is not usually felt anyway to be for public disclosure. Indeed, personal inhibitions largely prevented researchers talking to others, until Kinsey and may have retarded the whole field of systematic research into all forms of sexual behaviour, until the social climate was ready. The spate of research following in the wake of AIDS is now revealing much more about all aspects of the topic of sexuality although some are hardly touched upon as yet in Africa, such as childhood sexual abuse and homosexual behaviour. Some recent surveys are suggesting that adult-initiated sexual activity with children certainly occurs in some African countries while young girls' involvement in prostitution is increasingly described (Schurinck, 1995), as well as an increased tendency for men to seek out younger girls for fear of contracting HIV from their older sisters. It has even been suggested that some prostitutes now don schoolgirl uniforms in order to attract their clients. Mention is made elsewhere of the inferior status afforded women and girls, particularly in the sexual sphere but it must not be forgotten that in some societies, men still believe that they can discipline their girl children as well as their sons by the use of excessive and even extreme violence while wife-beating is too often condoned by those who should be up-holding the rule of law (Taylor and Steward, 1991). It is not possible to review the complexities of effectively changing the legal status of women and girls in this review paper, but I should mention that often women do not wish to take legal action because of fear for their children, fear that they may send their husband to prison and fear of increased violence in retribution. If fully grown women cannot act, how much less capable is the adolescent?

But certain facts have been available in the sphere of reproduction and they need to be reported first. At least in towns, male circumcision is often now carried out under hygienic conditions and complications are not so common. There are good medical reasons for recommending male circumcision - there is increasing evidence that HIV is less likely to be transmitted to the circumcised male for example. This is not so for female circumcision and for the more extreme operation of infibulation - when the entry to the vagina is almost closed, so as to leave only a small orifice for the escape of menstrual blood. quite apart from the suffering and morbidity associated with the operation itself there are also the consequent suffering and problems in relation to safe childbirth. Thus the operation can lead to chronic urinary retention, urinary tract infections, incomplete healing, sometimes with keloid formation and the need to cut open the vagina during childbirth - which can be severely traumatic to mother and child. It has been calculated that up to 100 million women in Africa may undergo some form of circumcision or infibulation. Many elders in Muslim societies believe that the operation is sanctioned by the Koran but I understand that this is not the case.

A major problem within the sphere of reproduction is that of early marriage and childbearing, before the body is prepared for the process. Both maternal and infant morbidity and mortality are increased as a result. One of the most distressing conditions occurs when the pressure of the baby's head during birth leads to the development of a hole between the bladder and the vagina resulting in constant leakage of urine (vesico-vaginal fistula).

Although sex is a natural activity, its techniques have to be learnt - and they include of course those involved in first finding and persuading your partner. Since the sexual urge is dependent upon physical maturing the young person will feel its expression whether forewarned or not; it is generally agreed that he/she should be informed and taught about what will happen. But no matter what teaching and advice are given, the circulating hormones and the need for actual sexual release are likely to lead to experimentation in a proportion of youth. It must be appreciated that the strength of the sexual drive depends upon a number of factors (some of which will not be under the control of the individual) and hence the teacher or priest (with a low sexual drive) may not understand that a youth with a much stronger one will not find it so easy to control his desires. Some figures are available from Kenya and Zambia which are probably typical of the current situation. In one Kenyan study (Kiragu, 1991) of schoolgirls and boys, 60% of respondents were male and of these 60% lived in town or semi-urban areas. Half to three quarters of the boys had experienced coitus but only 17 to 67% of the girls; mean ages of debut were respectively 12 and 14 years. Boys were seven times and girls three times more likely to have experienced sex if they associated with peers who were active. Girls were four times more likely to have engaged in sex if involved in substance abuse (not defined in more detail) which also marginally decreased the likelihood of contraception. Coitus was more likely if the respondent lived in a rural area, and contraceptive use was described as low but no details were provided.

In a study of adolescents in Zambia (Feldman et al, 1995) one fifth (including 53% of the girls) claimed never to have had sex. Boys had been much more adventurous in this regard. The sample was made up of two groups - school-boys and girls, and "compound" (out -of-school) boys and girls and of those with regular partners, 79% had sex within the previous four weeks but only 7% had used a condom each time they had sex; 58% never used one. The authors of this study also comment upon oral and anal sex as well as upon homosexual behaviour. Twenty five percent had engaged in oral sex and almost half of the compound girls had performed oral sex on their male partners. Ten percent reported anal (heterosexual) intercourse. No male homosexual behaviour was reported and, in this regard, it may be remarked that most Zambians report strongly negative attitudes towards homosexual behaviour between males, which is generally assumed to involve penetrative sex. In addition rectal gonorrhoea in the male is an extremely rare finding in the sexually transmitted diseases clinic. In a comparative study (UNV, 1994) from a rural and an urban sample of schoolchildren in Zambia it was reported that 81% of the urban and 85% of the rural children (number = 152) aged 10 to 19, modal age 14/15, had experienced sex. It is not clear from the report what proportions used condoms but 71% were reported as not using them because they were

not available. Thirty three percent of rural children and 41% of urban respondents reported having suffered from a genital infection. Self-masturbation and mutual masturbation were reported by about 20% and 6% of the respondents respectively.

Not only the numbers of those engaging in sex but also the types of sexual behaviour are important. Even when talking with colleagues who have mentioned traditional means of contraception, the topic of anal sex is rarely mentioned. We do not know how common it is in Zambia. It was reported quite frequently as a traditional method of contraception in about 1964. But because there is no reference to this, in public discussion of the need for (condom) protected sex, many of those engaging in anal intercourse may not realize that a condom is equally necessary for protection against transmission of HIV. Likewise oral sex has been thought to be much less common than appears from one of the reports mentioned above. It may rightly be asked therefore if a change in sexual behaviour is taking place. In an earlier survey (Haworth, 1983) I noted that while young men would admit to having masturbated (but not older persons), there was little mention of current masturbation. Since we ask about this routinely in clinical practice I can only assert impressionistically that male patients rarely admitted to regular masturbation. Yet their situation does seem to have changed. The UNV Project report from Zambia gives quite high percentages practising masturbation (including mutual - presumably homo-erotic, schoolboy experimentation) and an on-going study of tertiary level students gives a high proportion (perhaps as high as 50%) reporting that they are currently practising masturbation. This is important for this activity represents a form of safe sex while there are no physiological, nor necessarily harmful psychological consequences.

**Adolescent Pregnancy**

The consequences of "unprotected sex" (that is, without using a condom), can expose young people to the danger of sexually transmitted diseases, including HIV infection, and girls to becoming pregnant. This will lead secondarily, in a proportion to the dangers of (non-medical) abortion with the very real possibility of severe bleeding, or infection of the pelvic organs with consequent infertility, as well as much pain. Some girls may not even recognize that they are pregnant and, the fact not having been noted by others, the birth comes as a surprise. In other cases a pregnancy may be hidden, self-delivery takes place and the infant is abandoned, or even, say thrown into a pit latrine. In all cases there will have been severe psychological trauma to the girl and to other members of her family. At the least, if she happens to be of school age interruption of her education is likely. In Kenya, for example, it is reported that the overall, country-wide drop out rate in the years 1985-87 was over 10,000 per year (Kenyan Ministry of Health, 1988). A "pen picture" of a typical Kenyan schoolgirl dropout describes a girl of 18 years or older who has not been a high achiever in class, usually attending a day-school and becoming pregnant during a school holiday, on sleeping with a boy of her own age. (However this picture may have changed, with the advent of HIV and the "targeting" of younger girls and women by older men). The father of the baby is often

not penalized at all, and if a school-boy may not be expelled. This policy is beginning to lead to a recognition that girls who have had a baby should be allowed to resume their schooling; in general this has been much easier to effect in tertiary educational institutions. One factor leading to self-delivery or self-induced abortion is that many girls do not have access or do not know how to gain access to health services. It has been suggested that, because of the emphasis upon "sticking to one partner" many young people do just this - with the current partner, but nevertheless have several in succession - but trusting each in turn, do not use a wrong analogy - such as a raincoat or umbrella. It might better be asked if, because we occasionally get a bicycle puncture it would be better not to use tyres. The correct use of the tyre and inner tube will protect against a puncture, as will correct use of a condom. It has in fact been suggested that carrying a condom acts as a preventive against promiscuity in the sense that promiscuous sex often takes place as an opportunistic act, with little prior thought or planning; having sex only when a condom is used correctly means that the partners will have thought carefully about what they are doing - this diminishing the amount of promiscuous sex. Most moralizing on the subject of sexual behaviour does not take into account either physiology or psychology.

**HIV Infection and AIDS**

The question of HIV infection should be discussed in the light of my introductory discussion on the meaning of the word "youth". Before discussing AIDS we need to remind ourselves of some basic facts about the virus. It is transmitted in blood and blood products, and in semen and is found in vaginal fluid and in breast milk, but in much smaller quantities than in other fluids. A transfusion of blood containing the virus has a virtually 100% chance of transmitting the disease. Dried blood on an injection needle has a very much smaller chance of causing infection. Blood from one intravenous drug user, drawn up into a syringe is there in sufficient quantity to be very dangerous. The virus is transmitted more easily in sexual activity from the male to the female and anal intercourse is also dangerous, but transmission of sufficient virus to cause infection does not occur every time intercourse - vaginal or anal -takes place. As already mentioned, condoms are highly effective preventers of HIV transmission, if properly used. Taking alcohol may contribute to the transmission of HIV (Alcohol Alert, 1992), both in terms of its effects upon behaviour and also because of its impairment of immune responses - much better established than in the case of some other drugs, including cannabis. The presence of the virus in the body cannot be detected by the usual methods for a period of several weeks, or even longer after the body has been invaded. A "seropositive result" means that the body has produced a reaction to the presence of the virus, which is what is tested for and hence it indicates that the person is infected and can infect others. Although most persons know that the person with HIV infection has a weakened "immune" (body defence) system it is not generally realized that this system is highly complex and it has even been asserted recently that too little research has been directed at what are probably more important immune mechanisms in HIV infection than ones focussed upon to-date (Levy, 1995). This is one reason why

the advent of a cure for AIDS may still be a long time away (Lifson, 1995). AIDS may not develop for many years and is less likely to do so in persons who are otherwise very fit; this is one reason why women who are anaemic and tired from bearing and bringing up too many children are at especially high risk. Although there may be a brief illness when the infection is first acquired (which is not recognized for what it is), the person who is a "carrier" may otherwise be quite healthy.

Young persons put themselves at risk of acquiring HIV infection by engaging in unprotected sex with infected partners. From what has been said above, females are at greater risk while the risk is generally increased with multiple sexual partners and if the genital tract is already diseased or injured (e.g. because of infection with another sexually transmitted disease); there is somewhat less chance of transmission to males who have been circumcised. But young people are at special risk for a number of reasons. First, they may find it difficult to obtain condoms or be especially shy about asking for them, and if they have not had proper instruction, may be clumsy in their use, especially if, as is often the case sex takes place in a state of mild alcoholic intoxication or in less than ideal circumstances. Secondly, many young persons have no access to medical care or are reluctant to seek medical advice for a sexually transmitted disease, especially since they may fear that their parents may learn of their adventures. Many will already have been told that there are "street cures" and will seek these rather than any other method; often, with this type of treatment, acute symptoms will abate while leaving residual damage to the genital tract, leaving the person vulnerable to HIV infection. Prostitutes are at special risk, and whereas the mature and experienced woman may be able to call the tune and demand protected sex, this is often impossible for the young girl, forced onto the street because of poverty.

Figures on the extent or prevalence of HIV infection tend either to be out of date or otherwise inaccurate while at the same time it is difficult to really appreciate their significance. Percentages slip easily off the tongue. In Zambia (Fylkesnes et. al., 1994), the majority of reported cases of AIDS is in the age-range 20-39 years with a male-female ratio of 1:1. there is a peak at age 0-4 when the sex ratio is equal and a second peak, for females at age 20-29 and a peak for males at age 30-39. Although initial surveys seemed to point to an excess of the better educated being infected, this trend has now reversed, or is not at all apparent. An interesting set of figures for recruits to the Zambian copper-mining industry, mostly young males aged 18 - 20 show a somewhat stable seroprevalence rate of about 17% for the three years 1989-1991. If this is maintained it could be an important finding - but note that such a plateauing will not seriously affect the **rising** number of persons with AIDS in the next few years. The figures given for male recruits should also be compared to the figures for midwives, nurses and teachers or office workers in 1991/92 of 39,44 and 42% respectively. The seroprevalence for a sample of village women was about 12%.

The economic impact of AIDS can be described in gross terms, using economic simulation models and projections (Forgy and Mwanza, 1994). A baseline model on Zambia without AIDS projects that the economy would have to grow from $4.1 in 1991 to $5.5 in 2,000 just to maintain per capita incomes at the 1991 level and the stock of capital would have to grow by about 33%. AIDS will significantly affect these outcomes with medical expenses before death, the cost of replacing skilled workers who have died, the loss of human capital and, one might add the enormous increase in the number of dependents (the "dependency ratio"). If the economy were to be forced to absorb the additional costs the GDP would call by about 9% below the baseline projection, leaving the people of Zambia very much poorer.

At the community, family and individual level the economic impact of HIV/AIDS is experienced in many ways. Many fathers (they are almost always the breadwinners) become ill when they have teenage children who are directly affected. Where the prevalence of infection is high, say in a rural area, the whole of a rural economy may begin to disintegrate and, at the familial level, the traditional extended family system may also fail in its support. All too often, communities which ought to be mobilizing and regrouping their resources lack leadership, at least from the older and well-established; youth are looked upon as too inexperienced yet children are becoming household heads. HIV infection raises many other social and ethical issues, some of which I will merely mention as examples. I have tended to concentrate up-to-now on the disadvantaged youth. But consider the capable young man or woman who has got a good job, is engaged to be married and then discovers that they are HIV-infected. What of the questions of individual life insurance and of superannuation at work? To what extent should firms, or government invest in expensive training for persons who might be infected (in countries where there is a high sero-prevalence rate) - should this lead to the conclusion that one must impose mandatory testing upon applicants? And in large undertakings, will it be wiser to invest on short term training programmes, so that those who drop out through sickness will not have wasted too much of the company resources? All these and many other questions have a direct impact upon youth..

## Alcohol and Other Drug Abuse

It will be noted in the following discussion that much more is said of males than females. There is a very marked imbalance in the use of all drugs, between the sexes although this is not necessarily constant between different nations, nor drugs. Thus, in a study (Haworth, 1982) carried out in Zambia in 1979, student nurses reported a very high rate of "ever use" of benzodiazepines (such as valium) and it is certainly possible that some of the young women might have later become dependant. In Zambia, women tended to be allowed to drink after the age of 35, and this social "rule" still applies to some extent (Haworth, 1994); a proportion of these drinkers would develop alcohol-

related problems. This seems to contrast markedly with Lesotho (Maholiehi, 1994), where drinking in older women is also roundly condemned. Likewise in Zambia, many older women enjoy their pipe of cannabis. But girls and young women are hardly ever involved.

As in the case of HIV infection, before discussing interlinkages of health and economic problems with drugs, it is necessary to present a very brief review of some salient facts about drugs generally. It is important to appreciate that drugs per se are neither evil nor good although they may produce wanted or unwanted and even very harmful effects; both beneficial and harmful effects may occur physiologically or in the social sphere. In assessing the effects of drugs it will be important to be dispassionate (emotionally uninvolved) in assessing the evidence on what they actually do.

The drugs we will be talking about affect a person's behaviour but may also have major physical effects as well. A major effect of many drugs is that of dependence, whereby a person will need to continue taking the drug merely in order to feel normal; dependence is often associated with tolerance such that increasing amounts of the drug are required to produce the same effect. Not all drugs are equally dependence-producing while some drugs are taken, not only in order to feel "normal" but for their mood enhancing or other desired effects. A typical dependence producing drug is nicotine, a constituent of tobacco smoke; other constituents of the smoke can produce very dangerous physical consequences in the long-term. Alcohol, the "desired" constituent of many beverages may produce dependence, usually over a much longer period, in some persons and it too, especially when taken in rather high quantities can cause serious disease in many organs of the body; but the alterations in behaviour associated with imbibing high quantities over a short period can also produce many problems consequent upon violence or accidents and so forth. It should be noted that while youthful drinking is often more conspicuous because a young person may be acutely intoxicated and behave violently, the majority of problems associated with alcohol abuse tend to occur in older age groups.

Another drug derived from a plant growing readily in many African countries - cannabis - is not strongly dependence-producing and neither produces such serious psychological or physical consequences as alcohol (and tobacco); there is a much increased mortality associated with alcohol and tobacco use, but none is described for cannabis. Cannabis use is widespread in many African countries and there is little reliable data on trends in the number of persons experimenting (a very common phenomenon), initiating regular use or actually using on a regular basis. Statements are sometimes made regarding an increase in use without the necessary supporting evidence and particularly knowledge of the extent of use in previous decades. For example the missionary explorer Livingstone described (Schepera, 1960) quite extensive cannabis use in his "Zambezi diaries" and in a "snowball" survey carried out amongst adolescents in two Lusaka suburbs in 1969, no difficulty was found in recruiting informants (Haworth, 1982a). In surveys (Haworth 1982b) of secondary and tertiary level students carried out in 1979, 38% of males and 6% of females stated that they had ever used cannabis and

8% of males stated that they used it at least once per month and 3% at least weekly. These figures may be compared with a recent report (Wilson et. al., 1994) from a study of Capetown medical students. Only 60% of students in their fifth year responded to the questionnaire, but of these only 44.1% had never smoked it and 2.4% were weekly and 8.3% were monthly smokers.

Some substances of plant origin, like cannabis are taken in a more or less raw state and examples are "khat" (used in East Africa), coca leaves (used in the high Andes) and opium (used in countries such as Myanmar), and in all cases it is coming to be recognized that the physical effects (especially short-term) are not especially serious or dangerous. Both the World Health Organization (WHO, 1993) and the International Council on Alcohol and Addiction (ICAA), 1995b) have issued statements recently which some may consider provocative although they are deliberately couched in very cautious or even vague terms. For instance Paragraph 5.1.2 of the Twenty Eight Report of the WHO Expert Advisory Panel on Drug Abuse states:

> ... the Committee discussed the advisability of prohibiting under international conventions plant products containing psychoactive substances that are traditionally used by indigenous populations ... they usually have only mild psychoactivity in the form used ... However the prohibition of these products ... might outweigh any health benefits.

Likewise the ICAA has issued a Policy Discussion Paper which lists some objectives for the international community regarding aid for drug control in developing countries and its last paragraph reads:

> "Drug prevention and rehabilitation should be carried out at a local or regional level, taking into account traditional use of some psychoactive substances."

I will take up other aspects of the argument presented by ICAA later in this paper. Neither of the documents I have quoted names the substances of plant origin but it seems certain that they are likely to include coca leaves, opium and cannabis as well probably as catha edulis.

It is one thing to state that indigenous plant products, as traditionally used may not be especially dangerous, but some of them can be processed into much more powerful dependence-producing drugs - the two most notable (and notorious) being heroin and cocaine. Neither is now used therapeutically, although they have useful effects, but related substances are so used - for example drugs related to heroin are used for the relief of pain. It is a little appreciated fact that heroin and other products derived from opium, taken in a dose appropriate for the amount of tolerance, are not dangerous as such and may in fact be taken for years without harm, provided this is done under medical supervision. Yet there is such apparent "fear" of using opioids when they could be of great benefit that it has become necessary to draw the attention of the

medical profession to a powerful part of their therapeutic armamentarium (Zenz et al, 1993). This problem has special relevance in a country such as Zambia where a larger number of persons with terminal illness from HIV infection will need to be able to die the kind of comfort and dignity that morphine can give.

The danger arising directly from use of these drugs is overdose (say in a user who has lost his tolerance by having abstained for a time) and such overdose can be fatal. Other medical dangers are as it were incidental to the mode of use. Intravenous injectors may acquire other serious infections such as hepatitis B and, especially HIV, as well as bacterial infections. The style of life resulting from a high level of dependence in a person without ready access to the drug may result in that person acquiring other diseases. But it should be noted that, in the case of some persons, abnormalities of personality and behaviour had probably led to the initiation of drug use, and not vice versa. Other unwanted effects arise from the social circumstances surrounding obtaining supplies of the drug and so forth - resulting say in criminal or even violent behaviour. Violent or hypersexual behaviour, for example is less likely to be associated with intoxication than with other aspects of the drug user's life-style. In a recent newspaper report in Lusaka ("The Post", February 14, 1995) a police spokesman is quoted as stating that crime occurs while the drug abuser is intoxicated, while a spokesman for the Drug Enforcement Commission states that crime is related to the need to make money to support the habit. As occurs so often in the popular media, no effort is made to distinguish between the very different effects and potential for harm of different drugs. Even in the case of cocaine, where use of the "free base" (in the form often of "crack" has become prominent in some countries (but not, as yet in most African countries), a considerable mythology has been established; a recent review (Hohn, 1992) has shown that such mythologizing of the effects of cocaine is not new.

At least in Zambia, sniffing of gasoline has been well established as a habit amongst a proportion of boys for many years. The use is almost always experimental and transitory and no or perhaps no evident harm results. But many other inhalants have now arrived upon the scene and they are principally used by street children and youth. (Petrol sniffing was usually tried by ten-year-olds). The new inhalants have potentially very dangerous effects and long-lasting brain damage may occur to the extent that routine medical examination carried out long after use has ceased, may reveal abnormalities (Jenson et. al., 1990). These substances are relatively cheap and street children in Lusaka have recently produced another type of inhaled drug which they call Jenkem. No information on its nature can be given at the time of writing this paper since it has not yet been analyzed, but the effects of inhalation are said to include initially feeling stronger and more alert and feeling edgy and confused without the drug. Since it is made from sewerage, it is extremely cheap. But so also are other volatile substances and this is one of the reasons why their use tends to spread so rapidly amongst the street population. While much has been made of the use of "designer" drugs in developed nations (such as "Ecstacy" - MDMA - methylenedioxymethamphetamine) it must also be recognized that the youth of poorer nations are also ready experimenters. For instance, in Liberia (Haworth, 1992) in early 1992, a description was obtained of the

use of a drug called "dugee" by the locals and said to be a mixture of "embalming substance A with heroin, cocaine and amphetamine". If this description weref accurate, the combination could have had very strong dependence potential. Incidentally a similar mixture (heroin and amphetamine) was described at about the same time as being used in Nigeria. Could there have been a connection because of the presence, in Liberia of Ecomog troops, some from Nigeria, at this time? In Mauritius (Haworth, 1991) some individuals were described as having turned to the intravenous injection of what they termed "salad" a mixture of an analgesic, and sedatives in water or weak vinegar.

It must be appreciated that the pattern of drug use in any individual country may vary greatly over time - but that the variation may take place at very different rates for various drugs. As will be described below, alcohol and tobacco are drugs which are likely to have the greatest economic impact upon countries in Africa at the present time. Changes in their patterns of use tend to be relatively slow except in cases where sudden and marked changes in the supply position have been imposed. It should also be noted that the unwanted effects, at both the personal and epidemiological level may only follow after considerable time-lags. A series of surveys of drinking in Zambia over a period of 25 years (from 1969 to 1994) have shown a surprising constancy in proportions of persons who are abstainers or regular drinkers although absolute quantities of commercial beverages consumed have fallen, relative to population increase. (But nothing is known of the quantities of illicit beverages). The anthropologist Dwight Heath (1994) has recently revisited the Camba people and states,

> I am - like them - struck by how little has changed as well as how much has changed ... All these changes have occurred ... without extinguishing the distinctive pattern of alcohol use that made them famous three decades ago.

In the case of other drugs, there may be a very sudden expansion as has been the case with amphetamines and designer drugs such as MMDM. Reference has already been made to the use of a drug combination (dugee) in Liberia; the war in that country had a marked effect upon the spread of use of certain drugs and particularly a combination of alcohol and cannabis as well as (for a time) of looted benzodiazepines. A recent description (Okello, 1995) of the drug situation in Kenya refers to a perceivable upward trend in the abuse of "social" and illicit drugs; increasing use of solvents, and not only by youth; an increase in the use of depressants to counteract the sleeplessness induced by khat; and the use of cough mixtures for their drug content. Unfortunately, I have no figures as yet but, in any case this is to some extent a description of the types of inter-relationships between drugs such as is commonly seen. Cough mixtures, which contain the opium derivative codeine are well known by drug abusers.

I know of no adequate statistics, on drug use (including alcohol and tobacco), regularly collected, from any African country. Too much reliance has been placed on the statistics provided by drug enforcement agencies (which also have serious limitations

- including providing no data on legally consumed alcohol and tobacco) and urgent action needs to be taken to correct this situation. The World Health Organization Programme on Substance Abuse will hopefully be responding to this major need and has already taken preliminary steps.

**The Economic Consequences of Alcohol and Drug Abuse**

Tobacco and alcohol are the two most important drugs of abuse in most African countries and their use has important economic consequences, although it has been remarked that to try to balance the credit only in terms of an economic calculation does not make sense. While the use of tobacco is diminishing in developed countries, it appears that developing countries are being targeted by the tobacco industry and the numbers of smokers of both sexes is rising. The main economic consequences arise from the amount of serious disease consequent upon tobacco use - both in terms of the costs of medical care and also in terms of the loss of valuable trained manpower. Since it takes such a long time (measures in years) before the main harmful effects (such as bronchial carcinoma, or narrowing of the arteries of the heart) of tobacco use are usually manifested, the full economic impact has probably not really been felt in most African countries.

Neither are figures available for the economic impact of alcohol. But how does one calculate the cost? One would have to look at the loss in working hours, in investment in training and so forth of those injured and unable to work. The full range of costs (dealing, in effect only with direct costs - not costs to industry) include payments to hospitals and physicians and to specialized services and to ancillary service providers, the overall costs of morbidity in persons not needing institutional care, costs related to death, costs arising from crime, motor vehicle crashes, fire destruction, social welfare administration, costs in relation to victims of crime, the costs of applying penal sanctions and the costs of special diseases such as the foetal alcohol syndrome. Some idea of how serious the problem is may be taken from the United States (Edwards et. al., 1994) where it has been estimated that the cost in 1990 was over 100 billion dollars, with over 80% of these costs related to treatment, morbidity and mortality. Yet by far the greater cost comes from the impact upon industry and commerce. But one must be cautious about extrapolation from the developed to the developing world. At a meeting of experts convened by ILO in Geneva in January this year the ILO Director of Training stated that there were now well over 50 million drug-dependent people in the world, and alcohol ranked as the third leading cause of death after heart disease and cancer (both, it should be noted, also occurring more often in heavy drinkers). The excessive use of alcohol and drugs in the workplace results in increased risk of accidents, deterioration of health of workers, lower productivity and increased absenteeism - quite apart from the many other social costs. The preface to an ILO draft code which emanated from the meeting stated that while the elimination of drug abuse is a highly desirable goal,

experience has shown the difficulty of achieving this goal and therefore managing alcohol and drug related problems in the workplace would seem to yield the most constructive result. The code states that alcohol and drug problems should be considered as health problems and therefore dealt with:

> ... as any other health problem at work ... Employers should establish a system to maintain confidentiality ... Workers should be informed of exceptions ... which arise from legal and ethical principles.

In a survey carried out on behalf of one particular industry by the Alcohol and Drugs Unit of the National Mental Health Resource Centre, in Lusaka (Chita et. al., 1994), alcohol was confirmed as being the most important drug of abuse (and not a major problem in that particular industry). However, it was noted that the industry sometimes contracted transportation to private companies which paid drivers on a "distance driven basis" resulting in drivers resorting to obtaining supplies of catha edulis, to keep them awake. No data were available as to whether this eventually entailed any economic cost, in terms of greater liability to accidents but there was possibly a psychosocial cost to the drivers involved.

Similar gross figures to the ones quoted above from the United States may be given for South Africa (Parry, 1994). In 1985 it was estimated that the total cost of alcohol misuse was R1.2 billion per year and an estimate for 1994 was in the region of five billion, although this figure has been criticized as speculative. Since so high a proportion of these costs involve the established work-force and are related to alcohol consumption in older persons, it is difficult to relate these figures directly to youthful drinking. However, as has been remarked, youth are more likely to be involved in accidents and in many cases these involve extra costs from damage to property, vehicles etc.

## Some Economic Aspects of Drugs other than Alcohol and Tobacco

This paper is written from the point of view of demand reduction and harm minimization, since these appear to the author to be the more important aspects, in relation to youth. It must be stressed however that, from an economic point of view, except in the case of some nations whose economies largely depend upon growing and supplying illicit drugs, the greater effects, in most countries come from use of tobacco and alcohol, as discussed already. Youth may be involved in trafficking or in street sales but, at present, the economic impact is probably not great; but it does need to be monitored. There are however other economic aspects.

An important concept in relation to the consumption of any beverage or drug is that of price elasticity. This refers to the change in the consumption as the price changes - say the present change in consumption of beer in response to a one-unit increase in price. Where a commodity is said to show price inelasticity, a change in the amount of

consumption is less proportionately than the amount of change in price. A substance producing a strong degree of dependence will be more price inelastic than one with slight dependence potential. Alcohol is on the whole comparatively price elastic and hence demand is price-sensitive. Heroin on the other hand tends to be price insensitive. This has several effects. Because demand is not markedly affected by price increases, the consumer must seek ways of raising funds - or of using less heroin. For instance, in Myanmar some years ago, action against the cultivation of the opium poppy produced a marked rise in the price of heroin. Up until this time heroin had been widely smoked but now it was injected since this is a more cost-efficient way of taking the drug. Unfortunately the increase in intravenous use led rapidly to higher degrees of dependence (because of the more rapid "high" experienced) and hence to increased demand and also led to a very rapid increase in the spread of HIV infection amongst intravenous users.

The International Council on Alcoholism and Addiction has recently issued a policy discussion paper on aid for developing nations and drug problems (ICAA, 1995b) which deals further with some important economic and social issues. It was remarked that the criminalization of a vast number of drugs has brought or reinforced a certain number of phenomena such as powerful underground organizations, corruption in social and political institutions, economic distortions and international conflicts. As already mentioned, we need not consider the question of the impact on countries in which the production and export of illicit drugs is sometimes the main economic activity of that country; so far no African country is active in this way. The ICAA paper makes the point that where countries are involved in drug trafficking on a sufficiently large scale developed nations may use the drug issue to exert pressure on the developing country "to assert leadership" as the paper puts it.... The paper also refers to what is described as "inflation" of the public health situation:

> The focus of attention is centred upon drugs that are politically sensitive but not necessarily the major issue from the health point of view. Alcohol abuse (which, as already pointed out has major economic consequences) can thus be overlooked which cocaine or marijuana (cannabis)abuse is stressed independently from actual drug use patterns. Furthermore, prevention strategies are planned without relation to epidemiological realities and the results are not evaluated. In consequence the true drug abuse situation is not addressed because of misdirected resources channelled to inappropriate treatment organizations ... Regardless of public health issues, programmes tend to focus on substances that are of interest for donor countries but that are not necessarily relevant to the beneficiary countries ... There is disrespect for traditional consumption of some substances which play very important cultural and religious roles.

Some of you may well find that much in this paper is contentious, and yet we cannot afford to ignore the arguments. After all, if we do we will eventually be the losers - to the gain of the developed world. To give a context for arguments presented so far, I make reference here to one nation which has become notorious for its links with drug trafficking. Much is made of the spread of use of heroin and cocaine within Nigeria and recently, apparently in order to improve its international image, some thousands of killogrammes of cannabis were publicly burned. Yet remarkably small figures have been quoted for the number of cases of various types of drug abuse treated at some institutions in Lagos and Abeokuta. It must be remembered that Nigeria is the most populous country in Africa and that recent accounts have shown a very large increase in the number of breweries in the country; accounts have been given of many alcohol-related traffic accidents on Nigeria's notoriously unsafe highways. Yet at Aro Hospital (in Abeokuta) only 62 patients were reported as having been treated for drug abuse in 1985/86. In Lagos (a much larger metropolitan city of several million persons) the principal mental hospital reported 100 patients treated for drug abuse in 1992. This is not the only facility in Lagos for the care of drug abusers and in another facility 55 were treated in 1993. It should be remarked that the drug of primary use in the Lagos groups was heroin in one case and heroin and cocaine in the other. These numbers contrast dramatically with the thousands of heroin users being treated (sometimes in "batches" of several hundred, as in Myikyina in northern Myanmar) in some south Asian countries (Haworth, 1990).

The question of the cost of some types of drug is too often ignored in assessing potential dangers of a rapid increase in the numbers of users. Mention has already been made of "Jenkem" in Zambia. Likewise the increase in use of intravenous heroin in Myanmar was economically motivated. An illicit alcoholic beverage in Zambia, kacasu, with an alcohol content, often of about 25%, may be bought at a cost of ZMK400 - the same as the cost of the same quantity of lager beer, containing only 4% alcohol. There is an urgent need for studies to be carried out in order to determine comparative costs of various drugs and their likelihood of use, in terms of price elasticity, as discussed above. Thus, while "Mandrax" (methaqualone with diphenhydramine) is trafficked through Zambia, it is hardly used in this country, and certainly not by street children, because of its comparatively high cost. In any case, its use (with cannabis) is more often required in circumstances requiring a rapid "high" leading up to the slower effects of cannabinoids.

## Interlinkages and General Discussion

One of the topics for this review is entitled "interlinkages" and I have kept it in mind in much of what has already been presented. There are many obvious interlinkages which have been explored such as those between gender and dis-empowerment, and between youth and developing sexuality and the danger of acquiring HIV infection and

other diseases. I have neglected any further discussion of the impact of civil and military disorder and must do so in this final review of themes. At this point I wish to explore a number of themes, some of which have been explicit and one implicit in what has already been presented.

The implicit theme is that of taking on board, in our thinking the concept or perspective of "harm reduction". The concept was first developed in relation to the use of psychoactive drugs but I intend to examine how this concept can also be linked to sexual behaviour as well. Here is a basic, abbreviated working list of some of the principal components of a "harm reduction" approach:

1. Non-medical use of psychoactive drugs is inevitable in any society and drug policies cannot be based upon a utopian belief that non-medical drug use will be eliminated. It is likewise utopian to assume that mere information and exhortation will persuade people to desist from risk-taking forms of sexual behaviour.

2. Non-medical drug use and careless sexual behaviour will inevitably produce important social and individual harms. Policies cannot be based upon a belief that drug use or sexual activity will be engaged in safely.

3. Policies must therefore be pragmatic and assessed upon their actual consequences, not on whether they symbolically send the right, the wrong, or mixed messages.

4. Youth, using drugs or engaging in sex are an integral part of the larger community. In the case of drug users, protecting the health of the community as a whole means protecting the health of drug users and this requires integrating them within the community rather than attempting to isolate them from it. This policy may also be applied equally to our attitudes to protecting the sexually vulnerable girl; potentially dangerous and traumatizing methods of defence are less effective than empowerment of young women in the community.

5. Drug use and sexual behaviour can lead to a wide variety of forms of harm, through many different mechanisms and hence a wide range of interventions will be necessary to reduce drug use, or sexual activity to reduce harms.

It is easier to see some groups as more deserving of sympathy than others. As mentioned earlier, we have a tendency to stereotype the youngster on the street as at least a potential pick-pocket and purveyor of dangerous drugs, deserving incarceration in a policy cell, for the public ("my") protection. Attitudes (on the part of males) to attractive and importunate female prostitutes may be ambivalent, setting up defense mechanisms, leading to wholesale condemnation of the practice, and labelling of

prostitutes as unworthy of assistance. The sons and sometimes daughters of the very rich may be labelled as bringers of an unwanted "western, drug and sex-oriented" life style which undermines traditional values when, in fact their despairing parents and the youth themselves may need assistance in adjusting to a society they have grown away from - in the case of youth, while being educated, say far from their own country.

The principles listed above can be applied to these cases and many more where our reaction, if not checked against real needs may be destructive rather than constructive. However, applying these principles may mean throwing off the yoke of the new colonialism, which has been described (in effect) by the ICAA policy statement summarized above. I am suggesting that, in following current policies on drug abuse (by focussing mainly upon the internationally well known "hard drugs") we may be seriously neglecting far more economically harmful drug-taking practices. Adelekan and Stimson (1995) have drawn attention to the fact that (some) international agencies tend to reinforce over-criminalization of drug use in developing countries - they tend to favour those strategies which have an impact on donor countries - thus essentially making the same point as the ICAA. But these authors also draw attention to other problems in establishing a harm reduction approach, including the extra burden placed upon health and social welfare systems, discomfort those holding strong moral views, the actual costs of interventions and access to populations (in terms of public information and education strategies, for example).

However, the response to HIV has shown that a harm minimization approach can work. Advocating the use of condoms is essentially such an approach whereas an extreme form of the "supply reduction" approach would be to segregate all those found to be HIV infected. In my view we have much to learn from what work is being carried out in various spheres of social action which have, up-to-date tended to be looked at separately. This paper has presented an attempt to bridge this gap.

However, we must, as adults do much more than inform, teach or offer assistance. A recent article in the Lancet (Males, 1995) draws our attention to the need to re-examine the way we approach youth problems but examining and acknowledging the adult contribution to these behaviours.

> ... prevention campaigns are likely to succeed only when they finally limit the emphasis on youth-targeted campaigns, poster slogans, condescending attitudes and punitive approaches ...

I hope that my somewhat provocative stance will succeed in initiating some new thinking upon some old problems - the relationship of youth to their elders (and vice versa) and the relationships between the developed and developing nations.

***References***

*Adelekan, M.L. and Stimson, G.V. (1995) Harm reduction in an African Context: Problems and Prospects. (unpublished paper).*

*Alcohol Alert (1992). Alcohol and AIDS. Washington, NIAAA.*

*Barker, G.K. (1991) Reaching the Hard-to-Reach. Childhope USA, inc.*

*Centre for Population Options (1992) Adolescent Fertility in Sub-Saharan Africa.*

*Chapakwenda, K., Haworth, A. and Baboo, S (1994). Drug use among boys attending a "Street-kids Drop-in-Centre" in Lusaka, and their companions. Unpublished paper.*

*Chita, P and Haworth, A (1994). Report on A Study on the Potential for Alcohol and Drug-Related Problems Amongst Employees of BP (Zambia) Ltd.*

*Dareer, Asma el. Woman, why do you weep? Circumcision and its consequences. London. Zed Press. 1982.*

*Des Jarlais D.C. (1995) Harm Reduction - a Framework for Incorporating Science into Drug Policy. American Journal of Public Health 85, 10-12.*

*Donald, D. and Swart-Kruger, J. (1994) The South African Street Child - Development Implications. South African Journal of Psychology, 24, 169-174.*

*Edwards, G. et. at. Alcohol Policy and the Public Good. Oxford, Oxford Medical Publications, 1994.*

*Feldman et. al. (1995) High Risk Sexual Behaviour Among Some Female Zambian Out-Of-School Adolescents. Paper presented to the Society for Applied Anthropology, Mexico.*

*Forgy, L. and Mwanza, A. (1994) The Economic Impact of AIDS in Zambia. Ministry of Health, Lusaka.*

*Fylkesnes, K. et. al., Zambia: The Current HIV/AIDS Situation. GRZ, Ministry of Health, Lusaka, Zambia.*

*Government of Kenya, Ministry of Health (1988). Schoolgirl Pregnancy in Kenya.*

*Government of Republic of Zambia (GRZ). (1985). Report of a Workshop on Vocational Training for Disabled Children and Youth in Zambia.*

*Haworth, A. (1982a) A Preliminary Report on Self-reported Drug Use Among Students in Zambia. Bulletin on Narcotics, 34, 45-60.*

*Haworth, A. (1982b) Studies and Surveys of the Use and Abuse of Drugs in Zambia, 1966-1981. EPDAF/3i, UNESCO, Paris.*

*Haworth, A. (1983) Public Awareness of Sexually Transmitted Diseases in Zambia. Medical Journal of Zambia. 17, 9-12.*

*Haworth, A. (1990) Report of an Evaluation Mission to Myanmar. WHO/UNDCP.*

*Haworth, A. (1991) Proposal to Establish a Regional Consultative and Resource Unit on Drug Abuse and Illegal Trafficking. Commonwealth Regional Health Community Secretariat.*

*Haworth, A. (1992) Report of a WHO Consultancy on Mental Health Services in Liberia.*

*Heath, D. (1994). Book Review: Alcoholism in North America, Europe and Asia. Journal of Studies on Alcohol, 55, 635-637.*

*Heath, D. (1994) Agricultural Changes and Drinking Among the Bolivian Cambia, Human Organization, 53, 357-361.*

*Hohn Karen Dope Girls: The Birth of the British Drug Underground. London, Lawrence and Wishart, 1992.*

*ICAA News (1995a). Drug and Alcohol Problems in the Workplace.*

*Jansen, P. Richter, L.M., Griesel, R.D. and Joubert, J. (1990) Glue sniffing: a description of social, psychological and neuropsychological factors in a group of South African street children. S. Afr. J. Med 20 150-158.*

*Kiragu, K. (1991) Factors Associated with Sexual and Contraceptive Behaviour Amongst School Adolescents in Kenya. Final Report of the Nakuru Fertility Survey, Johns Hopkins University School of Hygiene and Public Health.*

*Levy, J.A. (1995) HIV research: A Need to Focus on the Right Target. Lancet, 345, 1619-1621.*

*Lifson, A.R. (1995) Prevent in AIDS, have we lost our way, Lancet 346, 299.*

*Males, M.A. (1995) Adult Involvement in Teenage Childbearing and STD. Lancet 346 64-5.*

*Mamoliehi, M. (1994). Female alcoholism problems in Lesotho, Addiction, 89, 945-949.*

*Mkandawire, R. (1995) An Alienated and Disillusioned Youth, Commonwealth Youth Programme, Africa Centre.*

*Okello, R. (1995) Lancet, 346, 111.*

*Parry, C. (1994). Alcohol Misuse: A Significant Public Health Threat Facing the New south Africa. Urbanization and Health, Medical Research Council, Tygerberg, South Africa.*

*Population Reference Bureau (1992) Adolescent and Women in Sub-Saharan Africa. A Chartbook of Marriage and Childbearing.*

*Post No. 256, 14, February, 1995. Impact of Narcotics.*

*Richter, L. (1991) Street Children in South Africa. Paper presented at the First National Workshop of Streetwise, South Africa.*

*Schepera, I. (editor) Livingstone, D. Private Journals (1851-3), London. Chatto and Windus, 1960.*

*Schurinck, W. (1995) Prostitution: Some Notes on Sex-for-Money with Special Reference to South Africa. Paper presented during a workshop on Impact on Commercial Sex on Society, Lusaka, June 1995.*

*Taylor, J and Steward, S. (1991) Sexual and Domestic Violence. Women and Law in Southern Africa, Harare, Zimbabwe.*

*UNDP (1993) Children and Families Affected by the HIV Epidemic.*

*UNDP (1993b) Female Genital Health and the Risk of HIV Transmission.*

*UNV Support Group, Zambia. (1994) Basic School KAP Survey Report.*

*UNICEF/WHO (1992) Strategies to Promote and Maintain the Healthy Development of Young People.*

*WHO (1983) Report on a Symposium on Accident Prevention in Childhood.*

*WHO (1989) The Health of Youth.*

*WHO/UNFPA/UNICEF (1989) The Reproductive Health of Adolescents.*

*WHO Technical Report Series 836 WHO Expert Committee on Drug Dependence, Twenty Eight Report, Geneva, 1993.*

*Wilson, D.A.B. and Karassellos, B.A. (1994) A prevalence survey of substance abuse, smoking and alcohol consumption in medical students. Southern African Journal and Child and Adolescent Psychiatry. 6, 57-61.*

*Zenz, M. and Willweber-Strumpf (1993) Opiophobia and cancer pain in Europe. Lancet 341 1075-6.*

# EXISTING POLICIES AND MEASURES AND THEIR EFFICACY FOR THE PREVENTION AND CONTROL OF ILLICIT DRUG TRAFFICKING AND ABUSE BY YOUTH*

## I. INTRODUCTION

Zambia is a very youthful nation with about 61% of the total population being under 20 years of age, in a country with one of the highest urbanization rates in Africa. This segment of the population is supposed to be the healthiest, most energetic, innovative, productive,imaginative and a significant human resource for national development. However, because of a number of factors such as the difficult socio-economic conditions and poverty, being out of school, youth unemployment, social changes arising from an unabated rural-urban migration, urbanization and industrialization, social decay in urban areas, over half of this youth population is being wasted and falling prey to AIDS, drugs and other vices.

Drug abuse is just one of the many problems affecting the youth today in Zambia. In general, most drug abusers are young, poor or both, and this is not an exception to Zambia. This does not mean that the young people who are rich do not abuse drugs. They do, but the poor, unemployed, out-of-school youth and those from either broken families without parental love and support or families with drug abuse history are more vulnerable to be completely destroyed by drug abuse.

> Drug abuse and alcohol abuse is rampant among street kids because they want to run away from the reality of this society which they believe is cruel to them. They take anything that will intoxicate them...dagga is widely abused because it is very cheap and readily available (DEC Reporter, DEC Journal, vol.3, No.3, p.11).

For example, there is a strong relationship between the number one youth problem in the country, unemployment, and drug abuse. The youth unemployment problem deprives the youth of income and degree of independence from the family, social contacts, controls and shared experiences, individual goals and purposes, personal status and identity, sense of achievement, satisfaction and personal worth.

As a result, some of the youth engage themselves in such problematic behaviour as drug abuse as a way of numbing their daily pains (a temporary escape from reality); expressing anger, frustration, joy and pride; and even making a living. On the other

---

* By Dr. Lawrence Mukuka, Head of Department of Social Work and School of Social Sciences, University of Zambia, Lusaka, Zambia.

hand, the young people from loving, supportive and rich families may engage themselves in drug abuse for other reasons such as peer pressure, curiosity, ignorance, assertion of sense of self, and validation of experience.

For a long time prior to the late 1980's, Zambia's geo-political position and centrality in the Southern African region made her a transit point for illicit drugs such as mandrax, opium and hashish from sources like India destined to markets in Europe, North America and South Africa. Although this pattern is changing rapidly making Zambia both a transit and consumer country for illicit narcotic drugs, the two common drugs which are usually abused by the youth are basically alcohol and cannabis because they are widely available in the country as they are locally produced, and relatively cheap.

The other drugs that are more sophisticated and expensive like cocaine, khat/miraa, opium, heroin, hashish, morphine, mandrax are available in the country mainly in transit to outside markets. The Drug Enforcement Commission has reported a wide use of heroin and cocaine among the youth drug addicts in Zambia, especially those from well-to-do families, who can afford to buy them at the high street-value prices.

It appears, therefore, that there are two significant groups of youth drug abusers in the country, that which abuses alcohol and cannabis, by far the larger group found throughout the country in both rural and urban areas, and the one that abuses sophisticated and more expensive drugs like heroin and cocaine, presently confined to the few with the means to obtain them.

The consequences of youth drug abuse are many for the individuals themselves involved, their families, communities and society at large. For instance, youth drug abuse drains the limited human and financial resources that might otherwise be used for social and economic development, hence undermining the national economy; destroys individuals, families and communities by giving up the chance to lead productive lives; increases the risk of spreading AIDS, crime, violence and corruption; and causes human developmental lags, learning difficulties and disabilities, deficiencies in interpersonal and social competence.

Different approaches and measures are required in dealing with the drug abuse problem in the two groups of drug abusers. The recommendation for an economy with an improved productive capacity, although may not necessarily be the panacea for the youth drug problem in the country, it would definitely and significantly reduce the scourge.

## II. EXISTING POLICIES AND MEASURES AND THE EFFICACY FOR THE:

### a) Prevention and control of illicit drug trafficking and abuse by youth

The abuse of drugs such as cannabis and alcohol is not a new phenomenon; it existed even in the traditional society. What is, however, significantly different now is the context in which these drugs are being abused. In the traditional society, there were serious social sanctions such as denial of marriage, respect and inheritance rites to drug abusers by members of the society. The consumption of both alcohol and cannabis was strictly controlled and families were proud and aspired to raise 'straight and responsible' children free of alcohol and cannabis.

This context of the traditional society has drastically changed with urbanization, rural-urban migration and loss of contact with villages and traditional family values, ties and social controls. The exposure to Western social institutions such as education, religion and the concepts of money and waged employment and their embodied values, have hastened the processes of social change from traditional society to the contemporary one.

At the onset of urbanization, created by the opening of the copper mines, the British colonial government in 1926, imported the English law into this country and passed The Dangerous Drugs Ordinance to control the intake and trafficking of illicit drugs. In 1967, the first Zambian government passed the Dangerous Drugs Act to replace the 1926 Ordinance. As drug trafficking became widespread and assumed local and international significance, the government supplemented the 1967 Act with the 1989 dangerous Drugs (Forfeiture of Property) Act, to strengthen the law on illicit drugs. This Act has been even strengthened further by the 1993 Narcotic Drugs and Psychotropic Substances Act, which has carried unprecedented stiff penalties and forfeiture provisions for drug crimes.

Before the mid 1980's, the sophisticated drug problem, as we know it today, was insignificant and the responsibility to check on the drug problem was given to a mere police squad within the Zambia police force. This squad, however, collaborated with the International Criminal Police Organization (INTERPOL) on a number of cross border drug-related crimes. But as drug trafficking became highly organized and sophisticated in the country, the government responded through a Statutory Instrument No.87 of 1989 and an Act of parliament No.37 of 1993 aimed at putting in place measures of prevention and control. A Drug Enforcement Commission (DEC) was created in 1989 charged with the following responsibilities:

- Reducing drug supplies from abroad, e.g.:

  1. supporting international efforts to curb the production and trafficking of drugs, and amending the laws to deter trafficking and dealers;

2. the government's ratifying the 1988 UN Convention against illicit trafficking in Narcotic Drugs and psychotropic substances. This convention provides, at the international level, for mutual legal assistance; facilitates the extradition and prosecutions of accused persons; facilitates the use of "controlled delivery", defines the responsibilities of commercial airlines and shipping firms and binds governments to eradicate illegal cultivation of narcotic plants.

- Making drug enforcement more effective;

- Strengthening deterrence and tightening domestic controls, e.g.:

1. raising the penalty for drug trafficking to 25 years imprisonment;

2. creating new offenses such as conspiracy and attempts to commit a drug offence, illegal possession of drug instrumentalities, smoking and consumption of drugs, manufacture, money laundering, illegal possession of property obtained from drug trafficking, seizures, confiscation and forfeiture of proceeds of drug trafficking or illegal property;

3. making a drug offence an extraditable offence and deportable under the Immigration and Deportation Act CAP 122 of the Laws of Zambia;

4. no granting of bail for drug trafficking offenses;

5. double penalty for Police and Drug Enforcement Officers involved in drug offenses.

- Developing prevention, e.g.:

1. the Demand Reduction Programme on alcohol and drug abuse which puts emphasis on drug awareness campaigns in the schools, work places and referrals for those already addicted.

- Improving treatment and rehabilitation, e.g.:

2. establishing a counselling centre for drug abusers and making referrals to Chainama Hospital for detoxification and treatment.

The weakness of these measures is a bias towards drug trafficking, and abuse of sophisticated illicit narcotic drugs, which currently only affect a small and insignificant proportion of the youth population in the country.

It is this small segment of the youth population that appears to have been the main target of the current prevention and control measures. The reasons for these biases include the externally induced drug activities such as trafficking and drug-related UN Conventions, easy publicity that goes with the seizure or use of sophisticated illicit narcotic drugs, the complicated and deadly nature of these drugs, and lack of resources to mount an effective country-wide campaign against drug (alcohol, cannabis and sophisticated drugs) abuse by the youth.

The larger youth population, scattered around the country, that abuses alcohol and cannabis for a number of reasons discussed above, is generally left out from the mainstream war against drug abuse and almost forgotten as if it did not present the more serious drug problem in the country, the educational drug awareness campaign is miserably inadequate. Alcohol abuse, although socially acceptable particularly in the urban areas, probably poses the highest risk for both individuals and society. Excessive intake of alcohol leads to poor health, serious disorders of the body's vital functions, low productivity, and eventually death. There are currently no social awareness and no measures in place to control alcohol abuse by the youth. Purchase of alcohol is actually unrestricted, regardless of age.

The combination of the lack of the nation- wide comprehensive drug prevention and control programme to cover even the abusers of alcohol and cannabis, and the stigma associated with drug addiction which discourages many drug abusers from coming out in the open to seek treatment leaves many youth drug abusers throughout the country without any treatment and rehabilitation other than what their families can offer them.

> ...It is sad to note that in Zambia, youths are great consumers of illicit drugs. Furthermore, youths have become expert drug traffickers. Some youths pretend to be selling sweets while conducting this evil trade...We need to identify the drug addicts, and what kind of addicts they are. It would even be necessary for us to identify the reasons why the addict had to start taking drugs if we are to change the addict... it is equally important to know the common problems of youths which make them find refuge in drug addiction so that we prevent more youths from falling into the same ditch (drug addiction) (Mulenga in DEC Journal vol.2, No.2, pp.9-10).

It appears, therefore, that while the current short-term and ad-hoc drug prevention and control measures should be encouraged and expanded, the long-term measures that are likely to yield significant national results are those that should address the circumstances and factors such as youth unemployment, poverty and high school drop-out rates which push many young people into drug abuse.

b) **Treatment, rehabilitation and social re-integration of youth drug abusers**

As discussed above, the larger segment of the youth population that abuses alcohol and cannabis has no formal drug treatment, rehabilitation and social re-integration programmes. However, for the small percentage of youth drug abusers of mainly imported drugs, the Drug Enforcement Commission has established a counselling centre, and a referral system to treatment institutions. After being discharged from Hospital, the patient is sent back to the counselling centre for follow-up programmes. At present, there is no Drug rehabilitation Centre.

> The policy on the treatment and rehabilitation of drug addicts in Zambia is aimed at working through the Primary Health Care System which basically encourages the community to care for its sick and take responsibility in re-integrating social misfits back in society. In the same manner, the community has been encouraged to identify those at risk and referring them for treatment at Health Clinics should there be need for medical treatment (Mwansa, 1995).

C) **Co-ordination among various national institutions and agencies and how it can be strengthened**

There has been some co-ordination among various national agencies in the general drug awareness campaign in the country. However, this co-ordination has only been recorded between the Drug Enforcement Commission (DEC) and non-governmental organizations (NGOs) such as Lions and Rotary Clubs, DAPP, Street Kids International, Catholic Church, YMCA and similar others, which may not have the required political power, will and vision, human and material resources with which to deal this national problem.

The problem of drug abuse among the youth is not a DEC's problem or one government Ministry's problem alone, but it is the problem of every one, it is a national problem. Research studies should be encouraged in this area to establish the definition, prevalence and magnitude of drug abuse among the youth in the country in order for the problem to gain national significance and urgency.

Like the fight against the problem of AIDS, which is directly related to drug abuse through impaired judgement and or use of contaminated needles, there should be co-ordination, first of all, at ministerial level, involving key ministries in prevention and control measures like Health, Education, Community Development and Social services, Sport and Child Welfare, Home Affairs, Legal Affairs, Agriculture, Commerce and Industry, and Finance.

The lack of co-ordination among such key national institutions imply that the severity and urgency of the problem of drug abuse among the youth in the country has neither been yet fully established and analyzed with empirical data, nor its consequences on the socio- economic development of the country understood and appreciated. In addition, it shows that the fight against drug abuse among the youth in the country is just in its infancy and ineffective stage.

## III. CONCLUSIONS

1. The incidence and magnitude of the drug abuse problem among the youth has been menacingly on the increase, especially since the mid 1970s with the absence of significant increases in post-secondary education, training, and employment opportunities.

2. The problem of youth drug abuse continues to be seen by the authorities as a minor problem that will be blown away by itself, when in fact, it is not. As a result, the search for its solution is sought, albeit in futility, in developing proclamations and Acts of parliament.

   On the contrary, the youth drug abuse problem has more to do with, and in fact, may be a direct consequence of a shrunk socio-economic structure of the country.

3. The problem of drug abuse among the youth would only be significantly mitigated when the country adopted a deliberate and comprehensive national socio-economic development policy framework aimed at maximizing the use of both potential and available human and material resources, narrowing the gaps between rural and urban, men and women, youth and adults, and attracting sufficient economic investments, especially in agriculture, in the rural areas.

4. The majority of youths engaged in drug abuse throughout the country, regardless of sex, are faced with lack of adequate finance, poverty, inability to support one's self and family properly, lack of essential commodities and lack of, or limited employment opportunities.

5. Information about drugs awareness and the dangers of drug abuse is generally inadequate among the youth and families in the country.

## IV. RECOMMENDATIONS

**For the Short-Term**

1. Supporting existing drug awareness educational and counselling efforts of the Drug Enforcement Commission (DEC) and establishing more programmes in the mass media to inform and educate the public about the dangers of drug abuse.

2. Mobilizing and supporting available governmental and non-governmental resources to establish new and expand existing drug abuse awareness campaigns.

3. Building and strengthening inter-ministerial collaboration and co-ordination between the Ministries of Health, Education, Community Development and Social services, Sport and Child Welfare, Home Affairs, Legal Affairs, Agriculture, Commerce and Industry, and Finance.

**For the Long-Term**

1. Designing a coherent and comprehensive national development vision and local agenda for the transformation of the socio-economic structure of the country in order to create a strong and open economy, link school to rural and urban production and to the development of self-reliance, leadership and strong character building, initiative and entrepreneurship skills.

2. Developing special drug awareness educational programmes in schools for pupils and families.

3. Pursuing at macro-level, policies that are aimed at poverty reduction and economic productivity, particularly through agriculture, and increasing the purchasing power of the majority of people who have been left out from the mainstream of the economy.

4. Any policy adopted aiming at solving the youth drug abuse problem should be based on and backed by a sound national economic policy. In that way, the youth would be able to be incorporated and absorbed into specific sections of the economy and regions of the country, and be helped to develop into responsible citizens.

In conclusion, a number of theorists and health practitioners have used the family systems theoretical framework in the effort to understand, explain and predict the cause of and therefore the solution to the problem of drug abuse among the youth. By this perspective, the development of an addiction is a symptom of a dysfunctional family

system, and the entire family is seen as the patient. This theoretical framework assumes that the addict's personality development, values, perception, socialization and behaviour were fundamentally influenced and to some extent molded by the structure of his or her family. The drug treatment and prevention planning, therefore, should be facilitated by understanding the family structure.

The argument can be expanded to include the fact that the family, as a unit and system by itself, is a part of a larger system, the social structure system or society, which it affects and in turn gets affected by it. The way the cultural, economic, political and social processes are organized and run in a social structure system, has a very significant and profound impact on the health and lifestyle of the family.

The process of control and prevention of drug abuse among the youth has therefore a lot to do with how the societal economic, social, cultural, legal, religious and political institutions are managed, upon which families depend to socialize their children.

The need to revitalize the economy, raise the purchasing power of the families, create training, employment and small-scale business opportunities for the youth, and uplift the general standard of living of the people, in order to fight the scourge of drug abuse among the youth, is of paramount importance, and the basis for all the other measures to be taken against drug abuse.

# YOUTH AND THE DRUG PROBLEM IN LESOTHO: AN OVERVIEW*

Lesotho like the rest of the world is faced with a growing challenge of harnessing the escalating use of drugs by youth. These drugs range from socially acceptable drugs such as alcohol and tobacco and the illegal drugs such as cannabis mandrax and cocaine. Youth also engage in solvent abuse. Health problems faced by youth include: teenage pregnancies; HIV infections; Unemployment leading to sex work, delinquency, assaults, arrests and the increase in street kids. In Lesotho, the Lesotho Narcotic Bureau (comprising of both Government departments, Parastatals and NGO, the Blue Society of Lesotho, the Christian Council of Lesotho and others, play a key role in addressing the problems of drug abuse in the country. Commonly abused drugs and substances include solvents, alcohol and cannabis.

## 1. Solvents

Youth from the ages of 7-18 or above abuse solvents. This practice is common in the Capital city of Maseru. Both school drop outs and school going kids abuse substances such as glue, thinners, etc. It is a known fact that depending on the degree of dependency some of these abusers never outgrow the practice hence it is common to find youth above 18 years still abusing these solvents.

## 2. Alcohol

The fact that alcohol is a socially accepted drug and that the act which regulates the age limit for purchasing is not enforced, youth start at the very early age to experiment with alcohol. Youth socialise with alcohol at end of term, end of year, birthday, and even "come together parties". A 1986/87 study of high schools in Lesotho revealed that by the time youth entered high school, about 45% of them had already experimented with alcohol. Hence, it is not also an unusual thing to see drunk youth anywhere in Lesotho.

## 3. Cannabis

Cannabis grows naturally, so herd boys start experimenting with it at an early age. It is also common boys at primary and high school levels. Cannabis is a highly incapacitating drug for the normal development of abusers as they never attain or reach full maturity in any aspect of their lives. They end up being drop outs, juveniles, and criminals with no family. It is difficult for people to come forward with their problems in this regard due to the legal status of the drug. The herdboys in the mountains end up

---

* By Mrs. M. Mphi, Social Worker, Alcohol and Drug Education Programme, Maseru, Lesotho.

in jail due to associated crime such as rape whilst under the influence of cannabis. Other Drugs abused such as mandrax, cocaine, and other concoctions including home made preparations are also a problem faced by youth, especially youth in the urban areas. Youth are involved in the trafficking of these illegal drugs but there are indications of a spill over.

## SERVICES AVAILABLE

### NGOs

1. **The Christian Council of Lesotho through the department of alcohol and drug** education offers the following:

    1. Training youth leaders
    2. Counselling
    3. Production of teaching aids both visual and audio targeted at youth
    4. Youth gatherings on the subject of drugs
    5. Helping the youth in fund raising for small initiative projects
    6. Campaigns on youth against drugs

2. **The Thaba Bosiu Rehabilitation Centre** which is a total abstinence Centre offers treatment and prevention to youth. Formation of Drug Free clubs is one of the activities targeted at youth.

3. **Community Alcohol Rehabilitation Centre**

    This is also a church based Centre. Along side the Primary Health Care System the Centre manages to empower youth in different aspects of drug free life.

4. **Lesotho Youth Federation**

    This umbrella body tries to provide education to their groups on the subject of drug abuse.

### Government

a) **The Lesotho Narcotics Bureau**

The Government has brought together different Ministries under the coordination of the **Lesotho Narcotics Bureau.** This Bureau is responsible for the prevention and research in matters relating to drug abuse.

b) **Mental Hospital and Observation Unit**

Patients with complications arising from drug abuse receive treatment in the form of counselling and inpatient care from the Mental hospital and other observation units throughout the country.

c) **Health Education Unit:**

Prevention is done by this unit at government level.

d) **The Youth Department**

The youth Department aims at empowering the youth, through skills training with the aim of discouraging the involvement in drug abuse particularly by school leavers and drop outs.

**Ministry of Education**

Currently the Ministry is working on the curriculum which will include the subject of drugs in all classes starting from grade one.

## CONCLUSION

We still need to encourage collaborative and concerted efforts in addressing the problem of youth and drug abuse. As at now the Government plays a minimal role in harnessing this problem. The national policy on this subject has not been devised. It is on such issues whereby government has to facilitate through its machinery, the move towards formation of the national policy. We however, would like to compliment the work done by the NGOs.

# DRUG ABUSE AND HEALTH WITH REFERENCE TO YOUTH IN MALAWI*

## INTRODUCTION

Malawi covers an area of 118,428 km$^2$, 20% of which is under water. It is land-locked bordered to the north, north-east by Tanzania, to the east, south and south-west by Mozambique, and to the west of Zambia.

Its population size was about 700,000 in 1901, 4m in 1966, 6m in 1977, 8m in 1987, and is now projected to be about 10m. The intercensal growth rate was 3.7% per annum during 1977-87. (See Table 1 below).

**Table 1: Growth of Total Population: Malawi, 1901-87**

| Year of Census | Population | | Intercensal Growth Rate % |
|---|---|---|---|
| | De facto | De jure | |
| 1901 | N/A | 737153 | N/A |
| 1911 | N/A | 970430 | 2.8 |
| 1921 | N/A | 1201983 | 2.2 |
| 1931 | 1573454 | 1603453 | 2.9 |
| 1945 | 2049924 | 2183220 | 2.2 |
| 1966 | 4039583 | 4305583 | 3.3 |
| 1977 | 5547460 | N/A | 2.9 |
| 1987 | 7988507 | N/A | 3.7 |

Note: N/A. not available;
Source: National Statistical Office

---

* By A.T.E. Kaunda, District Youth Officer, Ministry of Youth, Sports and Culture, Lilongwe, Malawi.

The youth form an important segment of the populace. According to the demographic data from 1987 census, more than half of the population were young persons below 25 years of age. Also that 46% of the total population was under 15 years with mean and median ages at 22 and 19 years, respectively. This shows that the country is a youthful nation.

This paper focuses on drug abuse and health of youth whilst suggesting possible solutions for discussion. In view of the above, the paper:

1. unveils the genesis and extent of youth involvement in the production, distribution, trafficking and consumption of drugs;

2. looks at the HIV/AIDS and the socio-economic implications, reproductive health and the interrelationship of these problems with regard to youth;

3. reviews the policy of the government and its programmes whilst examining the roles of the family, religious and non-religious institutions, their co-ordination besides the means of strengthening these; and

4. suggests possible solutions that may not only promote the campaign, but also attempt to alleviate the plight of the youth in the final analysis.

**DRUG/SUBSTANCE ABUSE**

The atmosphere of drug abuse is one of mystery. Many activities, especially the production, consumption and trafficking of marijuana occur undercover. It flourishes in a dimension of its own which may not be common. One needs to know the specifics of drugs, the general behaviour and attitude of addicts, the basic tools of using drugs and also the latest terminology. For instance, cannabis has several names like grass, marijuana, hashish, bhang, reefer cigarettes, Malawi gold, and more. It is therefore not surprising that its evidence is usually through indirect means such as juvenile delinquency, crime in general, including burglaries, robberies, rape, murder, and also prostitution.

Drugs make circumstances of life to the user different from reality. The user obtains false comfort, peace, and security. To be precise, the user refuses to face reality when confronted with problems and lacks courage. From less doses, if its use is not discontinued, makes the consumer tolerant and allows greater quantities than before. The situation becomes tragic when the user combines tobacco, liquor, marijuana and hard narcotic drugs, such as cocaine and heroin. The longer the use the harder it becomes to quit; see Shryock [10].

Drug abuse is not new in our country. From experience, cases used to be known but the recent excessive and indiscriminate use which is suspected to have risen to alarming levels, more especially by youth, has been the great concern of the government, NGOs, or indirectly in an interplay of influence fostering a common moral decay.

The main drugs of abuse in Malawi are cannabis, alcohol, tobacco and some prescription drugs like valium. Hard narcotic drugs such as cocaine and heroine have not been recorded except for trafficking cases.

**Cannabis**

Cannabis is a major problem in the country. It is from a shrub growing both naturally and illegally grown in a number of districts including Nkhota-kota, kasungu, Ntchisi, Dedza, Ntcheu, Mzimba and Nkhata Bay. A variety, known as Cannabi sativa, is commercially grown in other countries under a license by the Commissioner for Narcotics for the production of ropes and twine. The drug is obtained from flowers and leaves of both Cannabis sativa and Cannabis indica. It has glandular hairs that secrete both a volatile oil and a strong narcotic resin known as cannabin. This is usually consumed by smoking, snuffing, eating and is even taken like tea; see Martin et al [6]. The substance has been used locally from producing areas to cities of Blantyre, Lilongwe and Mzuzu, and also smuggled abroad. However, due to the paucity of information as a result of several reasons such as lack of research besides being an illegal business, the extent, magnitude and also the involvement of the youth is at present difficult to establish. The little available information is through the indicators compiled by the Resource Centre Against Drug and Alcohol Abuse. According to the Resource Centre, there is evidence to warrant great concern that experimentation and abuse at an early age of 10 years has ben recorded in a mini-study (see Table 2 below).

**Table 2: Proportion at first Use of Drug, and Total Percentage (%)of the Sample aged 8-16 Years for Each or a Combination of Drugs Used**

| DRUG | AGE | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| | 8 | 10 | 11 | 12 | 13 | 14 | 15 | 16 | Total(%) |
| Cannabis (can.) | - | 7.7 | - | 19.2 | - | - | 3.8 | - | 30.8 |
| Tobacco (tob.) | - | 11.5 | 3.8 | 19.2 | 3.8 | 3.8 | - | - | 42.3 |
| Alcohol (alc) | 3.8 | 11.5 | - | 15.4 | - | 3.8 | 3.8 | - | 38.5 |
| Alc/Can | - | 3.8 | - | 3.8 | - | - | - | - | 7.7 |
| Alc/Tob | - | 7.7 | - | 11.5 | - | - | - | - | 19.2 |

Source: Resource centre Against Drug and Alcohol Abuse

According to the chart of incidences of cannabis use for admitted psychiatric patients between 1st April to 31st May 1989, from Senior Government Psychiatrist, about 18% of the insane people were cannabis abusers. In decreasing order the percentage range of total cannabis abusers admitted by districts was 12.2% to 1.2% with Nkhota-Kota as the highest, seconded by Salima (9.8%). Indeed the data were in line with the experience that Nkhota-kota district was famous for cannabis production and abuse (see Appendix 1 and the Bar Chart below).

**Alcohol**

Liquor is posing as a major problem. It is indeed a drug because it alters the functions of the human body, more especially the brain. It is socially accepted though other types of liquor such as local gin (kachasu), are considered illegal. Like other drugs, it makes many users become addicts. It is popular not because of flavour, but because it affects the user's mood by providing a false relief.

In Malawi there are three main types of alcoholic drinks, namely chibuku, spirits and Napolo. The former is brewed in factories situated in Blantyre, Mangochi, Lilongwe and Mzuzu, the latter in Blantyre. About 52 million litres of chibuku valued at about K14.7m were consumed in 1986.

The second type of alcohol is produced by Carlsberg Brewery Company of Copenhagen. The factory is located in Blantyre, with distribution centres spreading across the country. Unlike the first one which is in one litre packets, this is bottled with 4-5 percent alcohol in each bottle. In 1987 about 14.8 million litres valued at about K21.8m were consumed, whilst in 1990, about 23.6 million litres valued at about K52.4m were used showing a significant increase in consumption of the product (see Table 3 below).

**Table 3: Production and Consumption of Carlsberg Beer and Chibuku, 1986-1990**

| Year | Carlsberg | | Chibuku | |
|---|---|---|---|---|
| | Quantity | Value | Quantity | Value |
| 1986 | - | - | 52165000 | 14774296 |
| 1987 | 148000 | 31056900 | 48742200 | 1581097 |
| 1988 | 162067 | 31056900 | 52418540 | 19903690 |
| 1989 | 201678 | 42962600 | 48980660 | 23537718 |
| 1990 | 235987 | 52404858 | - | - |

Source: Resource Centre Against Drug and Alcohol Abuse

Notes:

- Carlsberg shows a steady increase throughout the four-year period. The amount of money spent more than doubled in the same period.

- Consumption of Chibuku varies from year to year. Some of the reasons may be the availability of competitive alternatives, such as, Napolo (probably explains the trend between 1988 and 1989 when Napolo came into the market or other traditional beers that were widely available at more competitive prices).

The third type of alcoholic drinks is spirits. Examples include brandy, gin, whisky, which are distilled in Blantyre. Also in this category is the illicit distilled gin known as Kachasu.

According to small studies conducted by the Resource Centre, youth start drinking at an early age, maybe because of easy availability, social acceptability, and youth's imitation of parents who indulge in it.

The total consumption of the drinks in the country by the youth is hard to establish because of lack of research and records. But it is likely to be high considering the observed trends of alcohol consumption in the country.

**Tobacco**

Cigarette smoking is also a problem of the youth. These are made out of tobacco which is one of the main export products of the country. It is also a drug that makes the user end up in addiction with continued use. The compound at stake is the Nicotine in the tobacco.

Many people who smoke begin in adolescence and it is believed that it is unlikely to start after the age of 20 years. The reasons for smoking are indeed not worth the risk and usually include social pressures emanating from customs where boys and girls regard smoking as an evidence of manhood and camaraderie, respectively. The older people do it to appear younger whilst some smoke because they see others do it.

It is estimated that many millions of cigarettes are smoked valued at thousands of millions of currency units on the continent of Africa each day. Even though the populace is aware of the dangers and the need to stop the habit, the tobacco industry, because of money, tries to popularise it, and makes brands with low tar content besides the use of filters; see Shryock [10].

The results of a small study by the Resource Centre do not give a balanced picture because the subjects of the study were delinquent boys only. However, the experts should appreciate this as evidence of youth involvement. In this study, tobacco smoking was the most prevalent of the indulgences in the sample of 26 boys kept at the Home. Also that tobacco is mostly used in combination with liquor. To echo these revelations, it is not uncommon nowadays to see young persons smoking and drinking.

**Sleeping Pills**

Prescription and over-the-counter drugs have a chemical influence on the way the body functions. The body has its own way of regulating itself, but because of impatience, people resort to drugs unnecessarily. For instance, because of failure to sleep, many people turn to sleeping pills. And because these pills contain some barbiturate compounds which are used for settling nerves or inducing sleep, the user develops tolerance while becoming dependent on them and ends up in the same mess as those mentioned earlier on.

**Drug Trafficking**

Hard drugs like cocaine and methaqualone (mandrax) have been intercepted in large quantities. As can be seen from Appendix 2, cocaine was seized in 1987 and 1990. Methaqualone and cannabis have been confiscated yearly since 1986. According to the Malawi Police drug squad which has a comprehensive and accurate data, 5% of traffickers involved were females with the majority being males aged 25-60 years. Youth have been said to smoke cannabis for pleasure though this has not ruled out the youth drug-pusher who does it for profit. Also of significance has been the participation of foreigners who have been estimated at 5%. It has been known that cannabis has been taken from producing districts to the three major cities of Blantyre, Lilongwe and Muzuzu for local consumption besides being smuggled aborad.

**Effects of drugs**

Drugs have been shown to affect most organs of the body with the production of serious adverse effects. These are extensive though the extent of the effects of each in the populace are uncertain because of the complications caused by the poly-drug abuse. Some of the most adverse effects are deficiencies in learning and motor function; impairment of the immune response; adverse effects on both male and female reproductive functions; pregnancy and foetal development; lung and cardiovascular function; the production of psychoses and the motivational syndrome. With continued use the effects are intensified because of drug accumulation and persistence after withdrawals, especially for cannabis. It is also stipulated from recent evidence that an irreversible structural damage to the brain occurs. The most alarming aspect is that the abusers, especially the youth, do not recognise the harmfulness of these because of, among other things, the wrong conception handed down from seasoned abusers; see Harvey [1]. Though not significant as shown in Appendix 3, drug abuse has contributed to traffic accidents.

## YOUTH AND HEALTH

With reference to the characteristics of youth, it has become explicit why they have fallen victim to social, health and economic problems in the absence of effective control programmes. Of special mention has been the health problems related to sexuality in which sexually transmitted diseases (STDs) including HIV/AIDS have been causes of great concern.

There has been increasing evidence of early marriages, abortions, unwanted teenage pregnancies, pregnancy-related school-dropout cases, prostitution, and rape. To illustrate this state of affairs, according to the 1987 census, there were occurrences of male and female youth in the age segment of 10-14 years who were heading a significant proportion of households. And also that 55% of the nation's population was married with the singulate mean age revealing that girls marry at an early age. Also, that a significant number of cases of 10-14 years young persons were married, widowed and divorced with up to 3 children. To elaborate this further, about 15.7% of the total population were females who were also classified as women in the 10-24 years age bracket. And about 72.7% of these were not attending school. 80.5% of these (not attending school) were of the never-married status with about 2.9% of them having children (see Appendice 4 and 5.

### Youth and HIV/AIDS

As we have seen earlier, there is penetrative sex among the youth and it is documented that sexual intercourse is the main way of contracting as well as spreading HIV/AIDS infections. Therefore, the fact that young persons have been victimised by this 100% fatal disease cannot be ruled out. AIDS is a new disease discovered in 1981. In Malawi, its presence was first confirmed in 1985 and since then the disease has spread so rapidly and has claimed many lives (see Line Chart and Table 4 below).

**Table 4: Recorded Aids Cases in Malawi from 1985 to June 1995 .**

| Year | Recorded Cases (1000) | Cumulative (1000) |
|---|---|---|
| 1985 | 0.017 | 0.017 |
| 1986 | 0.127 | 0.144 |
| 1987 | 0.858 | 1.002 |
| 1988 | 3.034 | 4.036 |
| 1989 | 4.966 | 9.002 |
| 1990 | 5.859 | 14.861 |
| 1991 | 7.439 | 22.3 |
| 1992 | 4.655 | 26.955 |
| 1993 | 4.916 | 31.871 |
| 1994 | 4.732 | 36.603 |
| 1995(June) | 2.217 | 38.82 |

Source: Data Office, NACP, August 1995

NB • These numbers are only reported cases by those who present themselves at the hospital. There is some duplication so that is the reason for the total number being 15% less.

And the cumulative figure of AIDS in 1991 was said to be over 22,000 cases with about half of them already dead. In 1994, the recorded cases were over 36,000. According to the AIDS secretariat, over 15% of STD cases were HIV- positive. But in a study at the Kamuzu Central Hospital (KCH) in 1989, about 67% of STD cases were HIV- positive; see Ngaiyaye [9].

As shown by the indicators that young persons have been sexually active at an early age, it has been revealed that there has been the highest infection rate (40.6%) of STDs and HIV/AIDS within the youth group. Girls have been the most victims especially between the ages of 15-25 years. To illustrate this further, posters by the AIDS secretariat state that out of every 6 youths aged 15-19 years who are sick with AIDS, 5 of them are girls. Also, according to a report in a meeting of District Development Committee members attended by the author in 1993, out of a sample of 60 girls who were tested from a girls secondary school, 58 girls were HIV-positive. This may be controversial because the sample may have been biased. But the reader is hereby asked to appreciate the existence of the disease among the youth.

## DISCUSSIONS

In the light of the above stated situation of the youth with regard to compulsive habits of drug experimentation and sexuality, there seems to exist an interrelationship between most of these problems. The drug abuse problem produces serious adverse effects in much the same way as the sexuality problems. For instance, drugs lead to impairment of the immune response which is similar to HIV/AIDS. Also drugs have adverse effects on the youth reproductive function, pregnancy and foetal development which are the same with STDs and HIV/AIDS. In short, most of the effects are similar. Since these affect the same youth, the condition is aggravated. Also common to all these is the fact that these result from youth being misguided. In connection with this is the idea that the greatest threat to the desirable youth condition is the social disorganisation which has resulted from an increasing number of them having no means of obtaining adequate solutions to their problems. In the absence of meaningful programmes the young persons get influenced by anything that comes their way. To elaborate on this, Africa has been, and still is, reeling under the impact of many new western customs that are flooding the continent like a tidal wave. Nowadays, it is not uncommon to see youth morally weak and perverse, for example, boys make funny haircuts, wear blouse-like shirts, necklaces, earrings, engage in social drinking, smoking, necking, petting, which leads to total perversion. All these are imitations imported through reading exciting love novels, magazines, TV - hellvision and immoral movies.

## NATIONAL POLICY AND MEASURES

Until recently, Malawi had no clear youth policy even though youth programmes had been undertaken. Presidential statements had been used which lacked a framework and realistic guidelines from which action programmes could be developed to facilitate meaningful youth development programmes. Currently, a draft youth policy has been put in place, with embraces a wide range of youth issues including the subjects under study. The goal of the policy is to develop the full potential of the youth and to 'promote' their active participation in the overall national development. And some of the objectives that the policy seeks to address include the promotion of a healthy life among the youth through the provision of appropriate awareness and the Family Life Education (FLE) Programme; to create greater awareness among the youth of the dangers of HIV/AIDS and STD, and also to promote the care of infected persons; to provide appropriate social, vocational, physical and mental programmes for the rehabilitation of the youth with special needs to promote collaboration and co-ordination between the private sector, government, NGOs for the development and implementation of youth programmes at local, national and international levels; and to set up a data bank for easy and quick retrieval of information pertaining to the youth.

It also suggests, on the review of legislation, that those laws with adequate provisions catering for the youth should be enforced by the relevant government department. For instance, Probation of Offenders Act, Children and Young Persons Act, and the Liquor licensing Act contain adequate provisions but are not enforced.

It also has four priority areas for action and two of them directly address the issue of youth, drugs and health. The first is, EDUCATION, TRAINING AND YOUTH EMPLOYMENT and the second is, POPULATION, HEALTH AND NUTRITION in which the following are considered; early pregnancies and child bearing; empowerment of girls; Family Life Education and Counselling; nutrition, drug and alcohol abuse; HIV/AIDS and STDs. In all these, the policy calls for a multi-sectoral approach to intensify campaigns against these problems and the provision of guidance, care and counselling services; see ref.011].

**The Resource Centre**

In line with the policy is the existence of the Resource Centre Against Drug and Alcohol Abuse under the Ministry of Women and Children Affairs and Community Services, based in Blantyre with outreach centres in Lilongwe and Muzuzu. The Resource Centre was opened in October, 1991 in order to reduce the demand for the use and experimentation of drugs. Before this, reduction was done by the Police and Customs Department especially through confiscation of illicit drugs. The model in use is the Drop-in-Centres where clients receive counselling and guidance. This model was chosen because of inadequate financial and human resources. The centre also works through drug action committees on a voluntary basis and it has three components in order to meet the objectives, which are :. (1) Community based programme, (2) Workplace programme, and (3) Rehabilitation programme.

According to one official at the centre in Blantyre, the positive response to the appeals is indeed significant. Workshops have been organised to sensitise most of the ministries and organisations which work with the people.

**The AIDS Control Programme**

The National AIDS Control programme was established a few years ago to foster prevention and control activities of HIV/AIDS. Among other things, it has conducted seminars and workshops for knowledge and awareness of the disease, increased facilities for screening blood and also provided counselling services. Of special mention is the role played by the District Development Committee (DDC), mass media personnel, religious groups, youth groups, schools and community workers. They have helped to sensitise the populace. But to an extent, there has been some resistance with regard to change of behaviour.

**Roles of Other Social Institutions**

In a family setting, parents used to instruct their children on various issues of life. Extremes also existed. Drug abusers and morally corrupt people were considered to be odd and a disgrace to the society. But with the gradual destruction of the local knowledge and customs and their replacement by imitations with less advantages to the receivers than to the givers, the family as a primary institution has suffered a decadence. Children tend to be more influenced by external forces than by the family itself. Some parents have acted irresponsibly by setting bad examples to young ones. To an extent juvenile delinquency has been a result of parental delinquency. But through deliberate programmes initiated by the government or other agencies, the communities have been seen to participate in the interventional activities. Schools have also contributed to the shaping of the youth through regulations that prohibit drug use and sexuality. Religious groupings too have been trying, but their practices have been entrenched by different doctrines so much that the effects of their intervention has not been encouraging. One religious group permits drinking, smoking, another allows young persons to go to movies, dances, night clubs, bars, dating and petting to the point that there is hardly a difference between pagans and the church-going people.

## PROBLEMS IN GENERAL

These can be seen from three view points: those which need to be solved in the society; those which accompany the implementors, those which are within the formulated strategies. With regard to youth problems, these include inadequate education opportunities, unemployment and under-employment, HIV/AIDS and STDs teen-age pregnancy and early marriages, crime and general youth deviance, marginalisation of other youth groups, youth non-involvement in decision making, drug and alcohol abuse, and lack of the truth in the spiritual aspect. The second view-point involves funding, distribution and management of the finances, personnel, training, research needs, multi-sectoral collaboration, and no sound doctrines. Third set includes strategies being formulated without the community in a participatory way and solving problems in a piece-meal fashion when these are actually interconnected. Additionally, poverty is one of the major problems besides cross fertilisation of cultures, as well as the problem of the nations being least informed and least equipped for various problems.

## EXPERIENCES AND HINTS

According to Chatterjee (in ref.[12], reduction of the drug problem and its effects can be achieved through stringent drug law enforcement coupled with an effective programme consisting of prevention (through education and information), treatment, rehabilitation and social reintegration. On the gradual abolition of illicit drug production, he advised that consideration be given to the availability of the populace and the government. On the nature of illicit drug market, he said that it involves large profits from drugs as well as highly organised criminal activities. Also, that education and training be geared towards the local community with a view to change attitudes,

eliminate ignorance and misconceptions about drugs of abuse and the adverse effects whilst training personnel to be well qualified. Chatterjee also said that the demand for drugs does not necessarily depend on price, and that suppliers dominate markets even though available supplies generally surpass the total demand at a given point in time. Therefore, he cautioned, solutions should also address the factors that are conducive to the abuse of drugs.

Westermeyer (in ref.[12] wrote that patterns of drug use evolve from meanings, values, attitudes, beliefs, and norms that a society assigns to any particular drug. That increased drug-related problems in societies around the globe often appear as a result of diffusion, or the spread of a given drug or its mode of administration from one culture to another. He also mentioned the fact that in recent decades and centuries the diffusion rate of the use of drugs from one culture to another has accelerated rapidly and modes of administration have spread. Finally, that problems have arisen if the transmission has been without the donor culture's norms and rituals that accompany the drugs.

Tongue et al (in ref. [13]) suggested that the provision of a wide range of integrated approaches is essential if demand-reduction programmes are to be successful in contacting drug abusers, maintaining that contact and successfully assisting the individual through treatment, rehabilitation and social reintegration was essential. They also suggested that interventions to make changes in life style should be by therapeutic communities, acupuncture, spiritual approach and self-help groups.

Agreda (in ref.[12]) narrated the experiences of the drug abuse control plan in Peru. In the course of implementation a lot of problems also surfaced which included lack of resources, insufficient external technical support, lack of a national comprehensive plan, partially co-ordinated activities, isolated and unsustained activities, new plans too broad and difficult to implement in a systematic way, untrained staff, proliferation of overlapping agencies and ambiguity in the assignment functions, lack of policy and commitment of the government and also of the people, and inter-agency competence.

According to Elmi et al (in ref. [12]) with regard to Khat-chewing control efforts in Somalia, experiences had shown that there were problems faced such as lack of funding for compensations of the destroyed plantations, increased unemployment levels, inadequate law provisions, lack of external assistance though promised, and lack of effective alternatives.

Clements et al (in ref.[13]) also believed that with regard to addicts, external efforts often failed because of the vicious circles of frustration, tension and diminished creativity were usually not broken. These suggested that solutions be geared towards the restoration of the inner resources of the addict such as creative intelligence through transcendental meditation.

Crowly (in ref.[13]) mentioned that drug addiction is a magnification of serious dysfunctional relationships and interactions in the family and is often interrelated with child and spouse abuse, and suggested that these family situations also required multi-disciplinary therapy measures.

Van Der Vaeren (in ref.[14] suggested that an integrated approach was required in the combat against drug problems because from experience the causes and cures are said to be closely linked to the general economic and social development process.

## POSSIBLE SOLUTIONS

### General

For any of the programmes to have an impact, the population in this particular case, the youth, must be seen to participate at all stages. The bulk of them must feel that they share in the benefits of the activities. These should be promoted through sponsoring. Implementing agencies should be rid of organisational problems so that there is concentration on the needs of the society.

The strategies used should not address the needs in a piece-meal fashion and the measures should not be in conflict with existing cultures where alternatives are possible. For example, the use of condoms to young persons, though in principle may sound meticulous, in reality, this would just worsen the situation, because inter alia, it would encourage premarital sex leading to more problems including HIV/AIDS and consequently early entry into graves. Initiation ceremonies have been frowned upon as contribution to early participation in sexuality. The departure from morals has become fashionable and normal when it is actually abnormal. Instead, this should be taken as mere evidence of the problem rather than accepting it as a modern style of living. Pre-marital sex should be discouraged. Therefore persuade youth to take abstinence as a solution. Anything less will just be activities of a mock programme.

The family as a socialising agent should also be persuaded to impart basic morals. Parents in some families have behaved irresponsibly while preaching another message to their children forgetting that actions speak louder than words. This parental delinquency has contributed to juvenile delinquency. Therefore interventions should also include parent education on all issues pertaining to young persons.

Rapists should be dealt with by law by imposing heavier sentences. With reduced constraints and corrected errors, the interventional programmes about drug and health should be conveyed by the government, church, properly qualified counsellors, members of the target group, addicts and AIDS sufferers, drug abuse and AIDS action groups, doctors, community health workers, youth workers and public figures with whom the youth identify. The mode of transmission should be in a clear, understandable, enjoyable and relevant manner through videos, drama, songs with counsellors' presence who, among other things, should supplement, supply information, answer questions and encourage discussions.

The author feels that serious drugs of abuse whether licit or illicit have to be eradicated if our claim that they have serious adverse effects is genuine. The legal or illegal tagging is just a matter of criteria and interests while the effects are the same.

Alcohol and tobacco are equally evil because they have made many morbid and sent others to graves. The populace should be told in black and white in order to bring about the required attitudinal changes. Tobacco is the main export product of the country. Its benefit is only economic and can be compared with cannabis on the illicit drug market. To every Malawian and the government, the tobacco crop is looked at as a major fores earner. It becomes apparent that any statement against the production of this crop would be unpopular and unacceptable in the face of the prevailing poverty and unemployment. Similarly, alcohol is seen as a good social drink but if the total effects caused were measured in the society, no benefit would be attached to it at all. Like tobacco, a statement to abolish all forms of alcohol would be controversial.

Having looked at several experiences and hints, the approach that can handle the drug problem better in the country is an integrated one. All efforts should be geared towards prevention, control of licit and illicit drug production, consumption and trafficking coupled with treatment, rehabilitation, and social reintegration of addicts.

**A Comprehensive Strategy**

First and foremost is the need for the addicts, traffickers, community, industries, religious groups, agencies and government to be greatly concerned and make serious commitments. There has to be willingness to stop drug-related activities even if it means losing popularity and the economic benefits. All these players should learn not to be considerate to these problems.

Education and information on drugs of abuse and other issues such as HIV/AIDS should create awareness. Drug abuse activities should be gradually abolished with the introduction of safe programmes. A participatory approach should be used so that the interventional activities should be conceived by the society with support from NGOs and the government. As for legislation with regard to drugs of abuse, these should be revisited and wherever possible gaps should be filled so that an effective legislation is put into place. The law should be enforced nationally as well as internationally.

With an effective law that is relevant to the drug problems, all producers, consumers and traffickers should be controlled and monitored with the violators receiving punishment. To elaborate this further, producers such as liquor industries and tobacco farmers should be given limits in a sliding scale to effect a gradual eradication. No mass media sales promotions of drugs of abuse should be permitted, but only interventional messages to avoid contradictions. With the gradual eradication of the drugs of abuse the NGOs, community and the government should find substitutes from the alternatives. These should be supported by all nationally. For instance, the sugar industry in Malawi should be expanded far and wide with the support of the world

market by making it a high paying endeavour. The market for tobacco should be replaced by, say, that of sugar or other commodities as one way of assisting our developing country. As for the already addicted persons, clinics should provide the therapy where possible. Most of the activities should be community-based through self-help groups, religious groups, therapeutic communities, acupuncture, work-place groups, the family, schools, etc. Rehabilitation and reintegration should aim at making the abusers sustained and adapted in the community without recourse to drug use. Activities should include employment, participation in self-help groups, cultural activities, new friendship networks, skills training, basic education, doctrines, and regular discussions with counsellors.

## CONCLUSION

The youth developmental stages involve experimentation with behaviours which place them at a significant risk for drug addiction and HIV infection. Accompanied by other problems including poverty the plight is compounded. Also, misconceptions and beliefs are rife about drugs of abuse and HIV/AIDS. The cross-fertilisation of cultures has done more harm than good to our youth. And to mend these, the provision of education on all crucial issues to the youth as well as parents should be revived.

## *REFERENCES*

1. *Harvey D.J. (ed.), "Marihuana '84", Proceedings of the oxford Symposium on Cannabis, (1985)*

2. *"Identifying Family Life Education Needs for Youth in Malawi", Consultative Workshop Proceedings, parliament Building, Zomba, Malawi, 24th to 29th April, (1989).*

3. *Kalemba E., "Drug and Alcohol Abuse in Malawi: Some Indicators", Ministry of Community Services report, P/Bag 330, Lilongwe 3, Malawi.*

4. *Malawi AIDS Control Programme, AIDS Education Guide for Non-Health Workers, P.O.Box 30377, Lilongwe 3, Malawi, 1989.*

5. *Malawi AIDS Control Programme, Malawi's Information Sheet on AIDS, P.O.Box 30377, Lilongwe 3, Malawi, 1989.*

6. *Martin J.H., Leonard W.H., Stamp D.L., Principles of Field Crop Production, USA, Macmillan.*

7. *National Statistical Office, Malawi Population and Housing Census, volume II, Population Characteristics, P.O.Box 333, Zomba, Malawi, 1987.*

8. *National Statistical Office, Malawi Population and Housing Census, volume III, Economic Characteristics, P.O.Box 333, Zomba, Malawi, 1987.*

9. *Ngaiyaye R.G.D., "Development of Family Life Education Materials Targeted at Young People", Presented at District Youth Officers Workshop on Family Life education, Lilongwe, Malawi, (1992).*

10. *Shryock H, (MD) et al., Your Medical Guide, All-Africa Publications, 1987.*

11. *The Republic of Malawi, National Youth Policy (draft), 1992.*

12. *United Nations, Bulletin on Narcotics, Special issue on the prevention and reduction of the illicit demand for drugs, Volume XXXIX, No.2, 1987.*

13. *United Nations, Bulletin on Narcotics, Special issue on treatment, rehabilitation and social reintegration of drug dependent persons, Volume XL, No.1, 1988.*

14. *United Nations, Bulletin on Narcotics, General issue on drug abuse, Volume XLVI, No. 2, 1994.*

## Appendix 1

### Incidence of Cannabis Use by Patients at Zomba Mental Hospital and Lilongwe Psychiatric Unit from 1st April to 31st May 1989

| | District | First Admission at Zomba Mental Hospital and Lilongwe Psychiatric Unit | Readmission in Both Hospitals | Total | Number of Patients Who Abuse Chamba | Percentage of Total Cannabis Abusers Admitted |
|---|---|---|---|---|---|---|
| 1 | Chitipa | 5 | 1 | 6 | 1 | 1.2 |
| 2 | Karonga | 8 | 3 | 11 | 2 | 2.4 |
| 3 | Rumphi | 10 | 1 | 11 | 2 | 2.4 |
| 4 | Nkhata bay | 12 | 3 | 15 | 3 | 4.9 |
| 5 | Mzimba | 13 | 2 | 15 | 2 | 2.4 |
| 6 | Nkhota-kota | 17 | 3 | 20 | 10 | 12.2 |
| 7 | Kasungu | 11 | 1 | 12 | 7 | 8.5 |
| 8 | Ntchisi | 3 | 1 | 4 | 3 | 3.7 |
| 9 | Dowa | 8 | 1 | 9 | 4 | 4.9 |
| 10 | Mchinji | 11 | 0 | 11 | 5 | 6.1 |
| 11 | Lilongwe | 27 | 1 | 28 | 4 | 4.9 |
| 12 | Salima | 12 | 1 | 13 | 8 | 9.8 |
| 13 | Dedza | 15 | 1 | 16 | 5 | 6.1 |
| 14 | Ntcheu | 23 | 15 | 38 | 3 | 3.7 |
| 15 | Mangochi | 12 | 3 | 15 | 1 | 1.2 |
| 16 | Machinga | 20 | 13 | 33 | 5 | 6.1 |
| 17 | Zamba | 45 | 31 | 76 | 3 | 3.7 |
| 18 | Chiradzulu | 15 | 10 | 25 | 1 | 1.2 |
| 19 | Blantyre | 20 | 5 | 25 | 3 | 3.7 |
| 20 | Mwanza | 5 | 2 | 7 | 1 | 1.2 |
| 21 | Thyolo | 19 | 11 | 30 | 3 | 3.7 |
| 22 | Mulanje | 19 | 11 | 30 | 3 | 4.9 |
| 23 | Chikwawa | 4 | 0 | 4 | 1 | 1.2 |
| 24 | Nsanje | | 2 | 7 | 1 | 1.2 |

Source: Senior Government Psychiatrist, Zomba

**Appendix 2**
**Drug Seizures in Malawi**

| Year | Drugs | Number of Seizures | Quantity Seized | Arrest | |
|---|---|---|---|---|---|
| | | | | Foreign Nationals | Local Nationals |
| 1986 | Cannabis | 708 | 1155.053 gm | 16 | 699 |
| | Mandrax | 11 | 157.058 gm | - | - |
| | Cannabis | 726 | 1365492 gm | 35 | 719 |
| | Cocaine | - | 21 bottles | - | - |
| | Mandrax | - | 5905 tabs | - | - |
| | Cannabis | 662 | 158657 gm | 34 | 619 |
| | Mandrax | 4 | 438 tabs | - | - |
| | Cannabis | 579 | 1730559 gm | 31 | 549 |
| | Cannabis | 665 | 14664291 gm | 30 | 640 |
| | Mandrax | 3 | 1677 tabs | - | - |
| | Cocaine | 2 | 1250 gm | - | - |
| | Cannabis | 444 | 1302642 gm | - | 396 |

Notes:

- Only 5% of the persons involved are female
- The majority are male aged between 25 and 60
- The age group 14-20 smoke bannabis for pleasure

Source:

- Malawi Police Force drug squad - Zomba (September, 1991)
- The customs officials have also intercepted some drugs but their data are not quite as comprehensive and accurate as the Police data.
- Although the above presentation has drawn up evidence of drug supply reduction in Malawi from a variety of different sources, it can be considered that there is indeed a drug problem in the country.

Appendix 3

Main Causes of Accidents from 1974 to 1989

| | Cause | 1974 | 1975 | 1976 | 1977 | 1978 | 1979 | 1980 | 1981 | 1982 | 1983 | 1984 | 1985 | 1986 | 1987 | 1988 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 1 | Crossing road Without looking | 184 | 269 | 236 | 317 | 331 | 334 | 334 | 312 | 253 | 302 | 285 | 367 | 490 | 561 | 552 |
| 2 | Losing control | 166 | 159 | 173 | 120 | 135 | 150 | 182 | 92 | 69 | 193 | 931 | 869 | 614 | 382 | 423 |
| 3 | Failing to keep to nearside | 112 | 120 | 137 | 163 | 189 | 142 | 150 | 134 | 59 | 138 | 122 | 154 | 185 | 272 | 244 |
| 4 | Reversing negligently | 111 | 142 | 142 | 194 | 233 | 252 | 201 | 202 | 147 | 197 | 193 | 238 | 277 | 361 | 385 |
| 5 | Misjudging clearance | 112 | 93 | 133 | 109 | 101 | 113 | 125 | 107 | 71 | 118 | 155 | 174 | 183 | 191 | 183 |
| 6 | Following too closely | 151 | 180 | 137 | 167 | 169 | 227 | 222 | 153 | 138 | 187 | 216 | 293 | 380 | 298 | 297 |
| 7 | Road condition | 122 | 114 | 157 | 186 | 208 | 204 | 209 | 185 | 106 | 158 | 164 | 208 | 178 | 219 | 268 |
| 8 | Turning right without care | 90 | 67 | 97 | 100 | 96 | 75 | 83 | 46 | 63 | 53 | 60 | 68 | 62 | 98 | 107 |
| 9 | Learner driver | 87 | 110 | 107 | 114 | 116 | 128 | 122 | 107 | 81 | 115 | 88 | 118 | 124 | 136 | 115 |
| 10 | Other animals in road | 109 | 129 | 120 | 142 | 161 | 140 | 149 | 147 | 116 | 132 | 146 | 205 | 136 | 157 | 165 |
| 11 | Influence of drink or drug | 89 | 58 | 68 | 63 | 76 | 64 | 74 | 59 | 57 | 61 | 67 | 98 | 40 | 52 | 46 |
| 12 | Mechanical defects-brakes | 85 | 105 | 115 | 109 | 125 | 138 | 125 | 120 | 110 | 123 | 120 | 151 | 136 | 167 | 191 |
| 13 | Overtaking improperly | 128 | 137 | 164 | 150 | 168 | 166 | 176 | 174 | 129 | 120 | 122 | 173 | 189 | 241 | 258 |
| 14 | Failing to comply with traffic signs and signals | 60 | 58 | 67 | 69 | 82 | 82 | 81 | 51 | 46 | 66 | 62 | 69 | 98 | 138 | 129 |
| 15 | Excessive speed | 84 | 109 | 67 | 93 | 92 | 74 | 97 | 86 | 82 | 101 | 110 | 140 | 151 | 152 | 177 |
| 16 | Dazzled by oncoming vehicle | 75 | 73 | 98 | 93 | 94 | 101 | 84 | 66 | 55 | 82 | 78 | 99 | 102 | 113 | 88 |
| 17 | Swerving | 46 | 28 | 42 | 45 | 38 | 31 | 35 | 24 | 30 | 30 | 43 | 66 | 72 | 95 | 82 |
| 18 | Failing from vehicle | 56 | 74 | 61 | 90 | 110 | 115 | 105 | 93 | 81 | 117 | 116 | 163 | 147 | 134 | 175 |
| 19 | Mechanical defects-tyres | 64 | 55 | 56 | 75 | 78 | 65 | 77 | 72 | 59 | 83 | 88 | 90 | 96 | 98 | 112 |
| 20 | Any other negligence | 891 | 975 | 909 | 933 | 1246 | 1196 | 1097 | 1260 | 1826 | 810 | 716 | 70 | 46 | 116 | 112 |

Source: Annual Report, National Road Safety Council of Malawi, Year Ended 31st March 1990. Appendix V

## Appendix 4

### Proportion Never Married by Age and Sex and Singulate Mean at Marriage

| Age Group | Male | Female |
|---|---|---|
| 10-14 | 98.4 | 97.4 |
| 15-19 | 91.1 | 55.1 |
| 20-24 | 51.4 | 11.5 |
| 25-29 | 17.4 | 3.5 |
| 30-34 | 6.3 | 1.6 |
| 35-39 | 3.4 | 0.9 |
| 40-44 | 2.3 | 0.8 |
| 45-49 | 1.7 | 0.7 |
| 50-54 | 1.5 | 0.7 |
| SMAM | 23.2 | 18.4 |

Source: National Statistical Office

Note:
- SMAM
  1. Singulate Mean Age at Marriage
- An estimate of the average age at first marriage obtained from the proportions never married at successive age..

## Appendix 5

### Women Aged 10-24 Years , Marital Status with or without Children Born Alive

| Age<br>Marital Status | Total Women | Women without a child | Women with at least one child |
|---|---|---|---|
| 10-14 | 482243 | 477956 | 2401 |
| Married | 8022 | 6597 | 1344 |
| Widowed | 384 | 353 | 25 |
| Divorced | 853 | 626 | 217 |
| Never Married | 469684 | 467311 | 783* |
| Not stated | 3300 | 3067 | 32 |
| 15-19 | 402537 | 269577 | 115100 |
| Married | 155521 | 60113 | 92293 |
| Widowed | 1242 | 432 | 743 |
| Divorced | 14459 | 3863 | 10023 |
| Never Married | 221661 | 199725 | 9681* |
| Not stated | 9654 | 5444 | 2360 |
| 20-24 | 370119 | 67748 | 293363 |
| Married | 287081 | 33621 | 250193 |
| Widowed | 2795 | 394 | 2294 |
| Divorced | 29702 | 3952 | 24854 |
| Never Married | 42528 | 28012 | 10706* |
| Not stated | 8013 | 1769 | 5316 |

Source: National Statistical Office

* Note:

- 1254899 females also known as women representing 15.7% of the total population were 10-24 years of a ge.
- 72.7% of these females (911685) were not attending school.
- 80.5% women not attending school were of never married-status.
- 2.9% of the never married-status women in the same age bracket had at least children

# YOUTH AND DRUGS: GENESIS AND EXTENT OF THE PROBLEM*

## INTRODUCTION

There have been great changes during the past decade in the pattern of substance use and abuse in Africa as in other parts of the world. If traditionally Cannabis, Khat and locally brewed alcohol were being used in specific socio-cultural contexts with a lot of inhibitions and social control, such use, not abuse was almost exclusively limited to the adults and the elderly. Unfortunately the younger generation has quickly learned that they could get high by abusing these traditional substances and their derivatives.

Experience, research and communication have brought about a broader knowledge of the high addictive potentials of other drugs such as heroin and cocaine. At the same time the drug barons and their dealers are utilising more and more sophisticated means in their traffic and distribution strategies. Consequently new drugs are appearing on the market with new modes of use. In Thailand if the adults are still smoking opium, the youth are injecting heroin. In the Andes coca-leaf is being chewed to relieve thirst and hunger. It has pleasurable and convivial uses but the youth in the big cities of Peru and Bolivia are injecting heroin to cope with withdrawal syndrome. Khat is not being used in Ethiopia, Yemen, kenya and other neighbouring countries by the adult population alone. If the Rastafarians in Jamaica and Hippies in the USA used marijuana for philosophical reasons or in religious rituals, our young people today are injecting heroin, cocaine and abusing crack within other sub-cultures having almost nothing to do with religious beliefs.

If beer and wine have been culturally associated with rural and even urban African adults, spirits are being abused in the big cities where cultural settings and expectations associated with traditional drinking are totally discarded. Old drugs are being used in different ways or where new drugs introduced, old and new patterns are being mingled. There is a move away from a single drug use pattern of a given culture to a plurality of patterns. There is also large scale prescription of psychotropics. We find drugs that are foreign to the mainstream of the culture as glue, gasoline and PCP. Benzodiazepine, barbiturates and amphetamines are valuable therapeutic agents when used in a medical context but can cause considerable problems when used without constraint.

When drugs are used outside the historically and socially accepted patterns, the "deviant" pattern is often associated with criminality, health hazard and non-productiveness of the users. Deviant patterns involve more concentrated forms of drugs than do the integrated patterns of use (e.g. coca paste v/s coca leaf; heroin v/s opium;

---

* By Mr. Samioullah Lauthan, Social Worker/Counsellor, Dr. Idrise Goomany, Treatment Centre, Port Louis, Mauritius.

distilled spirits v/s wine or beer). Although the rate at which these shifts are taking place vary from region to region and country to country, the trend is almost always the same.

Mauritius is an example of how drug abuse and trafficking have flourished because of a series of inter-related factors.

## I. THE EVOLUTION OF SUBSTANCE ABUSE IN MAURITIUS

### A. SUPPLY FACTORS

**Availability**

Alcohol, Cannabis and, to a lesser degree, opium have been used traditionally by groups of people for generations without any serious harm to the population. In the early eighties Brown Sugar (an impure form of heroin) was introduced. Biochemical analysis shows that various substances are used to 'cut' the product namely paracetamol, aspirin, glucose, lactose, and sodium bicarbonate powder, but also mandrax (methaqualone), dextroxyphene and barbiturates. This drug arrived mostly from Bombay, India, though the routing has been varied during the past three years with couriers either transiting or relaying in Nairobi and Singapore. Specific urban areas were targeted and within one year, in 1992, this new product had taken over the market from cannabis and opium.

**Cost**

The marketing strategy was to introduce the new drug in small quantities and at a low and affordable cost. Brown Sugar, proving to be a powerful addictive drug, quickly overwhelmed the market, taking over as the number one drug of choice amongst established substance abusers and making new inroads in virgin territory. By making the product available in one dose equivalent to approximately 1/40 of a gram and selling that dose at the relatively low price of Rs 15.00 each (USD 1), Brown Sugar was an instant hit. Today, with an established market, Brown Sugar is available in both urban and rural areas and the price distribution has changed. It is now sold in 1/8 or 1/4 of a gm packets at an approximate price of Rs 6000 a gram, that is, a tenfold increase. This change in marketing has dramatically impacted the drug scene. It means that today a substance abuser unable to buy the small dose alone for his personal smoking, has to pool money together with two, three or more colleagues in order to buy 1/8 or 1/4 a gram. The best way to maximise the effect of that drug is to take it intravenously, mostly with the same needle. The consequences of this practice are far reaching.

**Political Apathy**

The climate from 1980 to 1985 concerning the drug issue was very different from what it is today. In those days, the official government stand was that there was no drug problem in Mauritius. The then Commissioner of Police candidly remarked in a T.V. interview when asked about Brown Sugar: "What is Brown Sugar?" The few people who raised their voices at the time on that issue were labelled irresponsible. The public too was insensitive to the problem. Indifference was the norm. it needed the arrest of four mauritian M.Ps at Schipol Airport in Amsterdam, one of them carrying a suitcase containing 20 kg of heroin, for the government to finally react and acknowledger that Mauritius had a drug problem. The official awakening was brutal and this triggered a number of decisions and steps to address the problem. Absolute inertia gave way to a flunky of activities.

## B. DEMAND FACTORS

**Affluence**

Mauritius experienced a burst of unprecedented economic growth in the early eighties which has continued up to now. This may be explained by a number of inter-related factors, both at the local and international levels. A blend of pragmatic fiscal policies and liberalisation of the economy, together with providing the necessary incentives for foreign investors to inject huge capitals in the burgeoning textile industry while also bringing in their technology from the Far East, led to a situation of full employment and cash-generating activities. A favourable international climate together with secured European and North American markets also contributed to this positive growth. This new-found affluence proved to be a magnet for traffickers who rightly diagnosed the country as an excellent candidate for their product.

**Industrialisation**

The shift from an agricultural-based economy to a mixed one, with a lot of emphasis on light industry has had a profound effect on Mauritian society - a phenomenon which is now being investigated and studied by our social scientists. this means that within a short period of three to five years, the emergence of a new, predominantly female workforce look over the running of the textile industry, involving about 100,000 women. The shift-system needed to run the factories at full beast, as well as working long hours overtime leading to the alteration of a well-established life pattern and inexorably provoked new stresses. Another target population was ripe for substance abuse.

**Population movement**

Factories, at the beginning of our "industrial revolution" were mainly found in the capital, Port-Louis. In fact, a major "Free Zone" where these factories were to be located, was built on the periphery of the capital. This in turn led to the migration of thousands of people from rural areas, where they either could not secure jobs or else were reluctant to work the soil, to Port-Louis where job prospects were considerably better. Lack of means to rent houses together with the shortage of affordable houses pushed whole families to squat on state lands in makeshift houses made up of tin-sheets. Cramming several people in one room, inexistent infrastructures like water and electricity, poor sanitary conditions and an unhealthy environment all contributed to make these areas insalubrious to health. They also provided an excellent medium for drug storage, trafficking, distribution and abuse.

**Dislocation of family structure**

The above developments promoted the breakdown of the extended family system into the nuclear one. This also stands true in the cases of professionals, who once married, either built or rented a house of their own and left the family roof. Young children in the past, while the father was at work and the mother taking care of the household, used to spend considerable amounts of time daily with either grandfather or grandmother. This ensured the transmission of cultural and moral values to the children. With now both father and mother at work, sometimes with the mother working extra hours or night shifts, specially in the factories, children are very often neglected, with the ultimate consequences of anti-social or deviant behaviours including drug use.

**Inadequate school capacity**

In spite of a quite low population growth (1.1% in 1994) due to good family planning practice according to public health authorities, but attributed to the high prevalence of abortions by others, the Mauritius Family Planning Association gives the unofficial figure of 15,000 to 20,000 of illegal abortions yearly during the past three years, the number of young people attending school has significantly risen during the past 10-15 years. The stark and profoundly disturbing fact is that in spite of a buoyant economy and an increase by major budget from the Ministry of Education, no new primary or secondary school has been built during the 15 years.

The first noticeable change has been that, the average primary class now contains 40 to 45 young boys and girls, as against 28 to 33 some fifteen years ago. The quality of the education dispensed has largely decreased due to this statistical increase, but also due to the frustration of teachers who have to work still harder and, in return, neither getting the status nor the salary they think they deserve. The same pattern is also true in secondary schools, but the problem is compounded by the wide gap separating "star schools" from "poor schools".

**Early school leavers**

Low achieving primary schools and a very hard and competitive Certificate of Primary Education (CPE) have led to another major problem. It means that every year, out of 40,000 young 10-12 year old boys and girls sitting for their examination, nearly 40% do not succeed and find themselves denied secondary education which is also free. The system is such that many of these young children can hardly read and write in spite of having spent six years in a primary school. This is a most baffling feature. The reality of this situation is that, most of these children come from poor families, live in depressed areas, attend low achieving schools, have uneducated parents, have had "bad" or frustrated or demotivated teachers and live in an environment where drug and alcohol use are rife. The recipe for disaster has never been better.

## C. CONTROL MEASURES

Fortunately enough, the Mauritian Government, following what has been referred to as the "Amsterdam scandal" in December 1985, has taken very strict measures to control the traffic, distribution and consumption of drugs. Special squads have been set up at the Customs and in the Police Department. A commission of Enquiry was set up in 1986 and a Trust Fund for the Treatment and Rehabilitation of Drug Addicts was created to assist NGOs in developing prevention, treatment and rehabilitation programmes. Presently, a Parliamentary Committee is enquiring further into the impact of these measures.

## D. PROBLEMS OF SUBSTANCE ABUSE IN SOUTHERN AND EASTERN AFRICA

Just as mauritius which was considered for too long as being a transit point became a heavy consumer of heroin, the barriers between producer, transit and consumer countries are fast disappearing. Producing countries have a high proportion of consumers and consuming countries are producing or refining large quantities of drugs. From country reports presented at the Regional Expert Forum on Demand Reduction in East and Southern Africa in November 1993 there was consensus that alcohol, including illegal local brews, is the most commonly abused substance in the region. Cannabis use, too is widespread. Street children are abusing volatile solvents such as petrol or glue. Khat abuse varies from country to country. It has reached serious proportions in Ethiopia, Somalia and even Kenya and is being perceived as a threat now in Tanzania and Eritrea. Khat abuse was also reported in Zambia. Heroin abuse is becoming a growing problem in Botswana, Ethiopia, Kenya, Mozambique, Swaziland, Zambia and Zimbabwe.

Abuse of psychotropic substances, particularly Methaqualone (Mandrax), is becoming common in Namibia, South Africa, Swaziland, Uganda, Zambia, Zimbabwe and Mozambique. Botswana also reported some abuse of Secobarbital and Nitrazepam. Cocaine abuse was reported in Botswana, Kenya, Namibia, South Africa and Zimbabwe.

## SIMILARITIES AND DIFFERENCES IN THE EXTENT AND PATTERNS OF DRUG ABUSE IN THE REGION

The similarities in patterns of drug abuse are due to historical and cultural factors, particularly in relation of the consumption of alcohol, khat and cannabis. A common colonial past has contributed to the similarities among the regional countries.

On the other hand, differences occur when certain drugs are available in sub-regional countries because of traditional use and climatic reasons. Noticeable differences between countries are reported in relation to legislation, demand levels and perceptions of the drug abuse problem by political leaders, legislators and the population at large. Opportunity for carrying out illicit drug-related activities vary from one country to another depending on the political will of the rulers and the intensity of law enforcement activities, but the lust for quick and easy money remains the driving force behind drug production, smuggling and dealing.

## YOUTH INVOLVEMENT IN ILLICIT PRODUCTION, TRAFFICKING AND CONSUMPTION

It is well-known that drug traffickers helped by their well-paid lawyers are almost always ahead of the police and customs officers in identifying any loophole in our legislations regarding the control of production, trafficking, distribution and consumption of illicit drugs. They would then exploit these loopholes for their benefit at the expense of the society they live in. Even in the absence of loopholes they would find more and more sophisticated strategies to get through the net and by-pass the vigilance of our often badly equipped police and customs officers. The easy money gained by drug trafficking pushes the unscrupulous traffickers to risk the lives of at times innocent or naive "couriers" even where death penalty for smuggling exits. There are presently unsuspected numbers of Africans in the prisons of Europe, the United States, South-East Asia and elsewhere. As the drug barons and notorious dealers are known to the police and customs officers they use young people as new faces to cross the borders with kilograms of heroin, cocaine and hashish.

After having crossed the border the traffickers often involve children and adolescents in their distribution network as young people are not usually suspected of being in possession of large quantities of drugs. We know of cases where the dealers exploit addicted youth by imposing on them to sell 10 to 15 doses of drugs before having the right to a single dose for their personal consumption. These young people take all the risks of selling drugs and even act as pushers without being paid in cash. This is a genuine case of pure slavery because the young person is forced to act as a pusher in order to avoid the dreadful withdrawal syndrome of heroin and cocaine abuse.

**Easy Money Turns Traffickers into Beasts**

the worst and most inhuman crime committed by drug traffickers are cases of infant assassination and the stuffing of their dead bodies with cocaine. The fresh little corpses are taken as being babies in deep sleep by women to cross the borders in Latin America.

**Local Brews and Underground Laboratories**

In many circumstances, the production and distribution of illicit substances are closely linked to extreme cases of poverty. The case of local brews is well-known where whole families including children and adolescents are involved in the brewing process. But at the same time, these brews represent a major and only source of revenue for thousands of poor families in so many African countries. It is also being reported that clandestine laboratories are operating to produce psychotropic substances and syntetised drugs.

**The Street Children**

One of the most complex problems we have to face today is the street children phenomenon. Its pandemic nature has been underlined by UNESCO which estimates at five million the number of street children on the African continent alone (Street kids-Cauri Cowrie-IFLOD, November 1994). If many of these children do work as loaders, parking boys or hawkers, others support themselves by begging, stealing, prostituting themselves and trafficking in drugs. For these children who have never been to school, the "tar of the road has become a school for life, a place for work and play and a shelter for all encounters" (WHO-PSA/95.12; street children, substance use and health: Training for street workers).

Due to economic constraints and massive rural/urban population migration most, if not all, the African countries are facing an acute problem of early school leavers (dropouts). According to A. Van der Merwe, in Botswana only 18.9% of primary school students progress to senior secondary education. In Lesotho, in 1990 the dropout rate for grades 3 to 9 was 58%. In Malawi, classroom ratio is more than 100; 1 at primary level with 20% of the teachers under qualified. Only 5% go on to secondary education. Malawi, one of the smallest African countries has one of the highest, if not the highest number of AIDS cases. In Zambia, in 1990, 190,000 children of primary school age could not find places in schools. 2/3 of the 7-year old only could be admitted in Lusaka. It is estimated that 7500 new classrooms are needed to cope with the demand.

The general dropout rate for African students is estimated at 54.2%. In South Africa as in many other African countries a high proportion of adolescents have engaged in political and criminal activities at the expense of their own education. Unlike their counterparts in Europe and North America who reject by choice the norms and lifestyle

of their parents and mainstream society, the street children in developing countries use drugs for various reasons to cope with the problems of life on the street such as hunger, boredom, fear, tiredness, loneliness and physical pain.

**Price and Availability**

Price and availability are two main decisive factors in the drugs of choice of street children. Given their severe economic situation they have very little extra money for drugs. Consequently, they choose the cheapest and most easily available ones: glue or petrol.

## DANGERS ARISING FROM GENERAL DRUG AND SUBSTANCE USE AND TRAFFICKING AMONG YOUTH

In many cases drug dependent adolescents are exploited and manipulated by adults who push them into prostitution, including male prostitution, with all the risks of infection of Sexually Transmitted Diseases (STDs) and HIV. This often results in dramatic and uncontrolled situations because once they get infected they conceal their health problems from their parents, peers and sexual partners. On the other hand, they do not trust and are scared of health and Welfare Officers whom they suspect of collaborating with the police or child protection agents who want to capture them. They also have to face the threat of their young leaders who do not want them to come into contact with law enforcement and other authorities because their drug-related crimes (violence, vandalism, theft) may be revealed. In the meantime, these children infected with HIV, hepatitis or other STDs continue to transmit the infection to other adolescents or adults through unsafe sex practice and/or sharing of needles. This lack of appropriate medical care explains the high mortality rates among infants of teenagers. Others would simply resort to abortions with all its health risks of simply commit suicide. As everybody knows teenage suicide is on the increase everywhere in the world.

**Heroin and cocaine abusers**

Long time heroin and cocaine abusers almost inevitably shift from sniffing to intravenous injection (shooting) because of the high price of these drugs. They usually need much less "stuff" (powder) to inject than they would need to smoke or inhale to have the same high or "flash". As heroin and cocaine addicts hardly bother about using a new or clean syringe each time, the shooting practice in groups puts them doubly at risk with regards to hepatitis and HIV/AIDS because they are at the same time sexually active.

**Violence associated with drugs**

Young pushers are often tempted by the huge amount of money they bring to their "boss" every day. They would dilute the "stuff" further to make some profit for themselves. After some time they want to break away from the gang and start a

'business' of their own. This type of situation often degenerates into violence and manslaughter. At the time of writing this paper, on the front cover of a weekly (Star) is the photograph of a young man of 23 years living a hundred yards away from house who was shot dead in the head for the reasons described above. The father, a big dealer himself, is in jail for 5 years. When he was brought home in handcuffs to attend the funeral, he wept and cried so much over the dead body of his son that he fainted while the relatives were taking the son away to the cemetery. One can fully understand his feelings for having witnessed the cries and tears of many more parents whose children have died of overdose from the drugs that have been put on the market by traffickers of his like.

Apart from violence and gang warfare, alcohol and drug abuse cause a lot of domestic, workplace and road accidents. Drivers of public transport under the influence of alcohol or drugs can kill tens of innocent passengers or passers-by. Other victims of these accidents are crippled for life. One must not forget the innumerable cases of alcohol-related wife and child battering and the cases of men and parents battering.

The worst consequence of substance abuse is the state of psycho-social deterioration of the addicted person whose whole life revolves around his next dose which has priority over his studies, job, ambition, career, family and social status, wealth and even his health.

Drug abuse is not limited to street children alone. It cuts across all barriers of colour, sex, class, caste, region and religion in a given nation. The affluent population, including the children of politicians and diplomats are also involved in drug abuse. Drugs have found their way into schools, too. However, one needs to "identify specific populations at risk and factors amenable to intervention with these different populations and to develop a sound theoretical base from etiological, human development and social change research for the design of prevention and early intervention programmes". (Nida Research Monograph 107).

## CONCLUSION

Drug abuse is a complex and multifactorial problem that requires a multidisciplinary and multidimensional approach "depending on the child's operative space, plans of action and relevant activities to determine the type of approach and the form of diagnostic at the level of:-

- the child himself, and/or
- adults and youngsters in contact with him, and/or
- the family, and/or
- the community or neighbourhood that pushes the child into problems and
- the village town or city in which he lives"

At the same time, "depending on the child's relationship with the family and for immediate community, the plans of action should determine whether emphasis should be laid on:-

- prevention
- family reintegration
- creation of substitute groups/families
- institutional adaptation/change
- a combination of the above", (UNICEF-1987)

It is not advisable to focus attention exclusively on drugs. Drug are, simultaneously, a problem in themselves, the cause of many problems and the consequence of yet other problems. It is now agreed that no single factor can explain initiation into use, or subsequent abuse, of drugs. Socio-economic disadvantage, family imbalance, lack of self-esteem, the difficulties of professional orientation, the stress of being unable to cope with the rapid and revolutionary progress in communication and technology, demographic explosion, adult models of use, lack of religious bondage, high tolerance for deviance, need for excitement and psycho-pathology are all considered as common risk factors.

But the most common and strongest etiological risk factor is negative peer influence. I highly recommend that peer pressure resistance skills as well as other life skills such as decision-making, problem solving, critical thinking, interpersonal communication, self awareness/self-esteem, ability to empathize, stress management etc. be integrated in prevention programmes for high-risk youth where availability of drug is high. This is a realistic approach. Instead of only hoping that our adolescents would not consume drugs, we better prepare them to face difficult and risky offer situations.

Any prevention activity or message needs to be designed according to the concept of social marketing: it must be correct, simple, attractive, specifically targeted for different populations, of easy access and adapted to specific socio-cultural conditions. The holistic approach must include the basic assumption that prevention is not something that a group of experts does for a target group in order to modify its behaviour. It is mainly a set of concepts, programmes, strategies and activities aimed at preventing and solving social problems. Consequently, irrespective of the number of professionals and experts working on it, without the direct participation of the ordinary citizens - parents, the religious bodies, civil servants, teachers, youth workers, street educators and the main potential clients - adolescents and youngsters in high risk situations, the problem will remain unsolved. (Gomez - 1994)

We must find ways and means to EMPOWER the population to deal with its own problems.

## REFERENCE

1. *Report of the Expert Forum on Demand Reduction in East and Southern Africa, 1-5 November 1993.*

2. *Street kids - Cauri Cowrie - IFLD - November 1994.*

3. *Papers presented at the 11th International Institute on the Prevention and Treatment of Drug Dependence, ICAA Publication, Vienna, Austria, 1981.*

4. *Papers presented at the 13th International Institute on the Prevention and Treatment of Drug Dependence ICAA Publication, Oslo, Norway, 1983.*

5. *Drug Abuse Prevention Intervention Research: Methodological Issues - (NIDA Monograph 107, Rockville, Maryland, USA, 1991).*

6. *WHO/PSA/95 12-Street Children, Substance Use and health: Training for street educators.*

7. *New Alternatives of Care for Children in and on the Street of Mexico, UNICEF Series, No. 3, Bogota, Columbia, 1987.*

8. *The Evolution of Primary Prevention Concepts and Strategies, A. Perez Gomez, 1994.*

9. *Southern - African Adolescents - Lifeskills and Alcohol, A. Van der Merve.*

# YOUTH, DRUGS AND HEALTH: SOUTH AFRICA COUNTRY REPORT*

## BACKGROUND INFORMATION

A lot of research has been done in South Africa in the field of substance abuse (Alcohol and drugs such as mandrax, cannabis, heroin, and more recently tobacco). The research done was biased by the apartheid infrastructure with its associated ideological and psychological parameters. In this regard, it became clear that more research was done by white people in the black areas, focusing attention only on black Street children. With the birth of "new South Africa", researchers are encouraged to work with all South African youth (Black and White), in all South African communities. This will, hopefully, increase the number of cross-cultural studies in this field.

## MAIN SOURCES OF DATA

Most organized research is done by the Medical Research Council (MRC) and the Human Science Research Council (HSRC). These groups work through Government Departments and Non-Governmental Organizations. Also, these major research centres have tapped information from the police department, traffic department, counselling services and reports from the media. The main NGOs involved in research are SANCA and the Centre for Drug Studies. The former is a national organization and the latter is based in Johannesburg.

## SUBSTANCES ABUSED

Alcohol is still at the top of the list, with 68% of youth (15-25) using alcohol. It is followed in terms of availability and frequency of use by Cannabis, which is grown in South Africa (illegally) and brought from Lesotho and Swaziland (also illegally) in big amounts. The other drugs include methaqualone (Mandrax), cocaine, LSD, Heroin and prescribed medication such as stimulants, anxiolytics, pain killers, and anti-depressants. Solvents/Inhalants abuse is common in childhood and adolescence, being more of a problem with street kids. The commonly abused inhalants are glue, benzene and petrol. Methylated sprites is used as an inhalant and also as an additive to alcohol. Finally, like in other countries, there are concoctions that are brewed particularly in the poor communities with high amounts of alcohol or unknown amounts of additives of other drugs.

---

* By Dr. Solly Rataemane, Psychiatrist, Southdale, South Africa.

## NATIONAL STRATEGIES

A. Government: The state President, Hon. Nelson Mandela, has identified substance abuse prevention as one of his major projects. This has stimulated activity in the Health and Welfare Departments in which clear guidelines are used to carry out drug demand reduction programmes. These departments share responsibility with the Education Department in carrying out and sorting life skills programmes for youth. This strategy includes an attempt to go into schools, NGOs and other organs of civil society such as churches and civic associations. There are many Government plans that cannot be listed here. Of importance though, is the State President's Children's Fund, which will also support projects involved with life skills programmes and substance abuse prevention for programmes youth.

B. NON-GOVERNMENTAL ORGANIZATIONS (NGOs) COMMUNITY BASED ORGANIZATIONS (CBOs)

There are many NGOs and CBOs, but in South Africa, most are concentrated in the white community. They concern themselves primarily with alcohol abuse. SANCA, Centre for Drug and Alcohol Studies, groups supported by the MRC and HSRC are in the forefront of this work. Other groups such as churches, civic associations and the SA Federation of Mental Health do not primarily focus on substance abuse prevention, but do this parallel to their many other projects.

The National Youth Development Forum (NYDF) co-ordinates many youth programmes including life skills programmes and substance Abuse and Prevention Programmes.

C. HARM REDUCTION/TREATMENT AND REHABILITATION

Treatment and rehabilitation centres are concentrated in the main cities such as Johannesburg, Cape Town, Pretoria, Durban and Bloemfortein. Such centres at the state hospitals tend to be poorly staffed and over-crowded. On the other hand, the non-governmental centres tend to be expensive and generally inaccessible to the majority of people. Most of the rehabilitation centres have a small in-patient component but a very large out-patient one. It is hoped that the new dispensation will make sure that the rural areas are also catered for.

Finally, the South African Alliance for Prevention of Substance Abuse (SAAPSA), was formed in March 1995. The first assembly of this alliance was on 9-10 November, 1995 in Johannesburg. It was formed with the support of international organizations such as WHO, ICAA and IOGT.

The main function of this alliance is to encourage networking, sharing of experiences, and research and collaboration in the field of substance abuse prevention. SAAPSA also encourages projects that are to be led by lead agencies around which collaboration can be built. This will include establishment of a data-base that can be accessed by appropriately linked groups by e-mail and other means. The main projects are:

1. Street children project
2. Rural project
3. Children at risk project
4. Youth and media, and the
5. Data base project

# YOUTH, DRUGS AND HEALTH IN TANZANIA*

## COUNTRY PROFILE

Tanzania is a developing country in East Africa. It covers 945,000 square kilometres and 1,424 marine coastline on the eastern border. It has a long land border with Kenya, Uganda, Rwanda, Burundi, Zaire, Zambia, Malawi and Msumbiji and it bestrides a number of inland waters. It lies within the tropics south of the Equator. Land elevation varies from sea level at the coast to temperate highlands in the range of 5,000 meters above sea level. It has a population of 23.9 million people with a life expectancy of 53 years. With a GNP per capita of 180 dollars it is among the low income countries of the world. Concerted effort over the past three decades in improving the social condition of the population is reflected by the falling crude death rate from 22 per thousand in 1965 to 14 per thousand in 1987 and infant mortality from 138 per thousand live births in 1965 to 108 per thousand in 1987. In 1965 40% of primary school age children went to school whereas by 1980 100% were attending school. The figure, however, has gone down to 70% by 1986 due to a difficult economic period the country has been going through.

Urbanization has been growing at a rapid pace. In 1965 5% of the population lived in urban areas. By 1987, 29% lived in urban areas and 50% of them in the commercial capital of the country, Dar es Salaam. At present the average annual growth rate of urban population is 11.3% against a national population growth rate of 3.4% (Bureau of Statistics, 1988).

## HISTORICAL PERSPECTIVE OF DRUG ABUSE IN TANZANIA

Non traditional use of substances of abuse in Tanzania probably had its early root during the period immediately following World War One. Soldiers returning from the war came with new tastes such as the use of cannabis for recreational purposes or for escape from unpleasant feelings and memories. It does appear, however, that the number of people who abused such substances with any regularity were few and were on the fringe of mainstream society. World War Two exposed Tanganyikans to more influence of the outside world, notably North Africa, Asia and the Far East. The post war period witnessed the increase in sale and use of cannabis in the community. The abuse of this drug, however, remained among criminal elements and marginalised individuals on the fringe of society. Khat was used mostly by people who needed to stay awake such as drivers and night watchmen.

---

* By Professor G.P. Kilonzo, Psychiatrist, Dept. of Psychiatry, Muhimbili Medical Centre, and V. Nankurulu, Youth Development Officer, Ministry of Labour and Youth, Dar-es-Salaam, Tanzania.

During the sixties drug abuse gained currency among the youth especially in the western world as part of "the drug culture". As part of "modernisation" an occasional youth in Tanzania became enticed into this. Regular use did not gain currency except in a rather small proportion of school drop outs and among the unemployed in urban centres. Exact figures are lacking but indications are that regular users of cannabis did not amount to more than a fraction of a percentage even in urban centres.

The drug known to be abused widely in Tanzania is cannabis. Abuse of hypnosedatives such as benzodiazepines and methaqualone has been sporadic depending on availability and movements of these drugs in different parts of the country. Khat (miraa) has been widely used by a segment of our population, especially truck drivers and other people who want to keep awake at night. During the past decade, more and more people are using this drug for recreational purposes (Kilonzo and Maselle, 1986).

During the 1970s and 80s there was increased use of cannabis among the youth in Tanzania. Seizures of people dealing in cannabis became more frequent and has been involving younger age groups. The youth have been more and more involved in the abuse and trading of this drug. Cases reported to the police show that 25% of persons arrested for being in possession of cannabis (popularly known as bhangi) were between 16 and 25 years. It was also estimated that 5% of pupils in some primary and secondary schools had been exposed to drugs of abuse (Kilonzo and Massele, 1986).

The late seventies and eighties saw increased effort placed on control of trafficking of drugs in the industrialised countries of the north. It became increasingly difficult to conceal drugs of abuse. For this reason drug traffickers started to look for other transit routes between the Orient and the industrialised countries of Europe and America. African countries were marked for this. By the mid eighties many nationals from Africa had been recruited as couriers and some had been arrested in Asia (African Concord, March 19, 1987). At about the same time evidence of increasing trafficking in mandrax through East African ports started to emerge. It may be that heroin was at the same time being trafficked through unsuspecting officials in these ports. It seemed only a matter of time before the drugs spilled over into the streets of these international port cities. In 1988 health facilities started to record a few cases of heroin addiction in Dar es Salaam. The victims indicated that they obtained these drugs on the streets. It did not take long before traffickers of these drugs were intercepted at international ports of entry. Since then there have been a number of arrests of traffickers in heroin. From 1980 to 1985 a total of 6,019 persons were prosecuted on narcotics charges, of whom, 7% were below the age of 16 and 49% between 16 and 25. During 1986 and 1989 alone more than 1/4 million tablets of Mandrax (methaqualone) were intercepted at ports of entry. During 1989 285.5 kg of mandrax, 1,732 kg of cannabis and 2.3 kg of heroin were seized. In 1990, 2,111 individuals were apprehended with a total of 13,279.57 kg of cannabis. During the first half of 1991 1,409 individuals were apprehended with 3,381 kg of cannabis. This may have been be only the tip of the ice-berg. In October 1991 five tons of contraband reported to be cannabis was seized from he port harbour of Dar es Salaam on its way to Dodoma. During 1990 there were 1.5 kg of "cocaine", and 2.2

kg "heroin" intercepted. During the first half of 1991 0.25 kg of "cocaine" and 1.2 kg of "heroin" were intercepted in the country. Results of government chemist analysis, however, indicate that about half the drugs thought to be heroin are fake, most of it being mandrax. A similar picture emerges with "cocaine". It is still worrying, however, that people think and do wish to deal with "heroin" and "cocaine". The situation is all the more preoccupying in view of the significant increase in the number of Tanzanian nationals being used as couriers in the international drug traffic. A total of 35 Tanzanian nationals were arrested abroad during 1986 for trafficking heroin in contrast to only 4 in 1981. The many direct international air and sea connections through Tanzania, make the country even more vulnerable (Kilonzo 1992).

## HOUSEHOLD SURVEY OF DRUG USE AND ABUSE

A household survey of sampled populations in four regions in the country during 1991 (Kilonzo 1992), indicated that cannabis and khat were the two major drugs that people ever experimented with (3.8% and 3.7% of respondents admitting to having ever tried the drugs respectively). The disturbing trend, however, is that 0.1% of the respondents already have tried either heroin or "cocaine". Since most of the "cocaine" peddled in Dar es Salaam turns out to be heroin, both figures may refer to this drug.

In this study, most experimenters were males (57%). A large proportion (32%) were between the ages of 21 and 30 years. Of all respondents (N=905), 69% reported to have used at some time in their lives one or several substances for non-medical purposes. Of these 8.7% have used codeine, 7.4% diazepam (valium), 5.4% cannabis, and 5.3% khat. Petrol sniffing was reported by 0.8% and solvents by 0.4%. Only two (0.2%) respondents admitted to have used cocaine and only one (0.1%) had tried heroin. Use of alcohol and tobacco was widespread. 85% and 43% of respondents respectively. Petrol sniffing was characterised by 71.4% of youth ranging from 11 to 20 years. Substantial proportions of respondents between ages 21 and 30 years have used a wide variety of substances: cannabis 49%, khat 46%, tobacco 26%, alcohol 34%, and heroin (n=1) as well as cocaine (n=1). Codeine and diazepam (valium) were mostly used by respondents between 31 and 40 years old. Use of diazepam, barbiturates, petrol, codeine and khat was higher for respondents drawn from urban areas. Use of tobacco, cannabis and alcohol appeared to be higher in the rural areas. The one respondent who reported use of cocaine and another who reported use of heroin and all respondents who used solvents were in rural areas.

43% of respondents reported sociability and the wish to have fun as the major reason for initial drug use, with curiosity (15%) as the second most frequently mentioned reason. These reasons and others were almost consistently reported by respondents from all regions. Some differences emerged for a considerable proportion (13% of respondents in Kilimanjaro region reporting relief of psychological stress as the reason for initial use; and 18% of Dar es Salaam reporting treatment of health disorder as one of their reasons. Use of drugs for religious purposes was reported by 15% of

respondents in Dodoma region. Overall 19% did not know the reason for their first use of substances of abuse, especially so in Iringa where 44 % did not know the reason for first use of drugs of abuse. 34% of respondents were introduced to the drugs by friends (30%) and family members (24%). Examining available data for each region, Kilimanjaro has a significant proportion (41%) indicating friends to be the main source of introduction. The Dar es Salaam sample has somewhat more respondents who reported they were introduced to substance misuse by their doctors (9%) and by drug pushers (8%).

## DRUG USE AMONG STUDENTS IN TANZANIA

Two studies of secondary school students carried out in a large municipality and a small district headquarters in Tanzania revealed virtual absence of abuse of cannabis, opiates and cocaine in the district town and 2%, 0.5% and 0.7% respective abuse by the youth in the provincial municipality (Mrango 1991; Kaali 1992). In a study of Ugandan students in 1992 0.3% of the youth were current abusers of cannabis, 5.5% inhalants, 2.0% opiates, 1.2% cocaine and 2.5% hypnosedatives (Nabunya 1992). There are some indications that the extent of experimentation and abuse of these substances among students may be associated with the amount of information they have on adverse consequences of the substances, doing more experimentation of substances they are least informed on (Kaaya et al 1992).

## YOUTH AND HEALTH

During the late seventies and early eighties abuse of drugs involved those that were easily available at the time. A review of psychiatric admissions to Muhimbili Psychiatric Unit showed that 0.05% gave a history of excessive khat use. A small scale survey indicated that 0.1% of all patients seeking medical attention misused cannabis (Kilonzo and Maselle, 1986). The misuse of other drugs was mostly limited to people with easy access to them. Abuse of hypnosedatives such as diazepam (valium) and methaqualone (mandrax) has been sporadic depending on availability. Among patients presenting with substance misuse at Muhimbili Medical Centre, use of hypnosedatives was estimated to account for 4.8% of the cases (Kilonzo and Massele, 1986). Cases of narcotic misuse were very few and in many cases involved medical personnel representing 1.1%. The Department of Psychiatry at Muhimbili is recording cases of narcotic addiction in which the drugs are obtained from the streets of Dar es Salaam with increasing frequency. At present such cases are seen at the rate of two to three every month totalling to about 30 per year. The results of the community survey in four regions of the country suggest that 0.1% of the population admit to abusing narcotic drugs such as heroin. Most of the victims smoke the heroin as "brown sugar". But an occasional case has reported using the injection route. This with the HIV epidemic is a source of great concern. During the latter half of the eighties cocaine and heroin started entering the picture. In 1988 first cases of heroin and cocaine dependence were

recorded at health facilities in Dar es Salaam. The victims indicated that they obtained these drugs on the streets of Dar es Salaam. Use of inhalants was reported by 0.5% of patients of substance misuse.

## HIV DISEASE AND DRUG ABUSE

Drug abuse impairs judgment, social inhibitions and impulse control, contributing significantly to risk behaviour leading to the spread of HIV disease. The youth are particularly at greater risk. Leshabari and Kaaya (1995) report that females aged 15 to 19 and males aged 20 to 24 have the highest rates of sexually transmitted diseases in the country. This is also true of HIV disease. HIV seroprevalence rates among male youth blood donors aged 15 to 19 increased from 0% in 1987 to 4% in 1992. HIV disease, therefore, is likely to have a very devastating effect not only on the physical health of youth, but also a crippling effect on the social and emotional development of the nation. Drug abuse can rightly claim a major contribution to this calamity.

## EXISTING NATIONAL POLICIES AND MEASURES

### Co-ordination of Drug Abuse Control

By the mid-eighties, it was very apparent that a major effort needed to be carried out to prevent the spread of drug abuse. The government therefore initiated action towards this end. Among such initiatives was the formation of the Inter-ministerial Co-ordinating Committee on Drug Abuse Control comprising of the ministries of health, education, home affairs, treasury, foreign affairs, justice, culture and youth, social welfare, agriculture and parents and youth organizations. The focus of the drug abuse control programme in Tanzania therefore, was vested in this Committee.

Drug abuse, by its nature involves many disciplines and sectors in public and private institutions. Health personnel may be the first individuals to attend to a patient afflicted by a drug of abuse that is otherwise not yet known to be available in the community by other officials. This was the case when patients addicted to heroin were first attended to by doctors from the Muhimbili Medical Centre. Close contacts and co-ordination between law enforcement officers and clinicians will alert the police and customs that certain illicit drugs are entering the country. Collaboration and exchange of information between law enforcement officers and health personnel will also make it possible for both sectors to follow trends in drug abuse and trafficking which is important in predicting events and forestalling problems that might otherwise arise. Likewise, the police officers may be aware of diversion of licit drugs to illicit channels and conveying this information to pharmacists will greatly assist in plugging the leakage of licit drugs for illicit use. The Ministry of Justice is involved in enacting laws to curb drug abuse, the Treasury in checking imports and exports of illicit drugs, Ministry of Community Development, Ministry of Education, Ministry of Foreign Affairs and other ministries and sectors are likewise involved in one way or another in promoting a drug free life and

discouraging drug abuse. There is no better way to encourage and promote cooperation between these various sectors and disciplines than to have a standing forum and machinery for discussion and working out an agreed programme of cooperation.

During the course of carrying out such a co-ordinated programme of action, there is need for frequent consultations for the purpose of streamlining activities in this regard.

This is the justification of a Co-ordinating Committee on Drug Abuse Control. The need for this was felt when the issue of drug abuse control in Tanzania was first considered a pressingas issue at the national level.

**Historical Development of the Committee**

Increased use of bhang (cannabis) among the youth in the country raised public concern during the mid eighties, leading the Party and government to take firm measures towards the control of alcohol and cannabis abuse. The National Executive Council commissioned a paper on this subject by Dr. V. Ngonyani, Medical Superintendent of Mirembe Psychiatric Hospital, to be presented during one of its sessions for discussion. This led to a directive given to all regional authorities to take active measures in controlling this problem. Various sectors, both public and private were to be involved. The result of this was to raise public awareness of the danger posed by substance abuse.

The first formal inter-ministerial meeting on drug abuse was convened at the Ministry of Foreign Affairs in 1987 in preparation for an inter-ministerial delegation to the International Conference on Drug Abuse and Illicit Trafficking held at the Vienna International Centre between June 15th and 26th, 1987. The Ministries of Home Affairs, Finance, Foreign Affairs, Justice and Health were represented. A number of meetings were held, the last of which at the office of the Minister of Home Affairs, under the auspices of Hon. Mr. M. Kimariyo. During these meetings, the situation of drug abuse in the country was reviewed as well as a relationship with international affairs. It became apparent that there was diversion of illicit traffic of drugs from the northern to the southern corridors. This was so because authorities in the northern hemisphere had been undertaking concerted measures using sophisticated means of interception to make it more difficult for traffickers to avoid detection. For this reason, many traffickers were looking for other transit points manned by unsuspecting authorities, less equipped and less experienced in this area.

West Africa, Nairobi and Zambia were some of the places where traffickers had been intercepted. It was already known that Tanzania was being used as a transit country for mandrax (methaqualone) meant for shipment to the south. It appeared only a matter of time before other narcotic drugs found their way into the country. This became a matter of great concern. Of concern also, was the inadequate facilities, equipments and availability of trained staff to meet this challenge. This concern was expressed by the Minister during the conference in Vienna, and the United Nations Fund for Drug Abuse Control and the International Narcotics Control Board were interested

in collaborating with Tanzanian authorities in reducing the risk of drug abuse problems in the country. During this conference, a final draft of the Comprehensive Multi-disciplinary Outline for the Control of Drug Abuse and Illicit Trafficking was prepared. As the name suggests, this document laid strong emphasis on the intersectoral and interdisciplinary approach as a method of combating drug abuse with proven efficacy.

The Inter-ministerial consultation and meetings continued after this as a follow-up of the conference and later in preparation for a series of UNFDAC missions that were to follow this conference. The first mission was led by Dr. Juhana Idanpaan-Heikkila as senior adviser of UNFDAC. Since then, there have been six such UNFDAC missions with special interests in preventive education against drug abuse, strengthening of law enforcement against drug abuse, improving laboratory services for drug identification, and control of psychotropic drugs from diversion to illicit channels.

The Inter-ministerial Committee on Drug Abuse Control has now grown to include twenty people representing the fields of law enforcement, mass media, social welfare, city council, health, home affairs, foreign affairs, justice, pharmacy, government chemist, education and community development. It has afforded members of various sectors an opportunity to develop ideas and proposals in concert towards influencing policy, it has encouraged and promoted exchange of information and stimulated activities related to drug abuse control. In addition to all these, perhaps the most important function of the committee is to open channels of communications between various sectors and development of individual contacts between people working in the field of drug abuse control. This is very important in facilitating co-ordinated work in any endeavour.

**Specific Projects on Prevention**

There are three specific projects that have been initiated for the purpose of addressing this issue: All of them are geared towards primary prevention of drug abuse. It is still possible to do so because the problem of drug abuse is at its early stages in Tanzania.

1. Preventive Education Against Drug Abuse;
2. Assistance in Drug Abuse Control (supply reduction); and
3. Assistance to the Government Chemist laboratory.

These projects have been made possible with a generous grant from the Government of Finland through the United Nations Fund for Drug Abuse Control and the United Nations Development Programme. They were launched in February 1990 during a training workshop for instructors and teachers on preventive education against drug abuse.

**Preventive Education Against Drug Abuse**

This project addresses the demand reduction subsector with special emphasis on primary prevention. In comparison with some other regions and countries of the world, drug abuse is relatively an emerging problem in Tanzania. This view is shared by the various UNFDAC missions that have visited the country since 1988. Tanzania, however, is at the cross-road of trafficking routes between the southern hemisphere and the northern hemisphere within the so-called southern corridor. It is important therefore to raise public awareness about the adverse consequences of drug abuse and orient the nation's attitude towards a drug- free lifestyle. For this reason it was felt important that while all aspects of demand reduction should be considered, special emphasis should be placed on primary prevention. A parallel project of "Assistance to Law Enforcement" addresses the issue of supply reduction.

The main objective of this programme is to increase public awareness of the harmful effects of drug abuse on the individual and the community. Emphasis is therefore placed on preventive education. Action planned includes assessment of the size of the problem and factors influencing the prevalence of drug abuse, promotion of educational and training materials, improving the skills of personnel in preventive education, provision of accurate information to the public, soliciting the participation of the public and various communities in the fight against drug trafficking and abuse and promotion of treatment and rehabilitation of drug abusers (UNESCO, 1987).

While treatment and rehabilitation is an important aspect of demand reduction, and activities addressed in this aspect are included in this project, at the outset, special emphasis has been placed on primary prevention. The strategy has been on the socio-cultural orientation of the community against drug abuse. A major way of doing this has been placing education against drug abuse on regular channels of flow of information to the community especially targeting the youth. This has been done by including the subject of drug abuse in the curriculum of most educational institutions of all disciplines.

The educational programme targets has been teachers, parents and community leaders. It is hoped that through this the community as a whole, and youth in particular, will be able to receive correct information that is integrated with the various modes of regular channels of flow of information. Direct beneficiaries of the project include teachers of family life education, teachers in various other educational institutions, journalists, community leaders and policy makers. The students in educational institutions benefit through their teachers. The whole population benefits through community leaders and the mass media, as well as through books, pamphlets and posters. NGOs receive grants for the purpose of educating their members and improving their effectiveness in community mobilisation against drug abuse.

The project provides assistance to all the regions of the United Republic of Tanzania with special emphasis in Dar es Salaam. The Ministry of Health is the co-ordinating authority working through the Interministerial Co-ordinating Committee. Specific activities involve many sectors including health, national education, justice, mass communication, law enforcement, community development and non-governmental organizations. The Government of the United Republic of Tanzania is already carrying out preventive education in educational institutions and community programmes, as well as using other means of public education against drug abuse. Institutions such as the radio, laboratory facilities, hospitals and other relevant resources including personnel have been made available to the project to ensure the most effective use of the assistance provided. The project forms part of a drug abuse control programme in the country that is complemented by a project that assists in strengthening the law enforcement sector in drug abuse control and improving the Government Chemist's skills in identification of narcotics and other drugs of abuse.

This project is linked to ILO project of "work place initiative in drug abuse control" that is being co-ordinated by the commission on social welfare. The project also naturally links with the ministry of education programme of family life education in which education against drug abuse features most prominently in school curricula. This project has been training teachers of Teacher Training Colleges on drug abuse prevention and proposes to continue training teachers of family life education who are involved in teaching students on the harmful effects of drug abuse.

Four training workshops have been conducted for teachers and instructors with participants from various training institutions such as Police, Teachers College, Mass Media, Health Education, Secondary School, Nurses Training School, Medical Assistant Training College, the University, the National Library and Institute of Social Welfare. At the end of the workshop participants set out projects they were going to carry out related to preventive education against drug abuse. These activities emphasized incorporation of the subject of drug abuse into the normal curriculum of the school. During repeat workshops for the same participants each year, they present results of their experience in implementing planned activities.

The 1991 training programme for the Master Teachers involved masters from teachers training colleges. This was followed by a two-day symposium for editors of mass media institutions, and a two-day training workshop for members of the Inter-ministerial co-ordinating Committee on Drug Abuse Control. These participants also carried out activities formulated during the workshop and reported their experience 6 months later. The results have been quite encouraging.

**Mobilisation of Community Response**

Another necessary factor in the success of preventive efforts is the committed involvement of the community. The programme aims at getting the community to make an assessment of the size of the problem of drug abuse at the local level and develop

their own approaches to discourage drug abuse within their ranks. This part of the project has started in earnest within Dar es Salaam with the view of extending this to other regions with the advantage of the experience gained in Dar es Salaam.

The community education in Dar es Salaam has included discussions with village community leaders regarding their perception on the extent of drug abuse and eliciting their opinion regarding the approach at prevention. This has often involved extended meetings with teachers and parents and finally including the youth in these discussions. The emphasis has been on building up peer pressure against drug abuse and using legal measures on recalcitrant individuals. The Community Mental Health Team led by Dr. J. Mbatia of the Department of Psychiatry of Muhimbili Medical Centre has been conducting meetings with community leaders of a number of villages to discuss their perception of the problem of drug abuse and working out means of preventing it. This is followed by meetings with parents, teachers, and the youth in which the adverse effects of drug abuse are discussed and cooperation of the community is solicited in the prevention of drug abuse. The disposition of community leaders at present is to urge all members of the community to apply communal and individual sanctions against drug abuse, and to report offenders to community leaders for legal sanctions.

Nine peri-urban villages in Dar es Salaam have been involved in the exercise so far. The village leaders, party chairmen and secretaries are informed of the nature of the project and their co-operation is solicited. They are asked to assemble key persons in the village (ten cell leaders, head teachers from village schools, village health workers, agricultural extension workers and village security workers). During the first meeting the discussion is centred on 6 key questions formulated by the drug abuse prevention team. The questions are discussed one at a time until all six questions are covered fully by the village leaders. The same questions are similarly covered for the whole village community. The questions are: Is there a drug problem in the local community? What drugs are abused? Do the leaders know the sources of the substances abused? Who are the abusers (age, sex, and occupation)? What do the community leaders think should be done about the problem? and (a) In what ways could the village community control the problem. (b) In what ways could the Drug Abuse Prevention Team assist the local community in their fight against drug abuse?

Six out of the nine villages have actively participated in the programme with enthusiasm. The most frequently identified substances of abuse were illicit alcoholic spirit and cannabis. The illicit spirit is distilled in secret in the village and cannabis is also grown in the villages in small quantities. Alcohol abusers tended to be older males, between the ages 30 and 40, and cannabis abusers were reported to be mostly boys in their late teens or early twenties. The community identified information and legal sanctions as actions that they were to carry out. They all elected to employ self-policing. Community leaders requested written information as well as audio-visual materials on the nature and adverse effects of substances of abuse. They also emphasized the need to enact more strict laws and punishment for offenders.

**Involvement of the Mass Media**

Education through the mass media and community meeting has been integrated with other aspects of healthy habits. Journalists and other health communicators among the mass media have participated in training workshops and have transmitted the information to the public through radio and newspapers. Perhaps one measure of the success of this activity is that the National Youth Movement has, during the past five years, selected drug abuse as the main topic to be covered during Uhuru Torch Race. The main message carried with the Uhuru Torch as it is raced throughout the country is the adverse effects of drug abuse. The Uhuru Torch is raced through most of the villages in the country for about three months. Selected youths from he National Youth Organization undergo training on the major issue selected for the year. Every year there is a special message that is to be carried to the youth. The torch race is one of the functions of the Youth Department of the Ministry of Labour.

**Activities by the Ministry of Labour and Youth Development since its formation in 1990**

The Ministry of labour and Youth Development was formed in 1990. Before that it was called the Ministry of Labour and Social Welfare. The Youth Development Department as such came into existence in 1990. Before that it existed as part of the department of culture, sports and youth. The activities by the ministry on drug abuse control include having a clear policy on youth development. Among the programmes given in the policy are family life education, creation of employment (organizing youth for income generating activities), skills training, establishment of a revolving loan fund for youth etc.

In implementing the family life education programme, the ministry has been offering preventive education to youths who are out of school, i.e. youths who have been organized into youth economic groups (YEGS). This is done though seminars, leaflets and posters. A number of seminars have been conducted by youth development officers under the ministry of labour together with other youth workers from government departments and non-governmental organizations. In these seminars, youth leaders have discussed the dangers posed by drug abuse, trafficking and production, and strategies to control them.

In November 1994 a national seminar was conducted in Singida and it was attended by regional youth officers of the ministry. It discussed the problem of drug abuse and came up with the following suggestions:

- The government should start community based development centres as an attempt to promote mental health, prevent problems from starting through community counselling and teach coping skills.

- The government should encourage health promoting programmes which would promote attitudes, behaviours and lifestyles which enhance wellness. Through such programmes youths would eliminate some of the unhealthy behaviours and lifestyles e.g. tobacco smoking, excessive alcohol drinking etc.

- The laws controlling couriers and users of drugs should be stricter and should be updated because some are absolute.

- The Anti-drug Unit should be strengthened and should be given modern equipment and skills to make them more effective.

- There should be staff exchange programmes in the region for the staff working on drug control in order to exchange experiences and skills in intercepting and apprehending couriers and drug pushers.

- The legislature should enact stricter laws on trafficking and abuse of drugs including nationalization of the property of drug abusers.

- A mechanism should be designed to enable youth officers in the ministry of labour to collaborate more closely with the anti-drug unit in the ministry of home affairs.

**Activities Among Non-governmental Organizations**

The TIOGT which incorporates religious youth, has carried out the production of songs against drug abuse, conducted youth camps for the same purpose, and conducted youth discussion meetings on the adverse effects of drug abuse. The Mental Health Rehabilitation Society carried out a training programme for community mental health workers in Dar es Salaam and prison health personnel with the main emphasis of learning how to recognize drug abusers and helping in the rehabilitation of addicts. The Mental Health Association of Tanzania has been continuing with the preparation of the resource book for teachers on preventive education.

**Supply Reduction**

A separate project is assisting the police, customs and immigration officials to gain more information and skills in intercepting and apprehending couriers and drug pushers. A special squad of police has been formed charged with this duty. Special units have also been formed in customs and immigration services. Assistance to the government chemist is geared toward improving detection and identification of drug abuse as an aid to successful prosecution of offenders.

**Treatment and Prevention**

Treatment and prevention has been going on as part of integrated work in mental health services. Two psychiatric rehabilitation villages in Dar es Salaam have shown promise in the rehabilitation of cannabis and alcohol addicted individuals. Treatment and rehabilitation of addicts is integrated with mental health services. There is need to develop these services more as part of the strategy in demand reduction.

## CONCLUSION

The main objective of the Tanzanian policy towards drug abuse is to avoid or limit drug abuse in the country and to promote healthy lifestyles for all its citizens, as well as cooperating with other countries towards achieving these goals in all other countries. Legal actions in this regard, as well as administrative and regulatory mechanisms are geared towards this end. Manpower development, social and health infrastructures also aim at these objectives. The Main strategies employed are to promote cultural orientation towards the promotion of healthy lifestyles and avoidance of drug abuse through education and community involvement for both supply and demand reduction.

## RECOMMENDATIONS

1. Increased emphasis should be placed on community involvement and mobilisations through various channels such as religious organizations, civic societies, NGOs, school systems and the like.

2. Increased promotion and employment of the family system in promotion of healthy life styles and prevention of drug abuse and trafficking.

3. Address the issue of youth unemployment and lack of healthy recreational facilities.

4. Develop culturally sensitive teaching materials.

5. Balance demand and supply reduction efforts.

6. Develop national Master Plans towards these ends.

## REFERENCE

1. *African Concord, March 1987 (Feature Article on Drug in Africa).*

2. *Bureau of Statistics (1988) Tanzania Sensa 1988, 1988 Population Census: Preliminary Report. Ministry of Finance, Economic Affairs and Planning, Dar es Salaam.*

3. *Kaali, S.N. (1992) Prevalence of drug abuse among secondary school students in Dar es Salaam. Field Project Report. Department of Community Medicine, Muhimbili University College of Health Sciences of the University of Dar es Salaam, October 1992.*

4. *Kaaya, S.F., Kilonzo, G.P., Semboja A. and Matowo A. (1992) Prevalence of substance abuse among secondary school students in Dar es Salaam. Tanzania Medical Journal, Vol. 7(1): 21-24, 1992.*

5. *Kilonzo, G.P. and Maselle, A.Y. (1986) Substance Misuse in Tanzania, Tanzania Medical Journal, Vol. 3 (1), December, 1986.*

6. *Kilonzo, G.P. (1992) Reduction of Demand for Dependence Producing Drugs - The Tanzanian Experience (A paper presented at the International Conference on Drug Abuse Control in Eastern and Southern Africa) - Arusha International Conference Centre - January 20 - 24, 1992.*

7. *Leshabari, M.T. and Kaaya, S.F. (1995) Growth of the Youth Population and Related Problems in Tanzania. MUTAN Workshop, Moshi Hotel, June 21-23, 1995.*

8. *Mrango, Z.E. (1991) Drug use among senior primary and junior secondary school children in Same District, Tanzania - a crossectional study. Department of Community Medicine, Muhimbili University College of Health Sciences of the University of Dar es Salaam, Tanzania, 1991.*

9. *UNESCO, Educating Against Drug Abuse, 1987.*

10. *Youth Development Policy, Ministry of Labour and Youth Development.*

# DRUG ABUSE AND HEALTH AMONG THE UGANDAN YOUTH*

The extent to which drug abuse is a problem to the youth in Uganda is not well not documented. In the words of Rogers Kasirye one of the leading advocates against drug abuse among the ugandan youth: "Drug abuse is a hidden problem whose magnitude is difficult to establish and the laws against it is also hidden". Only a few studies addressing drug abuse have been done among the youth, and these were especially on those in the street. The commonly taken/abused drugs among the Ugandan youth are alcohol, cannabis (marijuana), glue (tina), prescription drugs, khat (mairungi) and tobacco.

## Alcohol

Although Uganda laws (Enguli Manufacturing and Distilling Act) forbids the sale and consumption of Waragi (distilled spirits widely consumed in Uganda) home brewing and distilling of waragi is widespread. Most households produce some alcohol for home consumption, due to the weak enforcement of the law. Even the police and other law enforcement agents are themselves among brewers of local concoction. The brewing of beer and distilling of enguli does not require extensive skills, training or a large initial capital. Its ingredients and markets, are always available. Due to poverty, the brewing and selling of alcohol is done mainly by women and young girls. It provides them with a source of income.

In Uganda, traditional drinking of alcohol was reserved for elders and adults, but at present many adolescents and youth have taken to drinking. A study in Makerere University for example showed that three quarters of the undergraduates drank alcohol (Kabareiho, 1981) while in a rural district of Pallisa, youth with independent incomes were found to be prone to drinking of alcohol. Alcohol drinking is therefore a major problem among the Ugandan youth.

Alcohol drinking is known to expose young people to AIDS, STDs and unwanted pregnancies as the influence of alcohol makes them less careful in choosing partners and less conscious of the use of condoms or any form of family planning. Even the young females selling the alcohol are under constant sexual harassment from the male patrons. It has also disrupted some families, led to neglect of children and dropping out of school and poor nutrition in homes where it is brewed (Barton and Wamai) 1994.

---

* By James Odit, Youth Officer, Ministry of Gender and Community Development, Kampala, Uganda.

## Tobacco

There is no information on the pattern of tobacco use but indications are that an increasing number of young boys smoke. There is no law restricting its use by children although the law requires manufacturers to include a warning on cigarette products. The sale of tobacco products is not restricted either. It is one of the products which can be found, in any of the smallest retail outlets yet it is associated among others with diseases such as lung cancer.

## Other Drugs

The other drugs, especially in the urban areas of Uganda are cannabis, khat (mairungi), volatile substances such as aviation fuel, petrol and glue. Children in boarding schools have been caught and some expelled for drinking alcohol, smoking and experimenting with marijuana. Cocaine, heroin and mandrax are not common among Ugandan youth. This is because they are not easily available and are expensive if found. However, there are possibilities that youth from well to do families may want to take these drugs which have ever been confiscated by the Ugandan police.

## Purpose of Drug Use

Some of the known reasons for drug use in Uganda are:

- overcoming cold nights among street children, fishermen, etc
- forgetting worries and over-coming depression.
- coping with tough street life
- getting appetite
- promoting creativity and boldness-feeling better and courageous to commit crime
- increase in solidarity among the users/abusers.

## Other Effects of Drugs

The main effects are known to be intoxication, sickness, fighting and increase in sexual desire and violence. The buying, selling, possession and use of some of these drugs such as marijuana is outlawed in Uganda. But their genesis is not well known although most are from the several slums dotting Kampala city such as Kisenyi, Bwause and Owino (Kasirye, 1992).

## POLICIES, STRATEGIES AND MEASURES FOR THE PREVENTION AND CONTROL OF DRUG ABUSE AND THE REHABILITATION OF YOUNG DRUG ABUSERS IN UGANDA

### Policies on Drug Abuse

Drug Abuse in Uganda is a grossly neglected, misunderstood and unresearched problem. Many policy makers have tended to believe that the problem is imaginary and therefore non-existent. Such an attitude has given room to this social problem which is gradually reaching alarming proportions most especially among the redundant, unemployed or under employed, and frustrated street youth.

For policies to be able to address the problem of drug abuse, they ought to take into consideration the factors that drive young people into drug abuse such as curiosity, peer pressure, psychological trauma, frustration, lack of employment, parental or family mistreatment/torture, broken families and lack of parental love and counselling, early drop out from school etc. The present policy on drugs is very poor, loose and apparently lenient to drug abusers. For example, the Drug and Narcotic Act of 1970 is very loose; the definition of law in relation to drugs does not comprehensively address the nature, forms and means of combat. Laws prohibit children under the age of 18 years from drinking in public places (such as bars) but do not prohibit them from drinking at all. The buying, possession, or use of addictive drugs such as marijuana, is outlawed (Laws of Uganda 1970 Act 39) but, there is no law restricting the use of tobacco by children or anybody else. The law simply requires cigarette manufactures to include a warning that "Cigarette smoking could be dangerous to one's health".

The production of crude Waragi is not controlled. Waragi is produced almost every where, which leads to heavy drinking due to easy access and lack of strict restrictions.

For policy makers to be able to make meaningful policies in this regard, they need serious sensitization. As earlier pointed out, many think the problems of drug abuse are those of the Western world, not Africa. These are the people who think only in terms of expensive drugs like cocaine. They seem not to realise the havoc that can be caused by " simple" and easily available drugs like marijuana, alcohol etc.

The National Drug Authority established by an Act of parliament in 1993 is only concerned with licit drugs, not the illicit ones.

### Measures for Prevention and Control of Drug Abuse

Despite the foregoing weaknesses, a number of organisations helping in combating drug abuse exist. They include government institutions and departments such as:

- The anti-Narcotics section of the Uganda Police-Ministry of Internal Affairs
- Uganda Prisons Department - Ministry of Internal Affairs.
- Psychiatric Department of Mulago Hospital - Ministry of Health

Some of the non governmental organisations involved include Uganda Youth Development Link (UYDEL), Uganda National Organisation of good Tempers, Drug Sensitisation Organisation (DRASEFO).

In Kampala a network of 20 NGOs called the City Advisory Committee combating drug abuse was formed in 1995. City advisory Committee on drugs and substance among street children and slum youth meet monthly to plan jointly, share responsibilities, get training, undertake joint activities, share resources and literature etc.

Also, every year Uganda joins the rest of the world on June 26 in celebrating the UN day against drug abuse and the tobacco day on May 30th. From the above problems there is need for the following to be emphasised while combating drug abuse:

1. Remand homes; there are only four ill-equipped, ill-serviced remand home in the country; Makasa, Kabale, Kampala, Mbale. These homes ought to be equipped with skills imparting facilities. They also need to be able to provide counselling and guidance services so as to ensure behaviourial change among the young people.

2. Reformatory schools-there is only one reformatory school in the country - Jinja Bugunga. More well equipped reformatory schools are needed for character formation.

3. Approved schools - there are only two approved schools in the country: Kampiringisa for boys and Fort Portal for girls. Obviously these two are not enough.

4. Juvenile courts - there is only one Juvenile Court in the country (at Mengo-Kampala) with only one Magistrate. This is incredible and should not be allowed to continue if we are to have a headway in this direction.

## CONCLUSION

Despite the fact that many people may not see drug abuse as a major problem in Uganda and thus a non policy issue, the problem is slowly emerging. It needs Policy and programme directives to be developed to prevent its total emergence and programmes to rehabilitate those already hooked on the drugs. Policy makers also need to accept that Uganda could be having the problem of drug abuse although it may still be on a small scale.

## GENESIS AND EXTENT OF THE DRUG PROBLEM IN ZAMBIA*

Drugs, which by definition are substances that affect the senses, have a chronology that runs alongside that of the earliest days of humankind. Natural substances which act on the nervous system such as alcohol, were soon discovered, to relax a tired mind. Opiates were used to relieve pain and induce sleep to get rid of insomnia, while coca leaves were employed to numb the senses and increase endurance.

One of the worst tragedies of drug abuse is its effect on youth. Some infants have been born with drug addiction withdrawal symptoms. Attributed to cocaine abuse by the mother, some babies are born prematurely and with low birth weight. This is because the drug limits the flow of blood to the placenta and reduces the supply of oxygen and nutrients that reach the foetus. Babies are also being born with the AIDS virus through intravenous drug abuse by the pregnant woman. The virus is also spread between intravenous drug abusers who share contaminated needles.

In the Southern African region, alcohol is the most widely abused drug. Alcohol is socially accepted, easily available and in all countries it constitutes a lucrative economic activity as an industrial base. It is a source of employment and livelihood for many people. With the economic hardships sweeping the sub-region, business persons dealing in alcohol-related activities do not have much motivation to keep under-age youth from their premises. Every year a significant number of youth are caught in alcohol-related crimes, violence, poor health and social displacement. Alcohol is a factor in divorces which in the end create hostile environments for the youth in such homes. Further, youth are used as cheap labour in many industries including producers of alcoholic beverages, distilleries and breweries.

Cannabis which is the second most abused drug is illegally grown, distributed and trafficked in the region. It is now being grown by villagers as a cash crop for sale in Zambia, Zimbabwe, Botswana, Namibia, Lesotho, South Africa and Malawi. Information from the Ministry of Women and Children's Affairs and Community Services of Malawi, for instance, shows that about 20% of the annual cannabis production in that country is domestically consumed mainly by the unemployed youth. This has led to an upsurge in violent crimes and, therefore, has become a menace to public peace and human society. In the first 6 months of 1995, Malawian authorities registered 214 cases against 270 persons and 28,206 killogrammes of cannabis, the largest ever seized and destroyed over the same period. The majority of the consumers of this drug are youths. In Zimbabwe, the extent of abuse has increased due to the commercialisation of cannabis. It is being abused by all races especially by the youth who are aided by the fact that the drug is

---

* By Mukutulu Sinyani, Chief Chemical Analyst, Drug Law Enforcement Commission, Lusaka, Zambia.

readily available at a very low price per "twist". In Lesotho, the problem has been aggravated by the increase in voices advocating for the legalization of marijuana. Some members of Parliament have publicly announced their support for such a move. There now exists an illegal cannabis border post run by a group of smugglers where farmers take their cannabis to be exported. This scenario has attracted a number of youth. In Namibia, health and law enforcement authorities have indicated that the drug is abused mainly among the youth between the ages of 11 and 24 years.

There is also a new drug called "JENKEM" (named after a South African glue) being sniffed by youths in Zambia and Zimbabwe. The consumers put sewage material in a tin which is air-proof covered with polythene material and left to ferment until methane and other gases are released. A small hole is then made in the polythene cover from which the sniffer gets the gases into his system. Within a short time a "high" is experienced as the gases act on the central nervous system. Most of these youths become violent, disoriented and apparently intoxicated after the sniffing.

The Southern African sub-region continues to experience the negative impact of illicit abuse and traffic of methaqualone (mandrax) which has gained a notorious reputation as an economic drug. It is smuggled into Zambia, for example, from the Indian sub-continent by road and air and quickly finds itself exchanged with motor vehicles from South Africa. Those consignments which are smuggled into South Africa are exchanged with groceries which are in turn transported to Zambia by truck. Mandrax is, therefore, a medium of exchange for goods and services. South Africa continues to be the world's largest abuser of mandrax. In 1994 alone, the South African Narcotics Bureau seized 4,753,221 tablets worth a staggering 17.8 million U.S. dollars on the street. Over the past three years the country's seizures of this drug have continued to average 3.6 million tablets per year. While a significant quantity goes into illegal economic activities, there is also a large part being consumed by the youth who lace it with marijuana joints for intensified effect. By May, 1995, the Indian authorities had seized about 40 tons of methaqualone which was destined for Africa compared to 28 tones the whole of 1994. Most African countries have reported abuse by the youth and several countries such as Kenya, Zambia and South Africa have reported incidents of illicit manufacture. In 1993, fourteen Tanzanian swallowers were arrested in Lusaka with more than 700 pellets of heroin in their stomachs. All of them except one were aged 23 to 34 years. These were couriers for a Commission of between 1,500 and 2,000 U.S. dollars to be paid upon successful arrival by the baron in Dar-es-Salaam. A lot of mandrax transits through Botswana and in 1994 alone, about 267,000 tablets were seized by authorities.

Heroin continues to transit the African continent from South West Asia and South East en route to illicit markets in Europe and North America. African capitals with air links to the source regions are being used as transit or redistribution points. Many youths in this region, which constitutes non-suspect nations, are being recruited as couriers by well-established drug trafficking syndicates. The result is that the region is now experiencing an increase in addiction rates which in some cases out-strip rehabilitation efforts.

In South Africa, Mauritius, Lesotho, Zambia and Swaziland, a cocktail of mandrax, cannabis and cocaine has been reported to give a very rapid euphoric feeling which later gives way to hallucinations, illusions and charges in mental states which have a negative impact on the smoker. It has also been reported in these countries that youths use fresh milk (which contains fat) to dissolve the chemically active delta-9-tetrahydrocannabinol in marijuana and then drink the resulting solution to experience a "high" within minutes.

Cocaine has constantly appeared on the illicit market since 1991. Brazil remains the principal supplier of cocaine seized in West and Southern Africa en route to illicit markets in the Northern Hemisphere. West African traffickers continue to dominate the cocaine traffic due to their proximity to the illicit markets. In the Southern African region, while all countries are affected, South Africa has been particularly targeted by cocaine traffic over the past two years. New routes include those through Angola and Mozambique.

In Zambia, the number of drug dependent persons registered with the Drug Law Enforcement Commission has increased sharply since 1991 (see table below):

Table 1: showing number of drug dependent persons:

| Year | Number of dependant person | Drugs involved |
|---|---|---|
| 1991 | 06 | Heroin |
| 1992 | 98 | Cannabis, Mandrax, Heroin, Alcohol |
| 1994 | 168 | Cannabis, Mandrax, Heroin, Cocaine, Alcohol |
| 1995 | 271 | Cannabis, Mandrax, Heroin, Cocaine, Alcohol |
| 31.8.95 | 483 | Cannabis, Mandrax, Heroin, Cocaine, "Jenkem", Alcohol |

During the year 1994, the Zambian Drug Enforcement Commission successfully rehabilitated eleven drug dependent youths who have since been re-integrated into their respective societies-high school, College and University. It is also noteworthy to indicate here that all of the persons registered with the Commission are in the age bracket 10 to 35 years which fits the generalised definition of youth.

On the interdiction side, of 336 persons arrested in 1994, 80 were in the age limit of the youth, a situation which does not give a good picture for the future of the country. The sparsely-populated country of Botswana had a record seizure of 19.24 killogrammes of cocaine in 1993 in addition to 1.3 tons of cannabis and 8,000 tablets of mandrax. Youth consumers form the largest market for these drugs. Chewing Khat, also called miraa, (from Catha edulis) is a national pastime in Somalia. The Cathine in khat gives an amphetamine-like "high". The drug induces a mild euphoria at first and increases self confidence and alertness. It also induces insomnia. It is the lack of sleep that makes the user jittery and apt to over-react in certain situations. High doses may induce hyperactivity, manic behaviour or psychosis. Although khat is not internationally controlled, some countries have expressed concern over traffic in this drug. In Zambia, it is prohibited. In general, the illicit traffic in khat and other narcotic drugs and psychotropic substances is leaving behind a trail of abuse on the continent. The need for action to protect the youth cannot be over-emphasized.

Drug abuse problems appear to be increasing due to factors such as rapid urbanisation, rural-urban migration, unemployment and breakdown in relationships. Although concern is focused on the individuals, drug abuse occurs within socio-cultural and economic contexts and a strategy adapted to a specific society and even within a sub-culture of that society might not work in another. Thus, it is imperative to work out regional strategies of co-operation to fight the problems associated with the drug menace. Expert group meetings therefore, face the challenge of working out viable solutions to this problem, including, Inter alia: i) harmonization of legal instruments to ensure that there are no safe havens for drug traffickers; ii) effective networking strategies between supply reduction and demand reduction authorities on a regional basis; and iii) common curricula for training personnel involved in prevention and interdiction efforts.

## REFERENCES

1. *Barton. T. and Wami., Equity and vulnerability: A Situation Analysis of Women, Adolescents and children in Uganda, 1994.*

2. *Kasirye R. and Kyeyune. R. ; Drug and Substance abuse: A Community based prevention and rehabilitation programme for street and homeless Youth, Kampala City. (Friends of Children's Association kampala (FOCA, Uganda)*

3. *Kasirye R, Drug and Substance abuse: A study of Urban Youth in Kampala city. Dec. 1992 - March 1993 (FOCA, Kampala, Uganda).*

4. *Myangoma. N.M. an analysis of cases of alcoholism in Uganda at Butabika Hospital (Institute of Health Studies, Kampala, Uganda) 1979.*

5. *Munene, Operational research on street Children (Psychology Department Makerere University), 1993.*

6. *Kabireho, 1991 (as cited in barton, T and Womai. G, Equity and vulnerability. A Situational Analysis of Women, Adolescents and Children in Uganda, 1994.*

7. *Maseroka. J., The New Vision Newspaper volume 10 No.225, september 20, 1995.*

8. *Ayiga-Ondoga. A, The New Vision Newspaper volume 10, No.227, September 22, 1995.*

9. *Kasirye Rogers, Uganda Youth Development link, Kampala (personal communication) 1995.*

10. *Laws of Uganda.*