Report – 107/2021

Jarle Pedersen and Ingun Klepp

Ten Years After - Drug Use and Recovery Among Male Heroin Users in Zanzibar

VOLDA UNIVERSITY COLLEGE

Author Jarle Pedersen and Ingun Klepp
Publisher Volda University College
Year 2021
ISBN 978-82-7661-360-5 (digital version)
ISSN 1891-5981
Print set Author
Distribution http://www.hivolda.no/

Frontpage picture: A wall painting from Detroit Sober House made by drug user (s) in recovery.

Used by permission from Zanzibar Recovery Community.

© Author/Volda University College 2021

This material is protected by copyright law. Without explicit authorisation, reproduction is only allowed in so far as it is permitted by law or by agreement with a collecting society.

The Report Series includes academic work in progress, as well as finished projects of a high standard. The reports may in some cases form parts of larger projects, or they may consist of educational materials. All published reports are approved by the dean of the relevant faculty or a professionally competent person as well as the university college's research coordinator.

Preface

This report is based on research done by Volda University College (VUC), in cooperation with Zanzibar Recovery Community (ZRC), and dialogue with leaders of The Drug Control Commission in Zanzibar. Data collection was done during autumn 2019.

Responsible for this study from Volda University College has been Associate Professor Jarle Pedersen (Ph.D. in Sociology), assisted by Associate Professor Ingun Klepp (MA Social Anthropology). Our interest as researchers from VUC in this project is linked to our cooperation with ZRC according internship for our social work students in sober house in Zanzibar. Since 2015 VUC students have spent 14 weeks every year in sober houses as a part of their practical training as social workers. From Zanzibar Recovery Community the responsible persons have been the President of ZRC Suleiman Mauly and General Secretary of ZRC Abdulrahman Abdullah.

VUC is fully responsible for the final design, data collection, analysis, and development of the thesis, but without the support of ZRC on design, preparation, access to informants, and coordination, this project would not have been possible. It would also be impossible without the excellent efforts of all the informants who have shared their individual stories and contributed with necessary information during this research.

Finally, we would like to express our gratitude to the Vice President's Office in Zanzibar, that have been positive and supportive of the project and granted the necessary permits.

Volda, January 2021

Jarle Pedersen

Ingun Klepp

Summary

This study has explored drug use and recovery efforts among male heroin users in Zanzibar. Data were collected during autumn 2019 and our sample contains interviews with 89 informants, who all participated in the first sober house program in Detroit Sober House sometime during 2009/2010. The informants were interviewed about their drug use, recovery efforts, support, challenges, and successes.

Marihuana was found to be the far most frequently used onset drug (93%), sometimes in combination with hashish, alcohol, and/or pills. All informants at some point started to use heroin and on average it took four years from onset drug use to heroin use. It took informants additional 5,2 years to realize that they were addicted to heroin.

The average onset age for drug use was 17 years, for heroin use 21 years. The median onset age was respectively 16 and 20 years. The youngest half of our informants were on average 3,3 years younger when starting with drugs and 5,1 years younger when starting with heroin, compared to the oldest half. The transition time from onset drug use to onset heroin was 1,8 years less. These data suggest that the onset age for drug use and heroin use dropped in Zanzibar from the late 1980s to the beginning of the 2000s and support other findings of a steep increase in heroin use among young people in Zanzibar during the 15 years from 1990 – 2005.

Increased availability, cheap prices, and lack of knowledge about the addictive character of heroin seem to have been important factors causing this increase. Also, the relatively intermixed drug user's environment where marihuana and heroin smokers belonged to the same groups, seems to have contributed to increased heroin use and a faster transition from softer drugs to heroin. In these groups of drug users, often called "ghettoes", smoking a mix of marihuana and heroin in a "cocktail" was popular, something that seems to have lowered the threshold between heroin use and the use of softer drugs, increased heroin use, and contributed to a more rapid transition from softer drugs to heroin.

In the last decade, it seems that knowledge about the dangers of heroin use has increased, and the groups of drug users are more separated according to the kinds of drugs used. The presence and activities of the Zanzibar Recovery Community and increased government involvement seem to have contributed to increased knowledge and awareness about the dangers of heroin use.

At the time of the interview, 85% of our informants considered themselves as 'drug-free', and on average they reported to have been drug-free for 3,4 years. While considering themselves as 'drug-free' there was consensus among informants that this meant 'not using heroin', but beyond this consensus, there were differences in the perception of 'drug-free'. Some would still claim to be 'drug-free' even if they were using methadone or sometimes used substitutes like marihuana and alcohol.

At the time of the interview, 55% of our informants were participating in the methadone program, the first-ever in Zanzibar that started in 2015. Among informants in the methadone program, 88% would consider themselves as 'drug-free'. There was a difference in the perception of 'drug-free' among recovering drug users in Zanzibar that mainly ran along two lines. People with success from sober house recovery and with a close connection to and

Narcotics Anonymous would claim total abstinence to define ‘drug-free’, while for most methadone users to abstain from heroin was sufficient to be defined as ‘drug-free’.

Success in recovery is in this study measured in terms of total drug-free time (TDFT), starting from attendance in the first sober house recovery program in 2009/2010 until the time of the interview. Among the 89 informants, 14 (16%) reported having been drug-free throughout the 10 years without relapsing. Characteristics of this most successful (Level 1 A group) were that they: a) to a larger degree avoided injection of heroin, b) responded positively to the first sober house program (stayed longer and rated the support higher), c) engaged more in volunteer work supporting other drug addicts in recovery, and d) had more family support.

The group containing the *one-third most successful* informants (Level 1 group, N=30) on average reported a total drug-free time of 9,1 years. This group contains the Level 1 A group and had many similarities with those who did not relapse after their first program. Most of the informants in this group finalized their basic program and they stayed longer in the sober house during their first program attendance. To a large degree, they finalized their aftercare program of two months. This group had to a higher degree been avoiding injecting heroin and compared to the total average they had more than twice the number of drug-free years in connection with their first sober house stay. Many later did volunteer work in a sober house, and they estimated the degree of support from the Detroit Sober House program higher, as well as from their own families.

A less expected finding was that this group of most successful had more years on heroin before they started the recovery. We also found a positive and significant correlation between *using heroin for a long time before going into recovery* and *recovery success*. One possible explanation is what the informants described as the “hitting the bottom” phenomenon, that reaching the bottom can be an existential turning point motivating for quitting drugs and that reaching this point is more likely to happen the longer you have been on drugs.

Another unexpected finding was that *having a job/income* while leaving the sober house program did not seem to affect recovery success. This could be explained by a combination of factors. Firstly, the job/source of income often was low pay and/or temporary. Employment would then to a less degree function as recovery capital, in the sense representing social and economic stability and reliability. On some occasions work/income-related activities did not necessarily play the role of protection against drug use, on the contrary, some workplaces could be the very context of drug use, work and drug use could be intervened activities. Good money from well-paid temporary jobs could sometimes also have an encouraging effect on drug use. Finally, we might see the effect of volunteering among the successful, these would answer *‘no job/income’* while asked but have a high success in recovery.

At the other end of the scale, we find the *least successful one third* (Level 3 group, N=29), who reported on average 1,9 years of total drug-free time during the ten years. Here the opposite picture emerges, the percentage who had been injecting heroin was high and many were found to be in the methadone program. The majority in this group left the Detroit Sober House *before* finishing their basic program in 2009/10, and 79% relapsed within the first six months after leaving the sober house. These informants estimated the support they got from the sober house and their families significantly lower and only one person in this group had been participating in volunteer work during the ten years. *Gaining less* from important forms of recovery capital like

the sober houses and family support seems to have affected recovery success negatively the to the greatest extent.

The one-third with *middle-range success* (N=30) in our study had 5,1 years total drug-free time over the ten years and we find both similarities and differences with the upper and lower levels of success. These informants were closer to the upper third on indicators like time on heroin before first recovery, time spent in the sober house during their first recovery, and self-estimated level of family and sober house support. They were closer to the lower one-third on indicators like percentage injecting drugs, drug-free time in connection with the first recovery, attendance in the methadone program, and drug-free time connected to the methadone program.

There are always underlying factors affecting drug use and recovery success. In this study we have highlighted some of these in order to show their presence, draw awareness to their existence, and show how they might affect drug use, addiction, and recovery efforts. These are childhood trauma, stigma related challenges in the past or the present, family conflicts, poverty, violence, and marginalization. These underlying factors deserve more attention and should be looked at more systematically by conducting qualitative studies.

The Narcotics Anonymous and sober house movement have been active for more than ten years in Zanzibar and the methadone project has worked for five years. This study has revealed some of the characteristics of drug use and recovery efforts for a sample of heroin users, but additional perspectives are needed to understand more of this field in depth. One such perspective is the gender specifics, drug use is also a problem among women in Zanzibar. One sober house for women was established in Zanzibar but had to close down. A study should be conducted to understand better the characteristics of drug use among women and their recovery challenges in Zanzibar.

During this study, it has been impressive to see the contribution of recovering drug users in volunteer work at Zanzibar. This approach in encountering drug problems is rare in the African context and should be investigated further to understand its contribution to building strong recovery communities. A study should look deeper into the background of volunteers, user career, motivation, personality, and the contribution of volunteering to own recovery efforts. Furthermore, how this movement forms a culture of recovery influencing the Zanzibarian community as a whole and politics on drug use, treatment, and recovery.

Table of content

Preface 3
Summary 4
Table of content 7
Charts and tables 8
Introduction 9
Methodology 11
Drug use, age and time factors 13
Defining ‘drug-free time’ and measuring recovery success 16
Methadone use and controversies defining “drug-free time” 20
Sober house attendance, volunteering, and recovery success 26
Returns to sober houses 32
Job, shelter, and family support 33
Support and challenges during recovery efforts 36
Social marginalization, stigma, and traumatization 41
Childhood trauma, addiction, and recovery problems 44
Saidi: Becoming the bastard of the family..45
Ibrahim: Becoming the victim of racism..47
Ali: Becoming the victim of violence and abuse..50
Karim: Becoming the victim of sexual abuse..51
Conclusions and recommendations.. 54
Bibliography..57

Charts and tables

Chart 1: Age using drugs first-time 14
Chart 2: Years from first-time drug use to heroin use 14
Chart 3: Age first time heroin use 15
Chart 4: Age first time realizing addiction 15
Chart 5: Time from heroin use to first sober house recovery... 16
Chart 6: Age when attending first sober house recovery.. 16
Chart 7: Drugfree years at the time of interview 17
Chart 8: Total drug-free years since recovery start 17
Chart 9: Time spent in the methadone program 21
Chart 10: Methadone program attendance contribution to 'total drug-free years' 21
Chart 11: Time spent in Detroit Sober House 27
Chart 12: Relation 'time in the first Detroit Sober House program' and 'total drug-free time' ...27
Chart 13: Drug-free time related to the first sober house recovery program 28
Chart 14: Drug-free time related to the first recovery and total drug-free time 28
Chart 15: Estimated help from staying in DSH 29
Chart 16: Estimated help from DSH and 'total drug time' 29
Chart 17: Attendance in other sober houses 33
Chart 18: Month's attendance in other sober houses 33
Chart 19: Estimated help from own family to fight addiction 35
Chart 20: Relation 'estimated help from own family' and 'total drug-free time' 35

Tables

Table 1: Drug use, age and time factors related to recovery success 18
Table 2: Methadone use and recovery success 22
Table 3: Sober house attendance and recovery success 31
Table 4: Informants returns to sober houses and reasons for return 32
Table 5: Total number of returns to sober houses 33
Table 6: Job/income, shelter and family support related to recovery success and age groups .. 35

Introduction

Zanzibar has over the last decades experienced an increase in drug trafficking and social problems related to drug addiction.[1] This led to Zanzibar being included in The Global Initiative on Primary Prevention of Substance Abuse, a project implemented jointly by the United Nations International Drug Control Programme (UNDCP) and the World Health Organization (WHO) – starting in June 1997 and completed 2003.[2] Results from research carried out in three different countries in South and East Africa confirmed that the worries expressed about the drug use situation at Zanzibar were valid. In the presentation of their results Nkowane, et. al 2004 concluded:

> The expanding range of substances used, including injectable substances (e.g., heroin), is also a cause for concern, particularly in Zanzibar in Tanzania, where access to illicit substances is especially easy, considering that Zanzibar is a transit point for trade in these substances. The respondents particularly indicated that it was easy to obtain the substances they commonly used.[3]

The first interventions targeting drug use in Tanzania and Zanzibar were clinically oriented, with the HIV/AIDS epidemic in focus.[4] The aim was to get this epidemic under control by outreach programs, medical support, and education of drug users injecting heroin. The first sober house in Zanzibar, Detroit Sober House, was established in 2009 and the recovery program used was based on the 12-step concept of Anonymous Alcoholics, frequently called The Minnesota Model. This model was later used by Narcotics Anonymous as the basic model in recovery from hard drugs like heroin. This model has a human therapeutic approach to addiction where the aim is to retain dignity through behavioural change and with the support of a therapeutic community of self-help groups. The concept was introduced in Zanzibar through the effort of people at Jane Adams College of Social Work at the University of Illinois; people like Loretta Albright, Andre Johnson, Dr. Calvin Trent, and Dr. David Whiters.[5] The initiative emerged from the need for a recovery approach as a supplement to medical efforts and some of the few people in Zanzibar who already had experience from recovery were mobilized.[6] his was a first step, which soon led to training, the establishment of a self-support group, and the opening of the first sober house, Detroit Sober House. Considerable work was done at the time to bring Zanzibarian authorities on board in support of the recovery concept, the idea of a self-support model, where recovering drug users work with peers. Later, people who had already been attending the 12 - step program in

---

[1] Khatib, Ahmed; et al. 2017, Matiko, Eva et al. 2015, Beckerleg, Susan e.al. 2006., Worls Health Organization 2003

[2] WHO/UNDCP Global Initiative on Primary Prevention of Substance Abuse.
Substance abuse in Southern Africa: knowledge, attitudes, practices and opportunities for intervention: summary of baseline assessments in South Africa, the United Republic of Tanzania and Zambia / WHO/UNDCP Global Initiative on Primary Prevention of Substance Abuse. World Health Organization 2003.
https://www.who.int/substance_abuse/activities/en/substance_use_africa.pdf

3 Nkowane, et.al 2004.

4 Nkowane, M. et.al 2004,Dahoma, M et .al 2006, Beckerleg, S. at. al 2005 and 2006, Matiko E. et al. 2015, McCurdy S.A. at al. 2007, Ratliff E.A.et al 2013

5 White, W.L. 2013, http://www.williamwhitepapers.com/search/?query=Zanzibar&results=10&search=1

6 Ratliff, E. et al. 2013

Detroit Sober House opened more sober houses. Already in 2013, this one sober house had become 11 sober houses, eight in Zanzibar, and three in mainland Tanzania, all using the 12-step program. Thus, Zanzibar had at the time of our study 10 years of experience in implementing the sober house concept and thousands of people have participated.

Through research, we wanted to understand better who the recovering drug users are, their experiences with drug use and recovery, and how they perceive their situation ten years after attendance in the first sober house program in Zanzibar. Has the sober house concept been helpful to them and how did they find it helpful? The idea and design of the research were developed in June 2018 by Volda University College (VUC), in cooperation with Zanzibar Recovery Community (ZRC) and dialogue with leaders in The Drug Control Commission Zanzibar. The main aim has been to investigate recovery challenges, progress, and status quo of drug users who attended the 12 – step program in Detroit Sober House 2009 and 2010. We wanted to understand better the impact sober houses have on drug user's recovery and which factors that are influencing efforts and success.

Our theoretical approach aims at understanding and explaining individual recovery processes, as well as socio-cultural processes in the society when drug addiction is highlighted, and recovery/treatment introduced. As a theoretical approach, we found it useful to apply the *capital* concept – as introduced by Pierre Bourdieu – defined as *social forces* active in shaping *social fields*[7], and in the field of recovering from drug addiction referred to as *recovery capital,* the set of resources, *internal* and *external*, available to initiate and sustain recovery from addiction problems.[8]

Recovery capital can be personal, social network-related, or community-related. *Personal recovery capital* includes physical as well as human capital. It contains a person's physical as well as mental health, income/financial assets, access to shelter, food, transportation, etc. Human recovery capital includes according to White, W. & Cloud, W. (2008):

> ...a client's values, knowledge, educational/vocational skills and credentials, problem-solving capacities, self-awareness, self-esteem, self-efficacy (self-confidence in managing high-risk situations), hopefulness/optimism, perception of one's past/present/future, sense of meaning and purpose in life, and interpersonal skills. [9]

Social network recovery capital contains intimate relationships, like family and friends that are supportive in recovery efforts. To serve as a capital, a willingness is required from intimate partners and family members, to participate in and support the recovery process of the person suffering from addiction. C*ommunity recovery capital* refers to community attitudes, the policies, and resources provided for recovery efforts, as well as efforts to reduce addiction and recovery-related stigma. Habitus is by Bourdieu seen as historically formed and embodied dispositions active in any social perception and action. Drug use and recovery are in Zanzibar perceived in a certain way given the historical context, which in turn produce attitudes that influence the level of stigma as well as government policy. From a socio-cultural perspective,

---

7 Bourdieu, Pierre 1977

8 Granfield & Cloud, 1999; Cloud & Granfield, 1 2004

[9] White, W. & Cloud, W. (2008)

this includes, still regarding Bourdieu's field, habitus, and capital theory, one could claim that the self-help groups and 12-step program introduced in Zanzibar represents a *heterodoxy* that challenges established truths about *what drug addiction is*, *who the drug addicts are,* and *how drug addiction best should be dealt with in society* is challenged.

Methodology

The first phase of our data collection contains structured interviews with 89 informants, collecting quantitative and qualitative data in a triangulation. Data collection took place in September and October 2019 and the informants selected had two things in common; 1) They all attended the sober house program at Detroit Sober House in Zanzibar during the two first years, 2009 and/or 2010, and 2.) They still lived in Zanzibar. It is anticipated that between 120 - 130 drug users attended the Detroit Sober House program in 2009/2010. Having identified and interviewed 89 of them, access to more informants started to become difficult and we decided to stop as we already had a good number for our purpose. [10] The second phase of the data collection was in-depth second interviews with 18 of the 89 informants. These interviews took place during Oct – Nov 2019 and informants were picked according to recovery success to allow variations in experiences. Most interviews were conducted in the Swahili language, only in a few cases English language was used, in those cases the informant had excellent command of English and a wish to speak English. The researcher conducting the interviewing from VUC has many years of work experience from East Africa, a solid knowledge of culture and everyday life in Tanzania and speaks Swahili fluently.

Identifying informants was done with the support of the Zanzibar Recovery Community. ZRC also helped us to get in touch with informants and with coordination during data collection. Most structured interviews lasted 20 – 40 minutes while in-depth interviews could last from 1 – 2,5 hours. Interviews took place in different locations in Zanzibar, like inside sober houses, in parks, cafes, and at a venue close to the methadone clinic. The structured interviews were not recorded but collected by taking notes, in-depth interviews were recorded. All names of the informants used in this report are made up.

All informants got a compensation of five thousand Tanzanian Shillings, equal to 2.2 USD for participating in interviews. This amount was decided in agreement with the leaders of ZRC and was considered as a fair compensation for costs connected to travel and/or loss of income and/or other costs or inconvenience connected to participation in the interview. Besides being an incentive to participate and a fair compensation, we considered this amount to be too low to put pressure on the informants to participate, undermining the "free will" principle or influencing informant's answers.

---

[10] Due to incomplete records we did not have the exact total number of clients attending Detroit Sober house during these two years but putting together all available information we could concluded that the total number was somewhere around 120 - 130 people. We had the information that some of these people lived outside Zanzibar, others had died.

In the structured interviews, we first asked about characteristics connected to drug use like kind of drugs and age when first using any drug, age when starting with heroin (all reported heroin use), age when realizing they had an addiction problem, and age when attending the Detroit Sober House program. Informants were asked about their *recovery history*, like; how long they stayed in the sober house program the first time, clean time after their first attempt, relapses, attendance in other sober house programs, and if they had been receiving other forms of treatment for their drug addiction. This way it was possible to track details about individual recovery histories during the 10 years starting from the point they attended the Detroit Sober House program. Informants were also asked about access to housing and work/income at the point of leaving the program and how they perceived the level of support they got from the sober house program. The level of support was expressed as the degree of help/helpfulness on a scale divided into five, from No help – Very much help. The same scale was used to report the degree of support from their own family. These data are presented in charts as frequencies, in some charts the correlation with 'total drug-free time' is shown.

Recovery success was measured and reported as 'total drug-free time' (TDFT) starting from first attendance in the Detroit Sober House program until the time of the interview. Some methodical challenges occurred related to defining and measuring 'total drug-free time', these are described and discussed in detail under the section: "Defining 'drug-free time' and measuring recovery success". There were also certain methodical considerations to make during interpretation of the answers related to "having a job/income", "attending a sober house program" and how informants estimated the support from their families. These methodical considerations will be discussed as a part of the data presentation. The same will be done in some other sections where we found it informative and relevant to comment on and discuss methodical implications related to presentation of data.

The quantitative data analysis looks at the characteristics of informants with different levels of TDFT and three levels are presented. Level 1 A group contains informants who reported 'no relapse' over the ten years and Level 1, 2 and 3 represent 'upper third', 'mid-third', and 'bottom third' levels of TDFT. A comparison is made between the characteristics of groups with different levels of success. Differences between the younger and older half of informants were also looked at to reveal potential differences over time. In a statistic analysis, the correlation (*r)* between several variables and TDFT is measured together with the *p*-value for the significance of the correlations at $\alpha = 5\%$ level. The above analysis is to be found in charts and tables below according to subjects analyzed.

Most questions in the structured interview had a quantitative character but follow-up questions of qualitative character were also asked and answers noted. When informants answered about what age they were when starting drugs, they were also encouraged to tell *how* it happened, for instance, the onset of drug use and the road to heroin use. While answering about the helpfulness of sober houses and family support, the number of relapses and recovery attempts informants were also asked open questions about *what* they found most helpful (if they found it helpful). Furthermore, if there was something else in their life that was important/helpful in their struggle

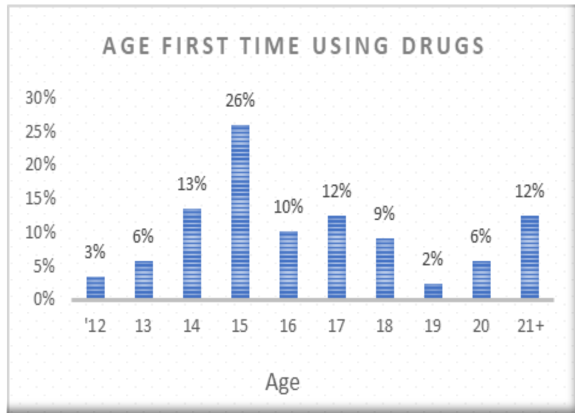
to become drug-free or had become a big obstacle in their struggle. The aim was to identify *recovery capital* or protective factors as well as a *lack of recovery capital* or risk factors throughout their recovery career. These follow up questions and the 18 in-depth follow-up interviews aimed at a better understanding of individual and contextual factors like childhood, family relations, life crisis, life as a heroin user, experience from sober house programs, and/or other treatment/recovery efforts done by the Zanzibar Recovery Community and the Zanzibarian government. Qualitative data is sometimes presented as comments to the quantitative analysis other times in comprehensive sections like the four cases in the last part of the report.

Drug use, age and time factors

Informants in our study reported their onset age for drug use to be between 12 and 35 years. The majority were 16 years or younger, 18% were 20 years or above (Chart 1). "Bangi", the Swahili word for marijuana, was the far most used onset drug and 93% reported marihuana as either their only onset drug or used in combination with other drugs like alcohol, hashish, and pills. A few informants (3) reported heroin to be their only onset drug, some more (8) reported that heroin was *among* their onset drugs. The three informants mentioning heroin as their *only* onset drug were all "late starters", i.e. from 26 to 36 years, those reporting heroin as their first drug emphasized *the opportunity*, there was a lot of heroin around, and people they knew recommended it. Some were in a life crisis and/or naive, underestimating the danger.
All informants proceeded from softer drugs to heroin use, a transition which took on average 4 years, and the average age for onset heroin was 21 years (Chart 2 & 3). The common pattern was to start with smoking the heroin, 66% reported that they had been injecting the drug.[11]
Having heroin as your onset drug is rare. When as many as 9% of our informants mentioned heroin among their first drugs, this could be explained by some characteristics of the user environments in Zanzibar, the availability, and prices. Some years back it seems that heroin users and marijuana users had more mixed environments or "ghettos" as these groups of drug users are called in Zanzibar.[12] In these "ghettos" the widely used Cocktails were popular, a mix of marijuana and heroin which is smoked. Heroin at this time, according to informants, "was everywhere", to a cheap price, and hit these "ghettoes". Some informants who were themselves involved in smuggling drugs into Zanzibar and in dealing describe a time where heroin was sometimes "given out like candy, even for free". Youth were easily exposed to heroin and some tell they believed they were smoking marihuana, just to find out later that

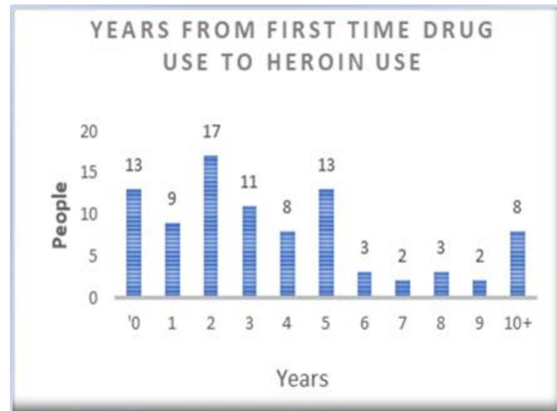
[11] Khalid, F e. al . 2014, estimated the number of people who injected drugs (PMID) in Uguja Island Zanzibar in 2011/2012 to be 3000 PWIDs. Beckerleg, Susan e.al. 2006, found that in that in a sample of 300 heroin users in Zanzibar 38% had "ever been injecting" heroin.
[12] The "ghettoes" in Zanzibar still exist but are less mixed than before, today you find groups and places of "clean former usesr», «marijuana smokers", "heroin users" and even "methadone users" have their own cafes where they gather.

Chart 1: *Age first-time using drugs among drug users who started recovery in Detroit Sober House in 2009/2010.*



Average = 17,02 Median = 16 N= 89

Chart 2: *Years from first-time drug use to heroin use among drug users who started recovery in Detroit Sober House in 2009/2010.*



Average = 3,97 Median = 3 N=89

joints had been mixed with heroin. At this time knowledge about heroin and *the danger of heroin addiction* was not well known or underestimated, something which also contributed to less awareness. One informant remembers:

> *The time you started to use heroin, did you know the danger of it?*
> Heroin? I did not know the danger of it, when I started it was like marihuana.
>
> *So, you did not know?*
> I did not know how it was going to be dangerous later. I was thinking that to smoke heroin was like ordinary smoking, like smoking marihuana…like if I wanted to stop smoking marihuana it was just to stop, but it was not like that.

Another informant explains how he was introduced to heroin and recruited as a dealer:

> *Why do you think just you started to use... (heroin)?*
> I think I started because of those people who were dealers...I came close to them. I was helping them to repair their equipment because I am a mechanic…
>
> *Ah…what kind of equipment?*
> I was repairing motorbikes.
>
> *You are a motorbike mechanic.*
> Ehee…so I was repairing the motorbikes they used. Sometimes they did not want to pay me, and I was saying; "give me at least *kete mbili*" (two fixes with heroin)
>
> *At this time, you were very young?*
> Yes, very young.
>
> *Did you use the drugs yourself or did you sell it?*
> Sometimes I was selling…other times I was thinking let me taste together with marihuana, so I took this, and I roll together with marijuana and a cigarette.
>
> *Was this how you smoked your first cocktail?*
> My first cocktail with heroin …there was this person from Dar es Salaam who came to visit, and when he saw me, and he was thinking; that guy would fit to help me in my business. So, he told

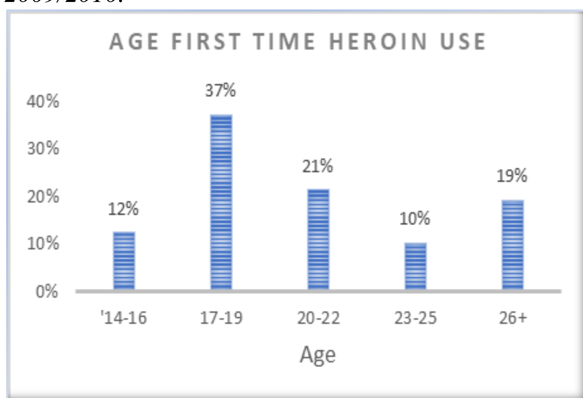
me; look bwana, I have this powder, let us sell powder and we will get money. So, he asked me if I would be able to sell the drugs, I told him that I would be able.

And until this day you had not tried heroin?
Until this day I had not tried, but when this brother gave me the drugs I stayed with it, I was playing with it, I sold it, I got money, I was playing with it, I sold it and got money, and then I said; today let me try this one fix...

A common explanation for their involvement with heroin was that; "it just happened", "one thing took the other". There were many differences in individual stories that can explain why some marijuana smokers continued with heroin and others not. Having said that, it is important to understand what the informants referred to while describing the contextual factors. The obvious lack of knowledge about the addictive character of heroin was important, in combination with the already mentioned integrated environment of marijuana and heroin smokers, the availability of heroin, and the cheap price. Many refer to "their street", "their neighborhood", as a place where heroin became more and more common during the 1990s and 2000s, something that also seems to be connected to very aggressive smuggling and dealing going on during these years. To be recruited as a dealer could also be a way into addiction as illustrated by the above story. This same informant claimed to be from an "ordinary family" and that out of six siblings he was the only one who started to use heroin. We will see later that drug users often came from broken and marginalized families with high conflict levels and abuse, but it illustrates a point; that youth from ordinary families seeking excitement easily could fall into addiction given the right circumstances.

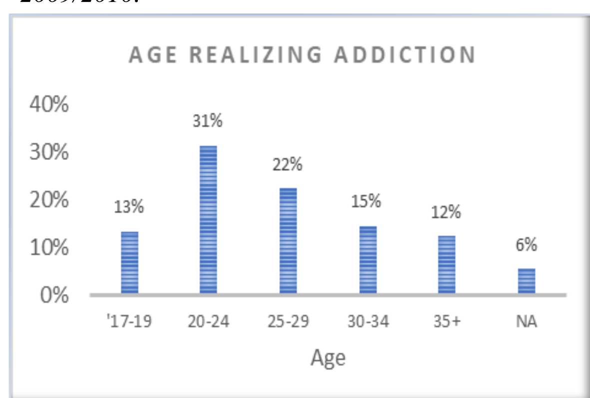
Close to half of the informants (49%) reported *still being teenagers* when starting with heroin (Chart 3) and informants report that it took them on average 5,2 years from starting heroin use to realizing they had an addiction problem. At the time of realizing addiction they were on average 26 years old (Chart 4). On average they were on heroin 11-12 years before they attended the Detroit Sober House program, and on average they were 32 years old at the time of attending the program (Chart 5 and 6).

Chart 3: *Age first time heroin use among drug users who started recovery in Detroit Sober House in 2009/2010.*



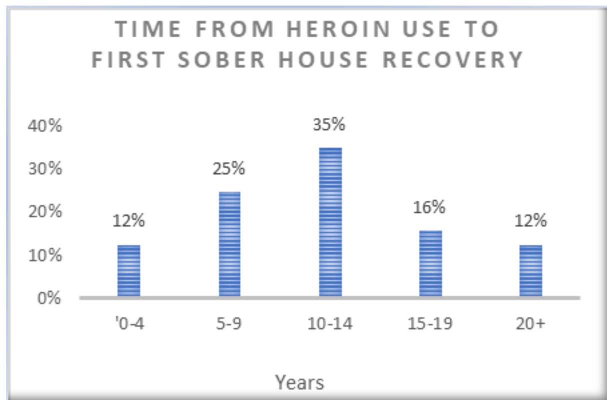
Average = 21,04 Median=20 N=89

Chart 4: *Age when realizing addiction among drug users who started recovery in Detroit Sober House in 2009/2010.*



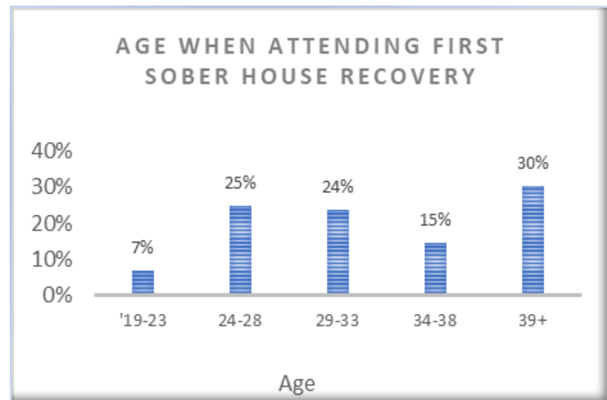
Average = 26,17 Median = 25 N=84

Chart 5: *Time from heroin use to first sober house among drug users who started recovery in Detroit Sober House in 2009/2010.*



Average = 11,68 N=89

Chart 6: *Age when attending first sober house recovery among drug users who started recovery in Detroit Sober House in 2009/2010.*



Average = 32,7 Median = 32

We will below look at how these figures differ according to the 'older' and 'younger' generation of drug users, suggesting a change in drug use patterns in Zanzibar over time. We will also look at their correlations with recovery success, but first to some controversies and methodological challenges related to defining and measuring 'drug-free time'.

Defining 'drug-free time' and measuring recovery success

The concept of being 'drug-free' and measuring 'drug-free time' turned out to be a challenging and contested area during the study. Important, since becoming 'drug-free' and sustain your drug-free condition are the main goals for drug users seeking recovery. One way to define 'drug-free time' was to count the clean time *since the last time using drugs.* This is for instance how the members of Narcotics Anonymous (NA) report their drug-free time in NA meetings, sometimes counted down to single days. Another way is to measure 'drug-free time' is as 'total drug-free time' during a certain period. This way of measuring will be less affected by recent relapses, which sometimes will give the wrong impression of recovery success measured over time. Since this study has been focusing on "recovery success" and factors influencing recovery efforts over ten years, the latter understanding of 'drug-free time' was more relevant.

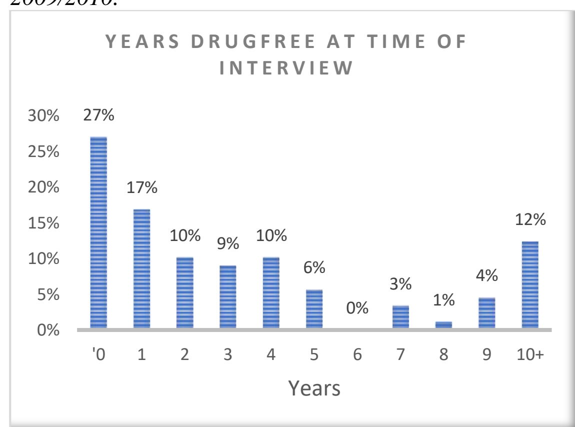
When we started interviewing we soon realized that 'drug-free time' had several other complications to it. Informants had a range of perceptions when considering "drug-free" conditions, from very strict interpretations to more liberal and pragmatic ones. An absolute consensus we found only at one point; "drug-free" means "not using heroin", but from here people differed in their perceptions. We will later discuss this in detail, as we in these interpretations also find some important ideological differences among drug users and within the recovery community.

One of the first questions informants were asked was; *do you consider yourself as drug-free today*. Out of 89 informants 77 (85,5%) answered "yes" to this question, 8 answered "no" and 5 found it difficult to state one or the other. First, as a single result, this is a high number and should be seen in connection with the follow-up question: *for how long have you been drug-free*? Second, in connection to *what informants meant by 'being drug-free'*.

Chart 7 below sums up the answers to the question *when did you last use drugs*? We see that 26% of the recovering drug users reported to have been clean for *five years or more*, 44% for *less than two years,* and 29% were in a middle range from 2 to 4 years clean time. Chart 8 shows informants' reported *total drug-free time* over the last ten years. All informants were asked in detail about recovery attempts and relapses. Based on these answers, figures were generated showing informants 'total drug-free time' counted from their first attendance in the Detroit Sober House program in 2009/2010 until the time of interview. Chart 8 shows that the average 'total drug-free time' was reported to be 5,4 years, meaning that informants had on average been clean half of the time since they started recovery in Detroit Sober House. It also shows how informants move up the scale when their total drug-free time over the ten years is included. Comparing the two charts we see that 'total drug-free time' is reported to be on average 2 years higher than 'drug-free time at the time of interview'.

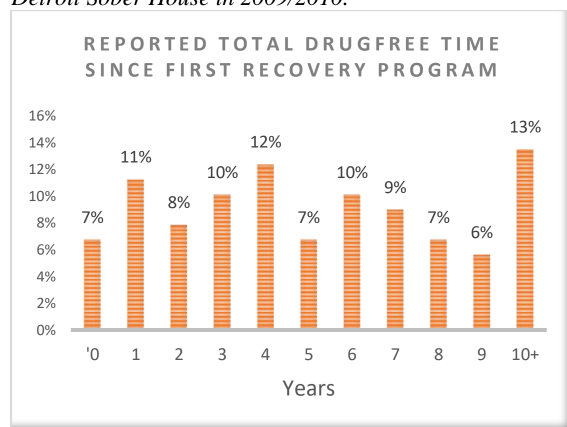
In the upper end of Chart 7, we find a group of 14 people (16 %) who did not relapse after their first sober house recovery program and had made it through all the ten years. These are in the following analysis defined as the **Level 1 A group** in terms of success. In the lower end of the charts, we see that 27% had less than one year and that 73% had less than 5 years drug-free at the time of the interview.

Chart 7: Drug-free years at the time of interview among *drug users who started recovery in Detroit Sober House in 2009/2010.*



Average = 3.37 N = 89

Chart 8: *Total drug-free years since recovery start among drug users who started recovery in Detroit Sober House in 2009/2010.*



Average = 5.40 N= 89

Table 1 below presents drug use, age, and time data along the lines of different levels of recovery success and related to two generations of users. First, we find the *Level 1 A group* referred to above, the "no relapse" informants. Second, the informants are divided into three levels according to success. *Level 1* – contains the upper 1/3 successful (N=30), who were in the range

of 7 -10 years drug-free time and had on average 9,1 years TDFT. Included in Level 1 is the Level 1 A group. *Level 2* - contains the mid 1/3 successful (N=30), who had 3,5 - 7 years drug-free time and on average 5,1 years TDFT. *Level 3* - the 1/3 with less success (N=29) – who had from 0 - 3,5 years drug-free and one average 1,9 years TDFT. The next row states the *correlation* r between age, time, and drug use factors and TDFT and the *significance* of these correlations (p-value) p, at $\alpha = 5$ %.[13] The next row states the *total average* for comparison and the two bottom lines show the *difference between two generations* of drug users.

In terms of *age and time factors*, we see that the characteristics of the successful are that they were slightly younger when starting heroin use, they were also younger when realizing addiction and used less time on average to proceed to heroin use. We see that the least successful were 3,5 years younger while attending the sober house program. Data show weak correlations between the above *age* factors and TDFT, none of these weak correlations were found to be significant at $\alpha = 5$ % level.[14]

Table 1. Characteristics of informants related to recovery success levels and generation among drug users who started recovery in Detroit Sober House in 2009/2010. (TDFT = Total Drug-Free Time).

Group	Total drug free time	N	Age time of inter-view	Age start drug use	Age start heroin use	Age when realizing addiction	Age first time in sober house recovery	Time from onset drug use to onset heroin	Time from onset heroin to realize addiction	Years on heroin before SH recovery	% Inject heroin	Clean years time of inter-view	Total drug-free years
	Years	N	Ave	Ave	Ave	Ave	Ave	Years/Ave	Years/Ave	Years/Ave	%	Ave	Ave
Level - 1A Informants with no relapses	9+	14	43,9	15,6	18,8	24,1	34,3	3,2	5,3	15,5	47 %	9,95	9,95
Level - 1 One third with highest TDFT	7+	30	43,6	16,7	19,8	25,1	34,0	3,1	5,3	14,2	43 %	6,9	9,1
Level - 2 One third middel range TDFT	3,5-7	30	43,2	17,7	22,3	27,1	33,5	4,60	4,6	11,2	80 %	2,4	5,1
Level - 3 One third with lowest TDFT	0-3,5	29	40,1	16,7	20,9	26,2	30,4	4,2	5,8	9,5	83 %	0,8	1,9
Correlation r with TDFT and significans of r (p) at $\alpha = 5\%$			r = 0.14, p = 0.20	r = -0.05, p = 0.65	r = - 0.14, p = 0.21	r = - 0.14, p = 0.20	r = 0.14, p = 0.20	r = - 0.14, p = 0.21	r = - 0.05, p = 0.62	r = 0.27, p < 0.01	r = -0.34, p < 0.002	r = 0.82, p < 0.001	
Total Average	5,40		41,8	16,8	20,8	25,84	32,3	3,9	5,2	11,60	66 %	3,30	5,40
'YoungerGEN' 29 - 40 y	4,80	45	36,3	15,4	18,5	23,3	26,6	3,1	4,9	8,2	84 %	2,5	4,8
'OlderGEN' 41- 61 y	6,00	44	48,4	18,7	23,6	26,9	38,9	4,9	5,5	14,6	57 %	4,1	6,0

The *time* factor that differed the most between the levels of success and also significantly correlated with recovery success (TDFT) was *'years on heroin before starting sober house recovery'*. The most successful Level 1 group had on average 4,7 years *more* on heroin

[13] Testing the significance at $\alpha = 5$ % as used in the Table 1 means to check if there is less than a 5% chance for the null hypothesis - H0 to occure, which is H0: *There is no correlation between the variable x and TDFT*. P-values of $p <$ 0.05 concludes the correlation to be significant between the variable x and TDFT at $\alpha = 5$ % level. Higher p – values fail to reject H0.

[14] A "weak" correlation is in this study considered to be in the range form r = +- 0.10 to r = +- 0.30.

compared to the less successful Level 3 group. A significant positive correlation of $r = 0.27$, $p < 0.01$ was also found between 'time on heroin' and 'total drug-free time'.

Concerning *drug use* factors influencing recovery success *injecting heroin,* not surprisingly, seemed to negatively affect recovery success. Characteristics of the top third successful were the low percentage who injected heroin (43%) compared to mid-range (80%) and less successful (83%). A significant negative correlation was found at $r = -0.34$, $p < 0.002$ between injecting heroin and TDFT.

Looking closer at the difference between the 'oldest' and 'youngest' generation of drug users we see that the older generation has more 'total drug-free years' and shares some characteristics with the most successful like less percentage having used injection, more years on heroin before the first recovery program, and a higher age while attending their first recovery program. On the other side, they have some characteristics in common with the less successful like a higher onset age for heroin, higher age when realizing addiction, and more time from onset drug use to heroin use.

The correlation between recovery success and 'time on heroin before first sober house recovery' could somehow be considered as a surprising finding. What this *could* be about is the phenomenon of "hitting the bottom". A common belief and saying among recovering heroin users in Zanzibar is that: '*you are not ready to quit drugs before you hit the bottom'.* Variations over this topic were also mentioned by informants while reflecting on things that helped them to become clean. They could use expressions like:

> "I was sick and tired"; "I became aware destruction of drugs", "I was hitting the bottom", "I was stuck, reached the bottom, sleeping outside", "I wanted my life back... drugs almost killed me".

"Hitting the bottom" is an individual feeling and how it is experienced will differ among drug users. Still, if it is influencing motivation to be drug-free it is reasonable to anticipate a relation between 'time on heroin' and the 'likeliness of hitting the bottom', and therefore between 'time on heroin' and 'motivation to quit'. If hitting the bottom represents a turning point for many drug users, which data suggests, and sometimes boost their motivation, we should expect to find this correlation between 'recovery success' and 'time on heroin before attending the first recovery'.

Thus, "hitting the bottom" implied reaching a point where drug users were forced to ask themselves the most fundamental and existential question: "do I want to live?". If the answer is "yes", the *wish* to live is not enough, it is followed by strong demands to change your life and requires a motivation to do so. The seriousness of addiction, the hard work of quitting, is what drug users early in their career tend to underestimate according to one informant who had long experience in drug use, leading NA groups, and managing sober houses. He expressed it this way:

> My experience is; *physically* you gain quick and most of the users they think the problem is only using, after not using they think the problem is over. They believe so themselves. They think now

> they are fine. And if they are fine now, why should they stay more? That is the most common experience that I have. And there are different other reasons, but this is the most common one. (….) ...and in the family's mind when that person looks ok, why should we pay to the sober house?... so, we will stop the money and give him a little capital so he can do business with."

Among our informants, we had a range in age of 29 – 61 years allowing us to explore the differences between the "younger" and "older" generation of drug users on drug use, age, and time factors. The youngest half of our informants had an average age of 36 years, the oldest 48 years. This concludes the years 1989 and 1993 to be the average onset years of drug use and heroin use for the 'older generation'. Accordingly, in 1998 and 2001 for the younger generation. Table 1 shows that the younger generation started earlier with drugs (-3,33 years), and started earlier with heroin (-5,10 years). They used less time from onset drug use to onset heroin use (-1,80 years), had a higher percentage injecting heroin (84% vs.57%), was younger when realizing that they had an addiction problem (-3,6 years), had less time on heroin before attending their first sober house recovery (- 7,10 years) and in total, they had less total drug-free years during the ten years (-1,2).

The difference in recovery success between the 'younger' and 'older' generation is there, but it is relatively small (+ - 0.6 years from average). More interesting is the tendency suggested by our data that young people in Zanzibar from the early 1990s to early 2000s started using heroin at an increasingly younger age, and to a larger degree injected the drug. This indicates a general increase in heroin use in Zanzibar during these years, which also other data suggest. When the 'younger generation' faster seems to realize their problem and faster seek recovery it indicates that the knowledge and awareness increased. On the other hand, attending sober house recovery, in this case, is also strongly related to access, since the first sober house program in Zanzibar was started in 2009, the older generation was excluded from attending recovery at Zanzibar at a younger age. Before the sober houses, to be kept at the mental hospital in Zanzibar seemed to be the only option for people addicted to drugs.

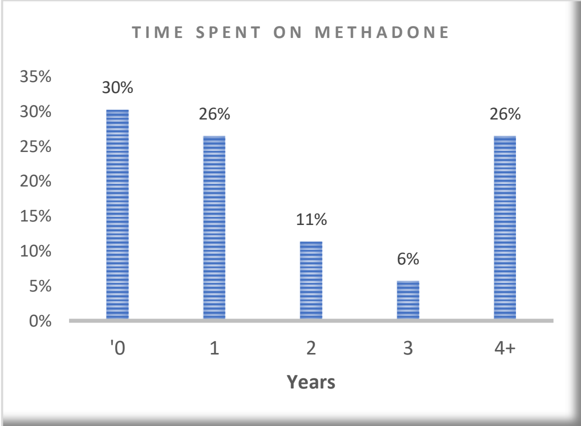
Methadone use and controversies defining "drug-free time"

In the year 2015, the first methadone program ever started in Zanzibar and we found that close to 1000 persons who inject drugs (PWIDs) attended this program in autumn 2019. Of our informants 53 (60%) reported that they had been in this program, 49 informants (55%) were still in the program at the time of the interview. Only one informant reported to have finalized the program as drug-free, two stopped their program concluding that methadone was not for them and one had been expelled from the program due to drug use.

One of the characteristics for those *less successful* in recovery was the high number of people injecting drugs (PWIDs) and methadone users. As we have seen 83% in this group had been injecting drugs and we found that 75% participated in the methadone program at the time of the interview. Chart 9 below shows the time our informants had been spending in the methadone

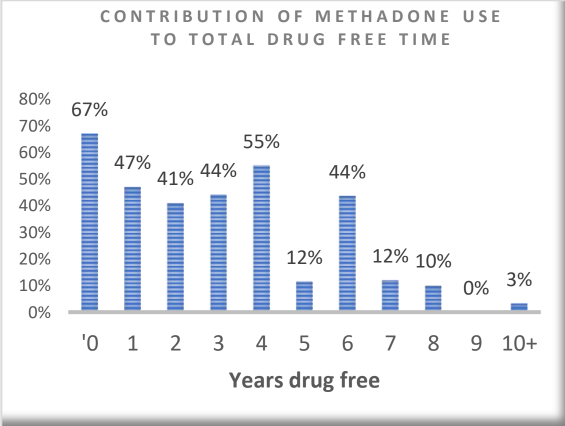
program and Chart 10 shows how the 'time on methadone' contributed to informants 'total drug-free time'. Among those who had been participating in the program 30% had less than one year in the program, 56% had less than two years, and 26 % had four years or more. The latter group contributed to 54% of all the time our informants had been spending in the methadone program, these were recruited in 2015 at the very start. Chart 10 shows that 'time on methadone' contributed significantly to the 'total drug-free time', and relatively more to the drug-free time of those with less total drug-free time.

Chart 9: *Time spent in the methadone program for informants who started recovery in Detroit Sober House in 2009/2010.*



N = 53

Chart 10: *Methadone program contribution to 'total drug-free years' for informants who started recovery In Detroit Sober House in 2009/2010.*



N = 53

Among informants that had been attending the methadone program, the average 'total drug-free time' was 4,1 years, compared to 5,4 years for all informants. On average two years of the 'total drug-free time' among these informants were related to methadone use. Thus, the time on methadone contributed to around 50% of the 'total drug-free time' in this group. In comparison, these figures were 1,17 years or 21,7% for all informants. The 36 informants that had no time in the methadone program had on average a 'total drug-free time' of 7,4 years.

Table 2 below illustrates how methadone use relates to recovery success levels. We see that among the *most successful* one third, only 20% had been in the methadone program, and methadone related 'drug-free time' in this category was only 6% of the 'total drug-free time' reported. In comparison, 82% of the *less successful* one third had participated in the methadone program, and their time in the program accounted for 53% of their total drug-free time. Participation in the methadone program also differed according to the 'older' and 'younger' generation, in the younger generation 80% had been in the program while the figure for the older generation was 41%. The youngest generation of informants had 27% of their total drug-free time from time in the methadone program, while this figure was 17% for the older generation.

When the methadone program came to Zanzibar it represented another chance for many drug users to stop using heroin. Among these informants, we find 'the frequent triers' those with three or more formal recovery attempts between their first attendance in the sober house and joining the methadone program. They would typically be in and out of sober houses. Among methadone

users, we also find those with few attempts to recover. Half of them did only one single attempt to recover in the years between relapsing after the sober house program and attendance in the methadone program somewhere between 2015 and 2019. This should be expected, taken into consideration that the methadone program is targeting *harm reduction* amongst the heaviest cases, targeting improved health, and reduction of crime.

Table 2. Methadone use and drug-free time among drug users who started recovery in Detroit Sober House in 2009/2010.

Group	N	Methd use	DF time related to methd use	Total drug free time excluded methd use	Total drug free years
	N	%	%	Years	Ave
Level - 1A Informants with no relapses	**14**	**0 %**	**0 %**	**9,95**	**9,95**
Level - 1 One third with highest TDFT	30	20 %	6 %	8,58	9,1
Level - 2 One third middel range TDFT	30	77 %	38 %	3,16	5,1
Level - 3 One third with lowest TDFT	29	82 %	53 %	0,89	1,9
Correlation r with TDFT and significans of r (p) at $\alpha = 5\%$		$r = -0.49$, $p < 0.001$			
Total Average		60 %	22 %	4,21	5,40
'YoungerGEN' 29 - 40 y	45	80 %	27 %	3,50	4,80
'OlderGEN' 41- 61 y	44	41 %	17 %	4,98	6,00

Out of 49 informants who were still on methadone, 88% answered that they considered themselves as “drug-free”. The rest would answer either “no” or “both yes and no” when asked because they defined methadone use as drug use, or they used marihuana or alcohol from time to time while on methadone. As mentioned, the consensus among informants was that “drug-free” implied the *absence of heroin use.* Some would claim that they were drug-free, even if they still sometimes used substitutes like marihuana and alcohol, often in combination with methadone. When it came to substitutes, we asked informants themselves to define if they considered a specific period as “drug-free time” for them or “a relapse”, even if substitutes were used. As we see it, these kinds of challenges to maintain accuracy will always be present to a certain degree in self - reporting studies about drug addiction, with its grey zones and complexity.

On the opposite side of the methadone users in this controversy, we found the NA and sober house community, where ‘drug-free’ was understood as absolute abstinence from drug use. According to one of the NA leaders in Zanzibar methadone use is something “totally different”, and illustrates that the characteristic of a drug user is that “..he loves to find the easy way out”,

"he wants to avoid the pain" and "..he is not ready to go out and hassle, fight for it". Another leader expressed himself this way:

> I see it like this; if you are clean (not taking any drugs) you can go anywhere, but if you are taking methadone I don't go *mbele* (forward), you are not free to go anywhere...you are in a program...so for me using methadone it is an addiction...every day you have to take it...so it is an addiction...Like every morning you have to drink some coffee.

The first quoted NA leader claims that among methadone users; "only a few cases are taking methadone as a medicine, not as a dope…", and he continues elaborating about the difference:

> … in the sober house, we learn the principles and discipline and the rules and regulations and the behavior and attitude you know…and the methadone, I am only going to get and then I am out. No behavior changes. They take the drinking cup. But in sober house, this is only the beginning of the stop... The behavior is just something else. You learn the discipline you learn to take responsibility; you learn having the program not only NA program, you know, you have to change your lifestyle.

Taking responsibility and behavioral change is essential in the 12-step program, and rules had been established in the NA meetings saying that people "under influence" are not allowed to speak in the meetings. This rule excludes methadone users from participation in the formal part of NA meetings and creates a "fight", as our NA leader expresses in this quote:

> We have our principles, that they cannot talk within the meeting. If they want to talk, they have to talk before the meeting starts or after the meeting. And this is where they fight. Why cannot we talk at your meeting? This is because we believe you are under the influence; this is why we are not allowing you to talk within the meeting. (…) So, if you have used today, we recommend that you are only listening for now and you talk to someone after group. So not only the methadone man, even the active one. That's a principle.
>
> *But this means that they are put in the same category as heroin users.?*
>
> Yes, and this is where we fight. And what happens; they choose to keep a distance from us!

These quotes from the NA leader illustrates the core of what is referred to as "the fight" between methadone users and members of the NA community. Methadone use is in the NA community considered equal to any other user of the drugs, like heroin use. The methadone users, therefore, cannot be considered full members of any NA group if they still use methadone, and considered to be "under influence of drugs". To many methadone users, it seems, this principle represents a lack of recognition of their effort to stop using heroin and contributed to keeping them away from NA activities.

To understand this part about allowing somebody to speak in NA meetings, we must be aware that NA meetings have a formal part, with a ritual opening ceremony and a closing ceremony. In this formal part recovering drug users share their experiences, give and receive guidance. People "still under influence" are normally not allowed to speak during this formal part, but can speak to members of the group before, after, or during breaks in the meeting.

The NA leaders refer to this “fight” as something also present in the global community of drug recovery:

> ... on a global level, this is a very contractional issue, because in the harm reduction they define recovery is to move from one place to another. From point A to point B. If you are using you are not going to work, if you go to methadone you look smart and go to work, that is your recovery. And this is why they answer, “we are drug-free”. Because they have moved. Maybe they didn't wash, they didn't go to work but now in a methadone program they have a wash in the morning, and they go to work. They consider that they are drug-free and recovered and..
>
> *But people are taking medicine for all kind of sicknesses and the medicine they are taking ..could be considered as a drug*
>
> Yes…even the members of the sober house take medicine, we call it "in time of illness" ..you cannot sleep...yes but you take it as prescribed. To be honest, if the doctor prescribes one tab you take that tab. And you are not relapsing, yes calming down tablets, maybe Valium, but the doctor prescribes, and you take one. And you take it at night only.
>
> *But a methadone dose is also prescribed by a doctor ..?*
> yes, it is a medicine…(laughter) yes, and this is where you have to say it is resolved! (laughter)

In their study exploring diversity in definitions of “What Is Recovery?”, Kaskutas, L.A. et. al (2014) found four domains and 35 elements in recovering or recovered drug user's definitions. “Abstinence in recovery” was one of the four recovery domains, found “to be robust regardless of the length of recovery, 12-step or treatment exposure, and current substance use status”. The approach in the study was to measure the importance of different recovery elements in the respondent's definition of recovery. Their data showed that “*abstinence in recovery”* for 65 – 79% of the respondents; *“definitely belongs in my definition”* this differed according to different statements on abstinence which were: “no use of alcohol” (79%), “no misuse of prescribed medication” (77,8%), and “no use of nonprescribed drugs” (65,4%). These answers illustrate that there was a certain agreement on these definitions, but also that 20 – 35% would not consider the three statements as *“definitely belonging in my definition”.* What is missed out in the statement alternatives, is what represents the core of the Zanzibar controversy, the statement that could be expressed as: “no use of prescribed drugs in drug replacement treatment of drug addiction”. At Zanzibar, at least among methadone users, the percentage would be high agreeing to this statement as; “definitely belonging in my definition”.

In this perspective, it is also interesting to have a closer look at the views of the Narcotics Anonymous World Service Board of Trustees on methadone use in Bulletin #29 - 1996, Regarding Methadone and Other Drug Replacement Programs which says:

> Members on drug replacement programs such as methadone are encouraged to attend NA meetings. But this raises the question: "Does NA have the right to limit members participation in meetings?" We believe so. While some groups choose to allow such members to share, it is also a common practice for NA groups to encourage these members (or any other addict who is still using), to participate only by listening and by talking with members after the meeting or during the break. This is not meant to alienate or embarrass; this is meant only to preserve an atmosphere of recovery in our meetings.

> (…) When an individual under the influence of a drug attempts to speak on recovery in Narcotics Anonymous, it is our experience that a mixed, or confused message may be given to a newcomer (or any member, for that matter). For this reason, many groups believe it is inappropriate for these members to share at meetings of Narcotics Anonymous.
> (…) Our fellowship must be mindful of what kind of message we are carrying if a still-using addict leads a meeting or becomes a trusted servant. We believe that under these circumstances we would not be carrying the Narcotics Anonymous message of recovery. Permissiveness in this area is not consistent with our traditions. We believe our position on this issue reinforces our recovery, protects our meetings, and supports addicts in striving for total abstinence.[15]

Bulletin #29 - 1996 aligns quite well with the attitudes we found among people in the NA and sober houses in Zanzibar.

Let's first emphasize that it was not our impression that NA oriented people were against methadone treatment as such. On the contrary, we found mostly liberal and pragmatic views on the different paths to recovery and a better life for drug users like expressed by this leader:

> …I will say any program that will make people stopping (as users); me I say that is good. Methadone, sober house, other people can go to the church program, Islamic program (…). So, for me, I say "good", if it will stop you from using drugs.

It was a clear opinion, also among NA oriented people, that methadone could be helpful and that a recovering drug user should "hold on to what helps you". On the other hand, there was no room for compromises with the NA understanding of recovery as "stop using all drugs" and "behavioral change". Thus, methadone users could not join sober house programs or participate fully in NA groups without giving up their methadone, since willing to give up drugs is seen as *the only* and *the absolute* precondition for participating fully in the 12- step recovery program.

Having said that, the quoted NA leader underlines that NA groups, according to "the 4th tradition" have autonomy and can be unique. Even if most groups would define methadone as a drug and apply the principles leading to reduced membership rights, it is possible to form groups with other rules. Another leader in NA Zanzibar tells who he tried to start a NA group for methadone uses at the clinic and how it fast collapsed.

> I started the NA meetings at the methadone clinic, but I closed – not many came. I was tired – they like very much to drink methadone – even Juma (another NA leader who participated) is tired – we want to help people who want to help themselves.

Finally, there is necessarily a risk of embarrassment for methadone users attending ordinary NA groups if they disagree on widely used NA definitions and ideology. As most of our informants considered themselves as drug-free even if they used methadone, they seemed to sense this risk. If you, as a methadone user, consider yourself clean and are proud of your clean time, you should be prepared that your potential NA group would not recognize this. Methadone is considered a drug in NA and total abstinence is a strong demand. For methadone users, it could be a psychological set back to not have their effort recognized, not be included in meetings when

[15] https://www.na.org/?ID=bulletins-bull29

others celebrate their clean time and being told that your clean time does not count. Clean time easily becomes a part of former drug users identity and pride, a source of status in a community of recovering drug users. To many, clean time is personal, self-defined progress and it may be painful if questioned. A feeling of being judged, not support could be the outcome and in this perspective it is understandable that methadone users sometimes prefer to keep a distance and are sceptical to attend NA groups.

Sober house attendance, volunteering, and recovery success

An important aim of this study was to look at the impact sober houses have on drug user's recovery. Informants were asked about their first stay in Detroit Sober House, if they during the ten years returned to Detroit Sober House, stayed in any other sober house, and for how long they stayed. While collecting data about attending programs in sober houses, we soon found that this was not straight forward to measure. Attending a sober house program, you can do as a drug user in immediate recovery *or* you can attend as a volunteer, doing service in the house after finishing your program. This became obvious when one of our first informants to the question; "…and for how long did you stay in Detroit Sober House", answered: "10 years and 2 months"! This person *never left* and was still in the house. He finished his basic and aftercare course and had since done all kinds of sessions, services, and had management responsibilities.

Many did not make a sharp distinction between 'being in recovery' and 'doing service' in sober houses. Recovering was *always going on*, since; "one time an addict, always an addict" was a common understanding, and *recovering* as such also contains maintaining your drug-free condition. Doing service in sober houses and working in peers with fellow recovering addicts, was not only seen as a help to others but also as a part of their recovery. To complicate this, even more, the scheduled time for each program, like four months basic program, two months aftercare, and two months refresh program after a relapse, was not necessarily the time implemented. Sometimes people extended their stay or got their stay extended if family or sober house management advised so. During this extension, they could somewhere in the process enter the role of a volunteer.

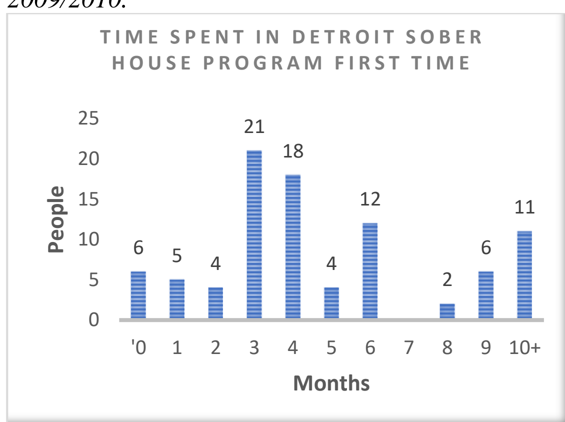
Methodically, this left us with some challenges as we wanted to measure the time informants spent *in recovery* in sober houses. If we included all reported time spent, the service time of a few informants would largely affect the figures. If we only accepted the *scheduled* program time as a maximum, we would not capture informants who used more time in their recovery than the scheduled time but still not doing service. In this situation, our approach was to ask informants to, as far as possible, distinguish between their *own recovery time* and *service time in support of others.*

Detroit Sober House was the first sober house in Zanzibar and attending their recovery program was the first sober house recovery attempt by the informants. The program contained a basic

program of four months and an aftercare option of an extra two months. The informants stayed on average 5,5 months in this program and on average they had 2,6 years drug-free time related to their first stay. Having in mind that this first sober house basic program lasted for four months, the figures below show that 36 informants or 40% never finished the basic program (Chart 11). About the same number (35) stayed longer than the basic program. Staying longer could be because they just needed more time, participated in aftercare, engaged in service in the sober house after finalizing their program, or did a combination.

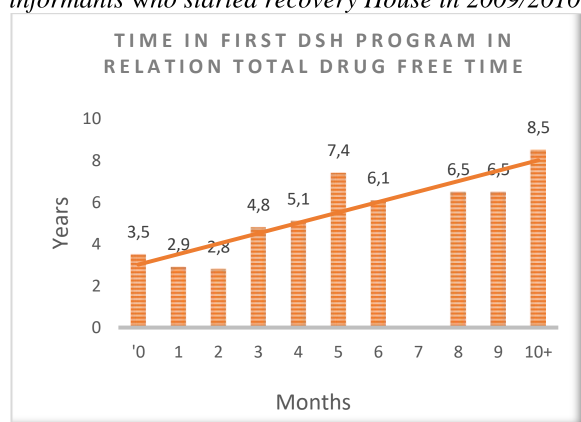
Chart 12 shows that there is a significant correlation between time spent in their first sober house program and total drug-free time during the ten years ($r = 37$, $p < 0.001$). This is an

Chart 11: *Time spent in Detroit Sober House for informants who started recovery in Detroit Sober 2009/2010.*



N = 89 Average = 5,5 Median = 4

Chart 12: *Correlation 'time in the first Detroit Sober House program' and 'total drug-free time' for House in informants who started recovery House in 2009/2010.*



N= 89 $r = 0.37$ $p < 0.001$

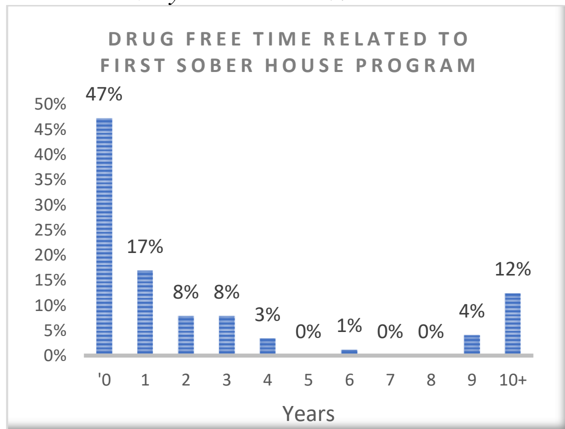
expected finding and could be caused by a combination of factors. One possibility is that more extensive attendance in the sober house programs provided knowledge, emotional support, and increased motivation to fight addiction long term. Another is that informants staying long in the program connected deeper with NA and the recovery community long-term, something which gave them a role to fill and a sense of belonging, itself important forms of recovery capital. Other data also suggest this relation and will be addressed below.

When informants answered to have left the sober house before the end of the basic program, the follow-up question; "why did you leave Detroit Sober House" was asked, which gave us a picture of *why* they did not finish. Several reasons were given like; lack of money to continue (8), started a business or got a job (3), conflicts in the sober house (4), and family obligations/illness (4). The most common reasons for quitting though were related to *not being ready to quit* or *having believed that they were recovered.* In total 21 of the 38 informants leaving early mentioned this, and it was expressed in many ways like:

> "I relapsed and ran away"; "I was not ready"; "I just escaped, thought that I was fine now"; "I was tired of being locked up"; "I was not ready, forced by mother and father to be there"; "I felt trapped and had paranoia"; "I thought I would make it"; "I thought this was enough for me, the drug is out of my body, but it was not out of my brain".

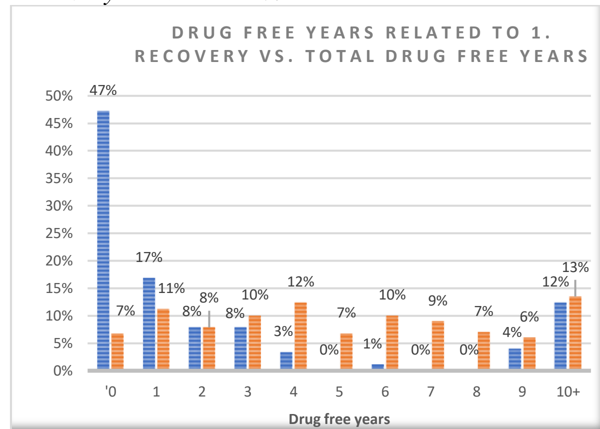
Following informants out of the sober house after their first recovery, we asked them to estimate *the time they stayed drug-free*. Chart 13 sums up these answers, drug-free time inside the house is included. As we see 47% relapsed within the first year, 64 % relapsed within the two first years and 83% relapsed before five years was gone. In the upper end, we again find the group of 16% who managed to stay drug-free throughout, following their first attempt.

Chart 13: *Drug-free time related to the first sober house Recovery program for informants who started recovery House in 2009/2010.*



Average = 2,6   Median = 1   N = 89

Chart 14: *Drug-free time related to first recovery and vs. total drug-free time for informants who started recovery House in 2009/2010.*

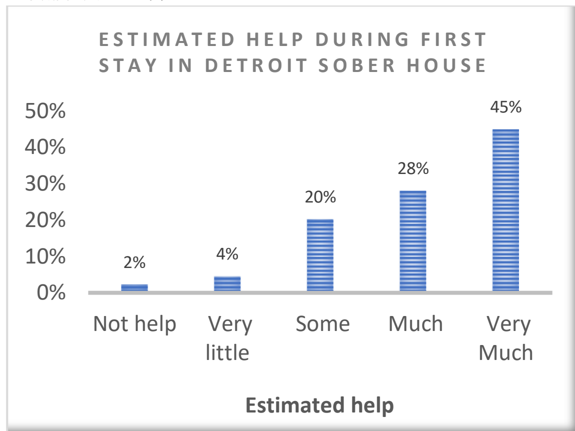


N = 89 $r = 0.72$ $p < 0.001$

Drug-free years connected to this first recovery attempt were on average 2,6 years but again, the median value of 1 year shows that the average is strongly influenced by the success of the top 16%. Chart 14 shows the relationship between 'drug-free time' related to the *first recovery attempt* and 'total drug-free time' ($r = 0.72$, $p < 0.001$). It illustrates that most drug users need time and several attempts to recover and move up the scale over the years. Somewhere during this journey, there might be turning points where they succeed to remain drug-free for a longer period or to quit totally.

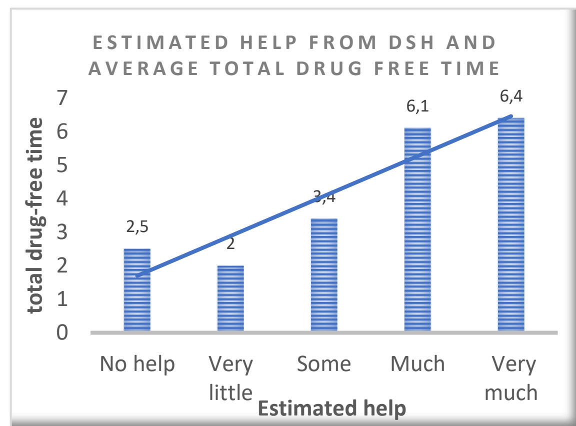
Sober houses and the recovery community in Zanzibar were important to make such turning points more likely. Informants were asked to value their stay in Detroit Sober House in terms of *how helpful it was to them* in fighting their addiction and in particular; *what* they found helpful. Chart 15 below shows that 73% found their first stay in Detroit Sober House *much* or *very much* helpful and that only 6% expressed that they got *no help* or *very little help* from the program. Chart 16 shows how the valuation of their first stay in Detroit Sober House relates to their total drug-free time and the correlation between the two variables ($r = 0.41$, $p < 0.001$).

Chart 15: *Estimated help from staying in DSH for informants who started recovery In Detroit Sober House in 2009/2010*



N = 89

Chart 16: *Estimated help from DSH and 'total drug-free time' for informants who started recovery In Detroit Sober House in 2009/2010*



N = 89 $r = 0.41$ $p < 0.001$

When asked *what* they found *the most helpful* during their stay in Detroit Sober House the answers were given along four lines. These we have called *protection*, *emotional support*, *knowledge,* and *behavioral change*-oriented answers.

Protection-oriented answers would focus on the usefulness of access to shelter and basic care like, food, medicines, a bath, a bed, clean clothes, good sleep, rest, and being protected from the drug-using environment of the street. *Emotional support-oriented* answers emphasized things like:

> "getting a family feeling", "experience unity", "togetherness", "the company of others", "respect from others", "belonging", "friendship", and "started to believe in myself".

To stay with others: "gave hope", it helped to be with and be seen by others and to see that others had the same problem, these were some of the expressions used:

> "I am not alone", "kindness of others", "to experience acceptance and trust from others", "watch others recover also gave strength", "get a wake up call", "seeing others who were able to quit drugs, "I could start to see myself like a human", "I started to hope", "the sharing made me change, I learned to listen and to share ideas"

Knowledge oriented answers emphasized how knowledge became a tool in the understanding of their drug problem, themselves, and their struggle to quit drugs. Most helpful to them could be expressed as;

> "knowledge, meetings, to be educated", "I started to understand my problem", "I understood that I am sick", "I understood myself as an addict", "I understood why I am using drugs", "learned how I could live my life", "helped me to stay away from former friends", "helped me stay clean and organize my life", "it taught me to understand myself, who am I, what problem do I have, how to deal with the problems", "learn from others experiences", "I realized that I have a problem, it helped my self-awareness", "it thought me that I have a choice", "I learned how to open up my mind, to stay without using", "I understood that I have to stay away from *all* drugs", "learned how to take care of myself, the lectures about how to live without drugs and how drugs affect you, it is staying in my head."

Behavioral change-oriented answers focused on how the sober house program changed them as persons and was expressed as;

> "being more open-minded", "started to believe and hope that I could stop", "I changed my attitude and wanted to take responsibility without drugs", "it increased willingness to stop using", "I learned to be more tolerant, patient and tell the truth", "I became more aware what I want to do and don't want to do, it helped me to build identity", "I understood myself better and that I have a choice, I became wiser and more humble."

The above would, of course, sometimes overlap, the point here is to illustrate what informants found helpful and that there are different profiles when estimating support from the sober house. These profiles also differ concerning recovery success or total drug-free time. Informants being knowledge, emotional support and behavioral change-oriented in their answer had all on average a higher total drug-free time than the total average, respectively *knowledge-oriented* (N=47) TDFT = 6,0 years, *emotional support-oriented* (N = 14) TDFT = 6,4 years, *behavioral change-oriented* (N = 9) TDFT = 6.8 years. Informants with *protection-oriented answers* (N = 15) had a TDFT = 2,8 years. These results should be expected if recovery success is influenced by the informant's involvement in and their gaining from the sober house program.
During their sober house recovery, some informants extended their stay *doing volunteer work* right away, others returned later, either to Detroit Sober House or to some other sober house to engage in volunteer work. In total 25 informants reported having participated in *service* or *volunteer work* in sober houses during the ten years. These 25 informants (28%) had on average 3.0 years higher total drug-free time than the total average.

Table 3 below shows how variables are distributed according to groups with different levels of success in recovery and between 'younger' and 'older' generations. *Staying longer first time attending the sober house program, clean time related to their first recovery attempt*, *experiencing a high degree of support in their first SH recovery program*, and *engaging in volunteer* work goes together with and have a positive and significant correlation with recovery success.

Table 3: Sober house attendance and recovery success for informants who started recovery in Detroit Sober House in 2009/2010

Group	Total drug free time	N	Monts spent in Detroit SH first-time recovery	DF time related to first SH recovery	Self-estimate SH support	Engaged in volunteer work	Total drug free years
	Years	N	Months	Years	5 = max	%	Ave
Level - 1A Informants with no relapses	9+	14	6,6	9,95	4,70	79 %	9,95
Level - 1 One third with highest TDFT	7+	30	6,7	5,9	4,5	63 %	9,1
Level - 2 One third middel range TDFT	3,5-7	30	6,2	1,3	4,2	17 %	5,1
Level - 3 One third with lowest TDFT	0-3,5	29	3,3	0,6	3,5	3,5 %	1,9
Correlation r with TDFT and significans of r (p) at α = 5%			r = 0.37, p < 0.001	r = 0.72, p < 0.001	r = 0.41, p < 0.001	r = 0.61, p < 0.001	
Total Average	5,40	89	5,4	2,6	4,1	28 %	5,40
'YoungerGEN' 29 - 40 y	4,8	45	5,0	2,3	4,0	22 %	4,8
'OlderGEN' 41- 61 y	6,0	44	5,8	3,0	4,2	34 %	6,0

We also see that ‘the older generation’, who had slightly higher total drug-free time during the ten years, participated more in volunteer work, stayed longer in the first sober house program, and had more drug-free time connected to their first recovery attempt, i.e. score higher on indicators of recovery success related to sober house attendance.

The relation between ‘volunteering’ and ‘recovery success’ informants reported as a two-way thing, or a working spiral, where drug users successful in recovery involved themselves in volunteering and through volunteering became stronger in maintaining their recovery success. Some sources of motivation were frequently mentioned while asked about the benefit of doing service. Firstly, *the reminding effect*, to see how people were struggling with addiction helped volunteers to stay clean. They were constantly reminded what addiction is about and how important it is to avoid relapsing. To stay vigilant, to know yourself, your problem, and your triggers are essential in NA philosophy and were in the consciousness of these people participating in volunteer work. Second, the last step in the 12-step program emphasizes the importance of *doing service*, now as you have reached the final step. Doing service is connected to *making up for yourself* as well as *building our community* reasoning. The first one refers to all the people you have hurt and done damage during your active career as a drug user. You should make up with those concretely affected by your behavior, but also “do a sacrifice” in general so to say, by investing your time and effort in helping others, as you now have been helped. This

sacrifice should help others, but in NA philosophy this is at the same time to help yourself, it "eases your pain", meaning the pain you feel after being aware of how others have suffered because of you. Here we move into the spiritual part of the NA ideology, which we found was of increasing importance the more extensive involvement informants had with the NA rehabilitation concept.

These informants reported about how they extensively engaged in the recovery community's work, they had been doing sessions and volunteered in several sober houses, participated in outreach activities, at drop-in centers, had been running several Narcotics Anonyms groups in parks, churches, and prisons, supported at the methadone clinic and some had been sober house managers. Doing volunteer work or to *engage in the movement* played an important role as an independent success factor in recovery.

Returns to sober houses

After their first recovery attempt in Detroit Sober House, 76 informants or 85% later returned to a sober house, either for recovery, to do volunteering or both. Table 4 below shows that 63 informants returned *to any sober house* to attend recovery, 18 for volunteering (a few did both). The table also shows the distribution of returns on Detroit Sober House and other sober houses. Some informants returned to sober houses several times and Table 5 shows where informants returned 2nd, 3rd, and 4th time.

Data show that return to sober houses was common among recovering drug users in Zanzibar. They also show that in addition to return for their recovery, many went back to support other drug users in recovery, and they could return more than one time to participate in recovery or

Table 4: Informants returns to sober houses and reasons for return for informants who started recovery in Detroit Sober House in 2009/2010

Returns to	***Reason for return***		
	Any reason	**Recovery**	**Volunteering**
	N %	N %	N %
Return to any sober house	76 = 85%	63 = 72%	18 = 20%
Return to Detroit Sober House	53 = 60%	42 = 47%	15 = 17%
Return to other sober houses	59 = 66%	46 = 52%	13 = 14%

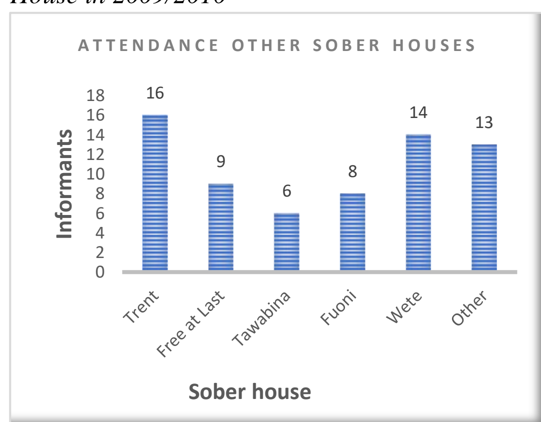
volunteer work. As an example, we found that 68% of those returning to Detroit Sober House *also* attended programs in other sober houses. Table 5 shows that the total amount of returns to sober houses was 152 times. This illustrates how the sober houses in Zanzibar are linked together, both in offering recovery to drug users and in support of each other through volunteering. In addition to sober houses comes volunteering in external NA group sessions, outreach programs, drop-in centers, etc. which was extensive, but we lack data to describe the scope of these activities.

Table 5: Total number of returns to sober houses for informants who started recovery In Detroit Sober House in 2009/2010

Returns to	**1. ret.**	**2. ret.**	**3. ret.**	**4. ret.**	**Total**
Returns to Detroit Sober House	53	8	1		62
Returns to other sober houses	59	15	8	8	90
Total	112	23	9	8	152

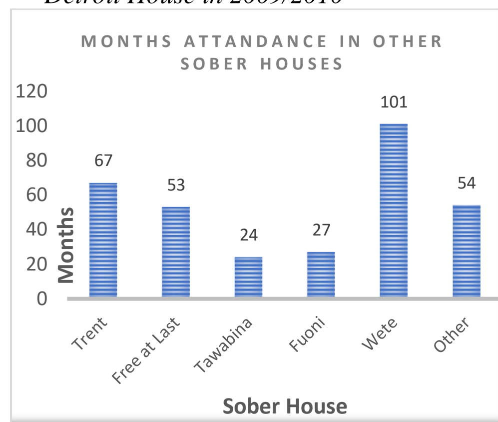
In total 13 other sober houses were mentioned by informants concerning their recovery. Some of these were in mainland Tanzania and even in Kenya, but the most used sober houses were in Zanzibar, as illustrated below (Chart 17 and 18). We see that Trent and Wete sober houses

Chart 17: *Attendance in other sober houses for informants who started recovery in Detroit Sober House in 2009/2010*



N= 66

Chart 18:*Months attendance in other sober houses for informants who started recovery in Detroit House in 2009/2010*



N=66

were most used in addition to Detroit. Trent has its location in Zanzibar town, close to Detroit sober house and was most frequently mentioned as the sober house the informants returned to (16), but in terms of *months spent in another sober house,* Wete sober House in Pemba Island had the highest attendance in terms of time with 101 months attendance from returnees in comparison with Trent's 67 months.

The different sober houses seemed to play different roles concerning recovering drug user's needs. When a sober house like Wete in Pemba was used frequently it was often mentioned as a conscious choice related to a need for getting far away. In Pemba, you were far away from your drug-using environment or "ghetto", there was no easy way out and you could better concentrate on your recovery. Others would choose a sober house far away from Zanzibar town because they were embarrassed having relapsed after their former attendances in sober houses close to town, relapsing would sometimes make drug users feel shame and they wanted to go somewhere nobody knew them.

Job, shelter, and family support

Informants were asked about jobs, shelter, and family support as these often are considered important forms of recovery capital. Concerning their first stay in Detroit Sober House, they

were asked if they had a *place to stay* and if they had *any job/income* at the time of leaving the sober house. In the same way, as they were asked to estimate the help they got from the sober house, they were asked to estimate the help they got from their families in their struggle to recover from addiction. We were also interested to see if there was any correlation between access to these important forms of recovery capital and informant's recovery success during the ten years.

There was often no simple “yes” or “no” answer to the question: Did you have any job or income at the time of leaving Detroit Sober House? *Having a job* is not necessarily a permanent job, having an income is not necessarily a permanent or substantial income. One of the most common sources of income was *small businesses*, which could be connected to the tourist industry like; tour guiding or musicians/artists, others targeted local markets like running a local bar, a hairdressing salon, shoemaking, farming, selling secondhand items, selling food locally in parks or markets. Others reported about different kinds of employments as drivers, conductors, fishermen, sailors, loaders, hairdressers, mechanics, building, or painting works. A problem with many of these sources of income was that they were seasonal, could be temporary, and/or low paid.

A part of the complexity seems to be that work/income-related activities do not necessarily play a protective role against drug abuse. In some cases it could rather be the opposite, the workplace was the very context of drug use, work/income-generating activities and drug use were intervened. It was also so, that good money from well-paid jobs could have an encouraging effect on drug use more than a protective effect. These factors will be addressed later.

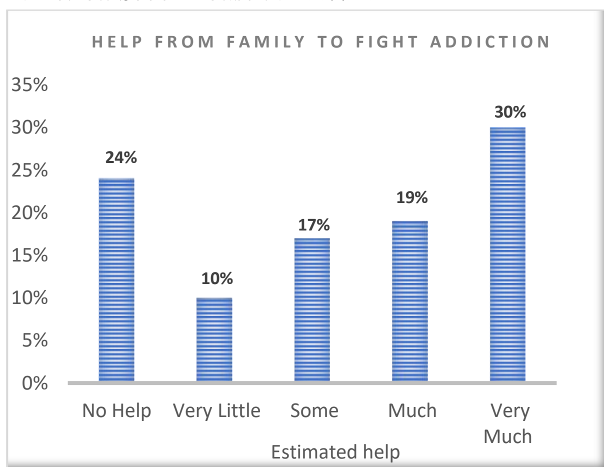
Leaving this complexity for a moment, looking at the figures, 48% of the informants confirmed that they had a job/income at the time of leaving their first sober house program (Table 6). No correlation was found between ‘having a job/income while leaving the recovery program’ and TDFT ($r = 0{,}01$). This could be considered a surprising finding, one could expect that ‘having a job’ represents some important forms of recovery capital like stability in terms of regular income, having a place to go to on regular basis, receiving recognition, and have some place of belonging. One explanation for this missing correlation could be, as already commented on, that many jobs and businesses were temporary and did not necessarily represent social and financial stability. Another explanation could be that many of those who continued to work as volunteers in the recovery community answer “no” while asked if they had any job or income at the time they left the program, these were at the same time among the informants with many total drug-free years. Testing this effect on the result by excluding all the 24 volunteering informants from the analysis gave the result of $r = 0.19$, a weak correlation was found, but the result was not significant at $\alpha = 5\%$ level ($p = 0.13$). Table 6 also shows that the ‘older generation’ to a larger degree had job/income after their first recovery attempt (57% vs 40 %).

Table 6: Job/income, shelter, and family support related to recovery success and age groups for informants who started recovery In Detroit Sober House in 2009/2010

Group	Self-estimate Family support	Had a place to stay after first recovery	Had job/ income after first recovery	Total drug free years
	5 = max	%	%	Ave
Level - 1A Informants with no relapses	**4**	**86 %**	**43 %**	**9,95**
Level - 1 One third with highest TDFT	3,5	90 %	43 %	9,1
Level - 2 One third middel range TDFT	3,4	73 %	53 %	5,1
Level - 3 One third with lowest TDFT	2,8	76 %	48 %	1,9
Correlation r with TDFT and significans of r (p) at $\alpha = 5\%$	$r = 0.22$, $p < 0.04$	$r = 0.25$, $p < 0.02$	$r = 0.01$, $p = 0.9$	
Total Average	3,2	80 %	48 %	5,40
'YoungerGEN' 29 - 40 y	3,3	80 %	40 %	4,8
'OlderGEN' 41- 61 y	3,2	84 %	57 %	6,0

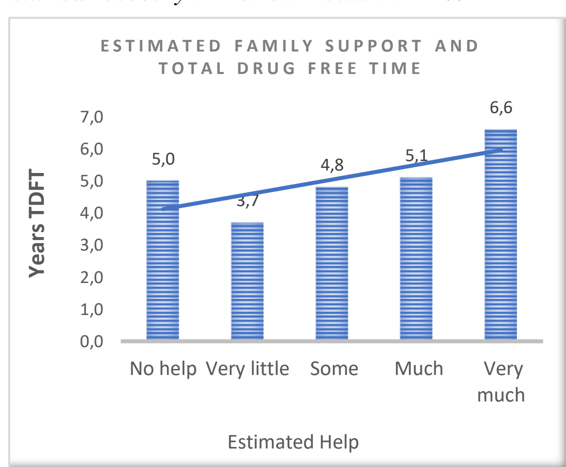
Support from families contained multiple forms of recovery capital like financial, social, and emotional. Chart 19 shows that close to half of the informants reported ‘much’ or ‘very much’ support from their family while 34 % reported: “no help” or “very little help”. Chart 20 shows how the estimated degree of support relates to their total drug-free time.

Chart 19: *Estimated support from own family to fight addiction for informants who started recovery In Detroit Sober House in 2009/2010*



N = 89

Chart 20: *Relation ‘estimated support from own family’ and ‘total drug-free time’ for informants who started recovery in Detroit House in 2009/2010*



N = 89, $r = 0.22$, $p < 0.04$

Estimating the level of support from your family also contained some complexity. It was not always easy to decide, since some people in the family could be supportive and others not. The family could also be supportive in one phase of the drug user's career and not in the other. A dimension here is that families could not only deny help, but sometimes contribute to the burden by being hostile, violent, and oppressive. Traumatic childhoods with abuse and violence are common among people addicted to hard drugs, so is a high conflict level within families or with some part of one's family. A high level of conflict and dysfunctionality could be present simultaneously with great support from other parts of the family. We will see later how family relations interact in complex ways with drug abuse and recovery success, as they many times are both a part of the problem and represent potential important recovery capital.

Table 6 shows that 80% of the informants confirmed that they had a place to stay at the time of leaving Detroit Sober House and that 'having a place to stay when leaving first sober house recovery program' significantly correlated with TDFT at $r = 0.25$, $p < 0.02$. When informants later were asked to *estimate* the help they got from their family on a scale from 1 - 5, we see that the 'estimated level of support' differed in the groups according to recovery success and that a significant correlation with TDFT was found at $r = 0.22$, $p < 0.04$. It is also important to notice here that most of those *having a place to stay* after their first recovery would report that they stayed with their family. Thus, having a place to stay could also indicate something about family relations like the level of conflict. Support from family did not seem to differ much between the older and younger generation.

Support and challenges during recovery efforts

In addition to specific questions about the helpfulness of the Detroit Sober House program and family support, the informants were asked open questions about *supportive and challenging factors* in their recovery efforts. They were first asked *what had been the most helpful to them* in their effort to become drug-free, then *what they would describe* as *most challenging* or *what prevented them the most* to succeed in their recovery efforts. By asking these open questions we hoped to a better picture of the variety in challenges and forms of recovery capital in play, and to catch the hidden or unexpected ones.

Among the most helpful factors, *family* and *recovery/treatment programs* dominated the answers, but as we have already seen "hitting the bottom" was frequently mentioned as helpful turning points. Family support was usually mentioned as direct support like:

> "My parents, they got me out", "My family, my parents - they helped me a lot, they pushed me a lot", "My wife and my parents", "My family helped me a lot, my father is himself a recovered addict and he is always there when I need him."

Direct support could be things like shelter, meals, medicines, a job, emotional and moral support. Other times family issues were considered the most helpful to them because of their desire to *restore* family relations, *maintain* family relations, or *start their own family.* Sometimes drug users do not realize the importance of family before they lose their family or are rejected by

them, thus the supportive factor in these cases is connected to realizing the seriousness of a need to change. Getting your family back, avoid losing your family or realizing the desire to establish your own family became incompatible with their life as drug users and therefore a strong motivation to quit drugs like;

> “I wanted to return to my family”, “I want my family to get together, I plan to have my family back”, “My family, my kids, when I get the motivation to quit and go to the sober house it is because of my children.”, “I have got a family and children to care for“, “I wanted to get married, that’s why I quit”, “I wanted to marry and get work”.

These kinds of concessions can become turning points in a drug user's career. Even if family relations often are complex and complicated it was a general understanding that maintaining good family relations is important in recovery, and on the opposite side, when family relations are broken, and drug users are rejected by their family this usually has a severe negative impact. Rejection or exclusion affects not only the level of protection in terms of a place to sleep and eat, but also emotionally like in the *sense of safety, sense of belonging,* and *self – esteem.*

Samir first describes how he had a good relationship with his mother, then how he felt the day his mother refused to have him in the house and turned him over to the police:

> My mother, she was treating me like a good boy... she took me to school and everything...but I came together with someone that was smoking...so I was smoking.
>
> *But before you start using any kind of drugs ..as a child ..your relation to your mother was good?*
> Yes, very good. (…) … but still, I was using and my mother doesn’t know, until she knows and she tries to help me but she saw I had problems so she helped, but I was still using and was not good so she came to a point where she said: "Samir, right now I don’t want to see you" (…)
>
> *… how did you react when your mother said you could not come to this house anymore?*
> I said ok, my mother...because I knew my problems…so I say ok but inside I was sad. I will not go inside there...my heart was in pain, but I said OK, I am not going there. my mother is very strict, she ticks me off and she was trying to put me into jail. She was very strict...I know my mom would take me to jail.
>
> *Did she do that? Take you to jail? She was reporting you?*
> Yes, she did. She said: I have told you so many times if you don’t want to change you can go to jail not to take drugs and you don’t listen ...so I have to take you to jail.
> She took me to the police, and I was there for two-three days.

Samir's story illustrates a point, you don’t have to have a traumatic childhood to become addicted to hard drugs, even if, as we will see later, this was quite common. Samir was the curious type who lost control and Samir’s mother became desperate watching her child falling into drug addiction. She believes in punishment, threatens him with physical punishment, and says she will report him to the police. The other punishment she believes might help is: ”you can go to jail not to take drugs”. She warns Samir that the police will take him to someplace and beat him up. By trying to get him beaten up by the police, jailed, and by denying him access to her house she hopes these punishments might help her son to stay away from drugs. What she might not be aware of is that in prisons in Zanzibar drugs are easily available, if you are ready to sell

whatever you have that could be attractive to those people controlling the inside drug market, this could be your clothes, shoes, food, your body, anything that could be traded in this market.

The phenomenon of 'hitting the bottom' was often related to the quality of family relations, both in terms of getting worse and getting better. Suffering from broken family relations meant experiencing isolation, rejection, poverty, often living in the streets experiencing contempt and despair, a life dependent on criminal behavior, often a life-threatening crime, with the risk of being victims of mob justice. There was always a combination of such factors that in sum concluded: ”hitting the bottom”. This state, which is *forcing* existential reflections and demands of a fundamental change, (re)establishing "ordinary life". In ordinary life, a common expectation is to be a part of a family, like one of the recovering drug users expressed it:

> "I wanted my life back, I want a family, I would hate to see myself again in that situation, drugs almost killed me."

Others used the concept of: "hitting the bottom" more directly as an answer to the question about *what helped them the most:*

> "I was stuck, had reached the bottom and was sleeping outside", "I hit the bottom, realized that I had lost too many years", "I was tired – had reached a limit where I decided to stop".

Sometimes single events could trigger these existential reflections about reaching the bottom and decisions about life and death. This could be a positive HIV test, it could be that they almost got killed by street mobs, about hardly surviving own overdose or experiencing the death of a friend from an overdose. The complexity in this is illustrated when the very same thing "a positive HIV test", for one person was mentioned as *the most difficult challenge* causing relapse and depression, while it for another was mentioned as *the most helpful thing* because it forced him to make an existential choice in life, to live and to quit drugs.

Recovery and treatment programs were more frequently mentioned than any other factors as *the most helpful* to the informant's recovery process. The answers were divided between the Sober House/Narcotics Anonymous activities and the methadone program. The answers could be expressed in many ways like just referring to recovery activities:

> "The sober house program", "The 12 – step program", " The power from sober houses and Narcotics Anonymous meetings", "The spiritual principals"[16] , or it could be more specific like "The sober house program made me stay away from former friends", "To do service", "I learned to know who I am", "To see people recovering", "Doing service helped me remember the shit", "The sober house gave me a new vision, chancellors gave me direction", "the recovery programs, I could use my talent to teach and I could stay for long", "I became aware destruction of drugs and decided to choose a good life, to take responsibility".

[16] The informant by "spiritual principals" refer to the content of the 12-step program of Narcotics Anonymous which has adopted the *Principles and Virtues* of Anonymous Alcoholics.
https://www.hopefortomorrow.net/PDF%20Files/12%20Staps%20&%20Principles.pdf

The content in some of these statements could be recognized from the section where informants answered about "what was the most helpful to them" in their first sober house recovery in Detroit Sober House. Again, we see that "doing service" can be important in own recovery process, in terms of the ability to use one's talents, reminder, and awareness through seeing others struggle and in creating hope by seeing others recover. Seeing others recover after attending programs in sober houses was also mentioned as "the most helpful" by informants as the *materialization of a possibility* to them. As soon as former friends from the "ghettos" started to return, drug-free – they created hope for those struggling close to the bottom, just by their presence:

> "I met those who came from the sober house, met them in the street, they were clean, looking good".
>
> "I was tired, condemned by my family, chased around in the streets, stealing, sleeping outside, to see others make it was the most helpful thing to me".

Many of those leaving sober houses also started to attend activities of the Zanzibar Recovery Community and this way they became resources beyond being role models, they contributed to the building of a stronger community recovery capital, both as role models and by engaging in activities to support others.

A few people were mentioning religious aspects as "the most helpful" to them in recovery efforts. One emphasized:

> "my belief, return to religion" as the most helpful, another that "the faith is helping me, the religion, I am a Rastafari and Muslim".

Others emphasized social structures outside their family and/or the recovery/treatment community, as in these cases elders and friends.

> "The elders in my street told me to stop, I had to show them respect and stop".
>
> "I have friends that are not using, it helps me because I am rejected by my family".

To conclude this so far, the sober houses and the existence of the recovery community seem to be the most significant forms of recovery capital contributing to progress in the informant's recovery efforts. The family could for some provide important recovery capital like shelter, food, rest, belonging, and emotional support but could also be a part of the problem and represent important obstacles to recovery.

The methadone program was mentioned by quite many as "the most helpful" factor in their struggle to be drug-free. As for the sober houses, they would just say: "the methadone program" or "methadone", others would be more specific or detailed in their answers like: "Methadone helped me to stay clean and eat regularly" or more extensively:

> “Methadone helps me, I can stay with people in a good way, it made me strong. The family has accepted me before they condemned me, now they believe that I have changed. It helps that I am praying.”.

To this last informant the “the most helpful support” has been from methadone because it helped him to get his life together or manage his life at a different level. He can now “stay with people”, has regained his families’ trust, has managed to change behavior, and found back to his praying. This was expressed by many methadone users, another put it this way:

> “I have got a new life. I am liked by my children, neighbors, and family. I have stopped my old bad behavior.”

Methadone helped some to stop using heroin, get off the street, and regain trust in the community and with their family, while others did not experience this progress. They were still considered as “users” and experienced stigma in their own families as well as in the community. They could also be struggling with side effects from methadone as a drug or the way the program operated could create problems for them.

Edwin complained about how participation in the methadone program created problems for him when he got a new job. Crucial to him was it that his employer should not know that he was on methadone, something he explains would lead to him getting fired. He was therefore forced to use his lunch break to drink his methadone, not without complications.

> *But every day you travel to the clinic to drink methadone?*
>
> Yes, but when you are on methadone, you have to be there between 7.30 am – 10.30 am. I start at my work at 6.00 am sharp, lunchtime is from 12.00 am – 1.00 pm – one hour. So you get problems, I have to get away from work, I am using a motorbike or a motorbike taxi, so I have to go pap, pap, pap…and when I reach there at the clinic I find that there is a line of people waiting and you say please help me…you want it to go faster, you want to go back to work.
>
> *Can you not make an arrangement with them at the clinic?*
>
> You can …I could try to make it or I could come at 12.00 am sharp…but you know at the clinic they close at 10.30 and you get problems….it would be better if they made an arrangement for those working so we could come during lunch break at 12.00 am sharp for the drinking of methadone…this is for you, here this is for you…so when the lunchtime comes you could run pap, pap, pap, god morning how are you, here is your cup, see you tomorrow…sometimes I have to go with a bicycle, so you understand *kazi kila siku..*(hassle every day)

For informants, who had some distance to travel from their workplace to the methadone clinic it could be a hassle to manage within limited time intervals. It could also be risky, as for Edwin, because methadone use is still stigmatized, the employer could discover that they were leaving their workplace and start asking questions. With the level of stigma in Zanzibar towards drug addiction and addicts, they could risk their jobs and had to handle how to justify their absence from work. It was our impression that the awareness of this challenge facing working methadone users was not properly understood, or the willingness was not there to make more flexible arrangements in the methadone program.

There is no doubt that methadone helped some informants to increase their quality of life, but being in the program was also encumbered with issues. Being on methadone would always be the second-best, there is always this ultimate goal of controlling your life without methadone assisted treatment, that is better. There is also this daily routine you always have to follow which limits your freedom, and the stigma that still sticks with you, the possibility of being downgraded not allowing you to be completely open about your situation.

Social marginalization, stigma, and traumatization

Looking at the informant's challenges or the most important factors preventing drug users from succeeding in recovery efforts, a frequent answer was what in Swahili is called; "arosto", meaning *pain* connected to withdrawal symptoms. This is something all heroin users will experience while trying to quit drugs and can be difficult to deal with. It is likely though, that in these cases there is more to it than the withdrawal symptoms as such. Sometimes drug users find it hard to say exactly what it is that prevents them from stopping to use drugs because they simply don't know or hesitate to talk about it. Others emphasized factors connected to social marginalization, stigma and shame, problems with leaving their drug-using environment, lack of knowledge and life crisis

Social marginalization could be expressed just as a lack of basic living conditions like work and a place to stay:

> "Lack of work I am going idle", "I have no job, easy to just continue", "No work, nothing to do", "Hard life, to forget hard life, no place to stay, no income, I would stay hungry".

Other times the answers indicate how social marginalization is connected to *social isolation*, as a mechanism encouraging drug users to remain in their drug-using environment:

> "I had no work, no family, loneliness", "I had nothing to do, stayed with the same friends", "No jobs, loneliness", "Hard life, I had no place to rest and that people close to me used drugs, they had not recovered" "Environment, I am staying with those who have not recovered".

Some explained their problem of social marginalization as connected to their social background and happenings in their childhood:

> "I don't have a family, my family came from far (another country) and my parents died both when I was around 2 years, I stayed with my grandmother, but she died when I was 10 years. I just stayed with friends. I have a younger brother; he was brought up by our neighbours. I am not married; I have no house. I had nothing to stop for."

> "You know my folks were alcoholics. My father was an alcoholic, he recovered two years now, my mother's side were alcoholics and also my parents divorced when I was 10 years old. My mother went away with a foreigner - so I was raised by my grandmother."

For drug users, the "ghetto" often becomes their family, it is the only place they have the feeling of belonging, are being treated as equal and respected. It is easy to understand that many have problems leaving their environment:

> "I did not manage to leave old friends", "People who use heroin stay very close to my home, I see them every day and I know all of them. I am a part of that environment."

In other cases, the drug-using environment can be the same as the one where you make your living, like for this informant:

> "What prevents me is friendship, I am running a barbershop and drug-using friends come to me every day, they encourage me to continue using".

In these cases, it is even more at stake for recovering drug users than social belonging and friendship. Leaving the drug-using environment means to lose income. This was the case when drug use was integrated into the workplace. This could be places like construction sites, heavy-duty transport, fishing, markets, or artistic work. A musician expressed his dilemma this way:

> "I need drugs for my musician work, I get confidence, every note I can play then, and it helps my breathing system to work properly - the music is a trigger, also because other musicians use drugs, it is a part of coming together. From music work, I get money in my pocket that I can use for drugs. I am like a candle burning out while people applaud my music."

In recovery therapy, it is common to encourage recovering drug users to stay away from their drug-using community to protect themselves from the strong social influence. We see that in some cases this would also mean risking your job or an income. One informant describes how he had to stop working as a tourist guide because he got tempted to use drugs:

> *So you are not going to Stone town?*
> Yeah...these days I don't go to town. I don't go.
>
> *You keep away?*
> Yeah
>
> *And then you also have to keep away from the tour guiding?*
> Yeah…because I meet my old friends…and whenever I see them they say oh let's go this way or that way. You know I cannot control my heart, really. That's how I can stay away from it.

Like social marginalization, also the stigma and shame can be "push back" mechanisms to drug users and was referred to several times as the biggest obstacle to recovery:

> "What prevents me is problems with staying away from my group, my friends - outside I feel the shame".

The stigma and shame could be directly connected to stigma in society or getting a job:

> "It is hard to get a job, people know me in Zanzibar, they believe an addict cannot change."

> "General problems in life, I am still excluded in the society, the stigma makes you give up, they will always see you as an addict."

Stigma and shame could occur in many different contexts and forms, and be different in the way they undermined recovery efforts like for these informants:

> "Family problems is an obstacle to me, I am born out of marriage, that's why I am excluded from the bigger family. My family is a block to me, I don't need any money from them, just to be a part of them, they have taken my children"
>
> "What prevented me was that I felt shame, did not want to go back to Detroit Sober House and my family is stressed about my methadone use, they don't believe I have stopped and rejects me"
>
> "I was feeling shame because of my relapse, I didn't want to go back to Detroit Sober House, I tried local medicine"
>
> "My children observe that I use methadone, it is still to be addicted, I get the steam, I want to stop and go back to the sober house"

One form of shame was the *shame of relapsing,* which could be so strong that drug users did not want to go back to the same sober house. Another form of shame was connected to *the use of methadone*. To some drug users that wanted to recover, the use of methadone was considered a defeat, the shame was felt during encounters with other drug users in recovery who had quitted all drugs or it could be felt in your own family, who would refuse to believe that the drug user *for sure* had "quitted" since they still could observe "the steam".

Relapse and shame were sometimes connected to sexual performance. There was shame connected to relapsing, but the shame could be even bigger if you were not able to satisfy your woman. Informants could express this in different ways while talking about the challenges of staying clean. They relapsed because;

> "I got sexual problems, I was not able to stay long and to make my wife happy",
>
> "I needed to have sex with my women, it (drugs) helped me to stay on",
>
> "I got married and got sex problems without drugs, so I relapsed".

Informants talked about how heroin made them able to keep the sexual act going for longer and how they were uncomfortable with disappointing their partner by finishing early, which they did while not using. This was reported both as an obstacle to quit and a reason for relapse. The problem of early ejaculation during intercourse is closely related to *failing* in satisfying your women, which for some men is shameful, undermining an important part of their identity of *being a real man*.

Lack of knowledge or understanding was frequently mentioned among obstacles to quit. Informants found that they had been naive or lack the knowledge and that this prevented them to succeed in recovery:

> "I lack knowledge, I did not know how to go about it",

"I did not understand my problem, I thought I could go on with the old life as Tour Guide, with parties, disco and at the same time stop using heroin.",

"I did not understand that I have to stay away from ALL drugs!".

We see here that one informant reports a general lack of knowledge, while the others are pointing at well-known challenges like staying away from your former drug-using environment and keeping away from substitutes.

Informants would sometimes refer to some *life crisis* when answering the question about obstacles or what was the most important in preventing them from quitting. These were often more fundamental changes in their lives that affected them like:

"I lost both parents when I was small, keep thinking about it.",

"I got an HIV diagnosis and depression, I also lost my mother and father that time",

"My girlfriend married someone else, I got a lot of thoughts",

"I have very weak family relations, only my mother cared and she died",

"My brothers and sisters did not want to talk to me, I was thinking of suicide".

Life crisis sometimes looks similar to "hitting bottom" experiences, like in this case:

"I lived a hard life, rejected by everybody, did not know what to eat, where to sleep, I just needed to forget my hard life."

Life crisis could be many things, sometimes related to childhood other times related to happenings later in life. To many, obstacles were closely related to childhood traumas and/or family conflicts and/or broken family relations. It could be single events in life, or it could be exposal to continuous stress because parents and other adults in the child's life were absent, unable to take care of the child, or were hostile and violent to the child. Many informants had this experience of being unwanted, labelled and stigmatized, rejected, and abused within their own family. They reported having been subjects to neglect, insults, physical and psychological abuse, as well as sexual abuse.

Childhood trauma, addiction, and recovery problems

Several studies show that heroin users have been exposed to childhood trauma.[17] These experiences are often associated with shame; they are social taboos and often kept as secrets. This has been the case around the world and is a perspective that has challenged explanations related to dangerous chemicals, biological dispositions, illness, and aggressive pushing. Childhood trauma could result from single events as well as a set of experiences of physically or emotionally life-threatening events and is harmful long term to our physical, mental, emotional,

[17] Dell'Osso, L. et, al. 2014, Mills K, et.al 2007.

social, and spiritual functioning and well-being. Heroin users at Zanzibar were no exception in this aspect, childhood trauma of different kinds was present.

Saidi: Becoming the bastard of the family

Saidi was born into a relatively rich family of businesspeople in Zanzibar. He tells how problems started when he came to know that he was *born out of marriage.* Saidi was still a child when he was sent away to study and live with his aunt outside Zanzibar. He tells how this suddenly became traumatic for him when his aunt during a quarrel told him that he was "a son of a bitch" and a "bastard":

> That is when I had quarrels with my aunt...
>
> *What was that about?*
> She was too harsh...because she wouldn't give me the love that I had from my parents, so we had a fight. Yeah. and one time she approached me…and told me ..what I have told you last time we talked, that "hey…you are not ..you are not part of the family .. you are just born out of marriage. Like a son of the bitch, you are a bastard".
>
> *Was this the first time you heard about it?*
> Yeah...the first time.
>
> *What did she mean about you born out of the marriage?*
> Ehh... mostly in our religion, when you are born out of marriage, then you are a son of the bitch..
>
> *..yes but why did she say that?*
> Because we had a fight you know, she just called me that, meaning that you cannot be part of this family, wherever you go you cannot inherit anything, you cannot get anything from the family. You get my point?

This quarrel seems to have been a negative turning point for Saidi and his *perception of self*. It turns out that he, as the oldest son, was born before his parents married. This had so far not been a topic in his family, but when getting into a quarrel with his aunt he gets to know this, and he tells how it affected him:

> I was labeled...I was running from that…why she had to tell me this??
>
> *What did this do with your thinking? How did it affect how you saw things?*
> It had a negative impact...It was running through me. Why did she tell this? I was thinking in this young age that when my father dies I will not get anything from the family...It made me thinking negatively...I will be kept out of my family without my father...This is Islamic law. Not the Tanzanian law. In Zanzibar they follow Islamic law. But in Dar es Salaam you will go with 50/50 with your father. Being born outside marriage doesn't matter. But here...

Being reminded about this became a problem for Saidi, as he started to feel that he was not an equal member of the family, he felt that something was wrong with him. It also seems like this episode was the start of more severe mistreatment from his aunt:

> I was there for three years, and in the middle, we had the quarrel. After that, I had to run away from her house. I came back to Zanzibar without my money without my passport without

anything. It was hot in the house. I was feeling jelly, she was beating me up all the time, shouting at me

She was physically beating you?
Yes sometimes with an iron, a hot iron

Hot iron ?!
Yeah…really it is not a created story. It was real

Was this after the quarrel, she started to beat you badly?
After the quarrel, she started to beat (…) Mostly all the time…whenever I make a mistake...maybe I don't wake up early, or I refuse to do something or send me somewhere... she was beating. So I run away from her.

During the time at his aunt, Saidi started to smoke marihuana, at an age of 12 – 13 years. His aunt had a son 3-4 years older than him and he was smoking. Saidi was stealing marihuana from his bag. Running away from this family, returning to Zanzibar Saidi continued to smoke and started to get problems also at home with his family in Zanzibar:

They saw the situation, the way I had changed, lazy, didn't want to wake up early, go to school...lonely all the time, so they knew. So one day I talk to my father, cause I had stolen some money from him, so I was kind of ...he said: why are you taking this money, what do you do with them ??!..so I had to tell him the truth, I am using it for this and that.

How did he react?
He was too harsh... too harsh. He beat me up.

What happened after that? After you were beaten?
He locked me up in the house for some time you know.., gave me house arrest. Tried to calm down the situation. (…) when he recognized that habit he had to send me away again from Zanzibar. Because when I started again with marihuana then I jumped to heroin too. When I came back after staying with my aunt...

So, when he beat you up you were already on heroin?
After I was beaten, I started with heroin. So, he made a transfer at school. He took me to a boarding school outside Tanzania.

How was that?
He was trying to control me from using drugs. So, in a year I only came to Zanzibar once. The whole month of December I was in Zanzibar.

From Saidi's story, we see how things can escalate in a child's life. Teenage rebellion leads to quarrels with his aunt, to labelling, mistreatment, and humiliation, to a crack in a child's self-perception and self-esteem, and in turn into drug use and conflicts with his own family. The circle continues with a desperate attempt from his father to solve the problem by again sending the child away for another four years of secondary school in a foreign country. Saidi expresses how he slowly feels excluded from the family, how he loses his heritage, and how he experiences continuous mistrust from his family.

Because at the end of the day, when our father died, he had a big shop, and my brothers and sisters they sold that for 600 million Tanzanian Shilling. So they divided the money between themselves, I never got a single pence. You got it?

> That is when I became more angry.., because when you are dividing some money while you know you have a bigger brother ..even if he is not part of the inheriting, why should you just donate some money for him and just give him? To run his life and do some business. Whenever I want to go with this program...maybe I want to run a shop, or maybe I need to do business...but they just knocked the head off me.

Saidi is still in contact with his family, they also take care of his children. But there is no trust, he experiences no help from them or equality in status. He is all the time coming back to his trauma, that he to them is “a son of a bitch”, that he has lost most of his heritage and that they have taken his children. He keeps referring to his father who kept protecting him as long as he was alive and helped him, but now after his father’s death, he feels left alone.

> Maybe there is an occasion, maybe there is a wedding there is ..yeah a family gathering...especially wedding ..or funeral. I would go there but whenever I enter their house all the doors inside are locked...of the rooms. So, I feel like am not welcome. That’s why I don’t want to go there.
>
> *They want to control where you are moving? Want to protect their property?*
> Exactly. But I don’t go to their place…and I don’t want…I don’t like that kind of life. Somebody following my back like that.

Saidi also describes how the damaged trust within his family demotivate him in his recovery efforts, why he soon gives up and runs away every time he joins a sober house:

> Sometimes I felt that even if I quit, I go to my family and there is no trust anymore. I was a drug user forever for them. That’s how they think. That’s how I was feeling. And that is how it feels. Because till this age I never go home, I don’t go home these days! I don’t go to my sisters. I don’t go to my brothers.

Ibrahim: Becoming the victim of racism

Ibrahim was also suffering from exclusion, physical and psychological violence as a result of stigmatization within his own family. He tells how he and his mother was abandoned by his father and his father’s family because of the dark color of their skin and ended up poor, without a place to stay:

> There was a conflict in my family. Daddy and my mummy, and because of my aunt, that died, they were complaining about my mother, that she had dark skin.
>
> *She had dark skin…?*
> Yes, like me.
>
> *Did not your father have dark skin?*
> My father was a kind of Arab…I have a picture of my father (shows a picture).
>
> *So, he had a little more Arabic appearance?*
> Yes…and his grandfather and grandmother…so they were complaining…he had to…they wanted him to marry a woman like him.
>
> *So, from the same background like him…and he chose to…did he marry your mother?*
> Yes, so then they separated, and it was two of us, me and my young brother. My brother is like my father, color, and everything. So, they took him, and I was left with my mother…

Ibrahim tells that he and his mother had no place to stay, they did not get any support from the father's side even if his father had the means to help. They had to move to live with his mother's sister. Then his mother left him alone there for one year, at this time he was five years old and he recalls:

> "I didn't like that place…I didn't like the place… and I was like a…I was jealous… sometimes I could see my cousins, they were getting hugs…. and everything."
>
> *Did you not get any hugs?*
> I didn't...

Later his mother came to pick Ibrahim and they go to Zanzibar together, struggling to make ends meet. Ibrahim remembers one incident clearly that illustrates their difficult condition and explains how this incident for the first time made him hate his father:

> One day I remember we were around Mlandege, we went to a café I think, there were mandazi, mkate, chai…(cakes, bread, and tea) and then my mum said, she had no money; "Hey, can you give me a mandazi to my kid…my son has not eaten", and the guy came out and pushed my mum, I remember that…that day, the first day I started to hate my father. So that time, when he pushed her, I wanted to do something. But I couldn't – I didn't' have that power that age… so I thought…this wouldn't happen if my father was there…so I started to hate him. He was responsible – he left us – that would not happen if he was there - we had everything – I know the story – he took everything in the house and left my mum with nothing.

At the time of this incident, Ibrahim was around 6 years old. What he describes is a state of poverty, and feelings of fear, humiliation, betrayal, and powerlessness. He remembers when living with his father they had everything now they are poor and have nothing. To Ibrahim, the following two to three years alone with his mother (he was 5-8 years) was a difficult time. They lived with friends of his mother in small shelters in Zanzibar town. His mother at some point wanted to marry another man and Ibrahim recalls his worries;

> This (the difficult life with his mother) ended up when my mother got married again – so when she got married, I didn't want to go with her and her husband. I feared...maybe the guy would come to…be punishing me, or something like that, I was worried. (…) Maybe that I wouldn't enjoy, maybe I would see my mummy fighting with her husband or whatever…something like that. So I went to my aunt and told her that I want to come to your place – my other aunt, from the other side of the family… my father's side, they were around here in Zanzibar at that time and my daddy also was here...and my young brother was here.

To Ibrahim, it had been traumatic to have been rejected by his father. He would normally have a wish as a child to again be connected to him, but it was not into his father's house he was welcomed, more to be a servant in his aunt's house;

> So my aunt said "OK come" I stayed there with my aunt, they were two of my aunts staying together, it was a family house and the next house was a family house too – and my daddy was there…so I was thinking that it could be different this time, by my aunt… she is dead now… father stayed in that house.
>
> My aunt would always talk about my color …she would always accuse me, shout at me ..sometimes she would say; "Ah…I don't want my son and my daughter to eat with this Swahili – this Swahili will take a lot of food". So… sometimes I would go to the corner, stay there…eat alone… I was eating alone, and this continued. I was sleeping in the sitting room, the first one to wake up and the last to sleep …and maybe… I was the only one to be sent to buy carnosine,

water when the water was empty – I was the only one. Sometimes we were playing – and no one called anybody, but they would call me. And at night, when we go outside sometimes at night playing and maybe come home at like 8.30 pm I am the only one who gets beaten.

Ibrahim was again able to link up with his father since they were now neighbours, but it did not become the relation he had hoped for. He recalls a situation in his father's shop;

> (…) …and one day, my father was there we had a shop, and there was his friend, and I went there. His friend asked him "Bakari", his name was Bakari – he asked him "Bakari, is this your son? " …the guy asked about my young brother who was there. He said; "yes, my son". And then the guy asked again; "and what about this", me…"is this your son?" he said: "this?… that is what his mother told me"…" that's what his mother told me"…so I felt so bad and I cried.. there.. and then his friend told him "Oh… Bakariii!...don't say that in front of the kid" and.. something like that. Sometime he would come to school to visit my young brother…but he would never come to my class or visit my teachers…(…) even teachers would not know that the guy was my father. Only my mother would come to visit me...only mother...but my father, when he came to visit he would visit my young brother only… and sometimes I saw him in school...I would go there and say hello…he asked like…then shout…he shouted at me…

Ibrahim tells that he was good in school, but it was not appreciated in his father's family, on the opposite it was punished and for Ibrahim related to fear;

> My aunt, she came to… she slapped me one day when we got the reports from school. I passed my trail, but my cousin…my cousin was standard 6, I was standard 5..yeah…but I did good in school and when we took the report to my home my aunt slapped at me: "hey, you…you roho mbaya..(you are so selfish)..you don't teach them"…how could I teach him, he was in Standard 6 and I was in Standard 5. (…) At school I was really bright – you know there was a time…at home…my mother did that, and my aunts also they were doing this. They were beating me over…maybe I will do mistakes, but they will beat me more than this mistake. Sometimes I could not even stand…they were using wires, or pipes, plastic pipes, the black ones… they hit me with that…they punished me often. I was bright, my results were always good…but Form 4 I could not finish, I was already an addict.

Ibrahim's story is a story about continuous stigmatization, discrimination, violence, and other forms of abuse from his father's family. He does not experience the love that he seeks at his father and father's family but is constantly reminded about his inferiority as his skin is too black and thus also a sign of his questionable origin. What Ibrahim experience seems to be classic racism and the hate that often follows racism.[18] Ibrahim's problem, as Saidi's problem, starts with comments from the father's family about somethings that are not right, or shameful concerning the child's status. This time the color of his skin, the fact that his father married, and had a child with a black woman – a *Swahili* woman. The structural racism, which in this context historically is intervened with class issues and class contempt, is expressed by poisoning comments about his father who has *married below his (their) standards*. His father had humiliated them by marrying a woman of lower race and from a lower social class and for this, he has to be corrected. He had brought shame to his family and Ibrahim becomes *the always visible sign* of this disgrace, the *reminding object* that they first try to get rid of by excluding him

[18] The historical roots of racism in Zanzibar is well documented by Glassman 2011

from the family together with his mother, but later he turns into their hate object. Ibrahim tells that he stayed in this family until Form 2, he was then 18 years.

> I was so tired so I decided to stay in the Ghetto. I was around 18 years. I started to use drugs…so I started to call myself a "nigger" – I wasn't playing with my cousins, so I ended up playing in another street. Because when they were playing with me or me with them they were doing some things like…they would kick me…they would kick me bad…so I didn't like that. I thought maybe they were told to kick me like that…yeah…that's what I thought. So I started to go to the next street and I started to play with other boys…who were like me...and there I started to smoke Ganja… first time I started to use Ganja – I decided to move from the place – so when I would come back home I would be…If somebody told me something I would have the power to reply.
>
> *Did they find out that you used drugs?*
> They heard about it – myself I changed, and my behavior changed and everything – they said, "don't come in here" – yeah…" don't come here".
>
> So they chased you away?
> .. so they chased me away – so I had nowhere to stay – I tried to push myself at school, but when I came to… I maybe wanted a book or needed to bring school money for some months…I couldn't get these things. I couldn't get the stuff I needed…for the school so there were no options for me. So then I quit school.

Ibrahim's story is the story about a child rejected and abused by his own family until he cannot take it anymore. He seeks company with people who can give him at least some respect and recognition – his *fellow blacks* in the next street – who are not concerned about his colour of skin or his origin. Unfortunately, this street also has a "ghetto" of drug users that Ibrahim is drawn to, and relatively fast he loses control.

Ali: Becoming the victim of violence and abuse

Ali experienced some of the same, in the sense of *blame for being born outside marriage*, but his problem was the resentment of his mother. Ali's father disappeared and left Ali and his mother behind in poverty. Asked about his childhood Ali soon comes to the traumatic experience with his mother:

> …It was about how she was treating me. There is one thing until today, there is anger between me and my mother. Because of the way she treated me. I remember I was hit a lot.

Ali explains how his mother could not control her anger. According to Ali, she was not happy to have got a child outside marriage and she was angry because her husband left her just after giving birth to him and whenever she was angry, for whatever reason, she was mistreating him.

> I was caned a lot, I was caned a lot...
>
> *You were caned a lot during childhood?*
> Yes, in my childhood. She was angry, quarrelling with somebody else, not me, but she came my way with her anger to finish that on me, she hit me. Do you understand? Insulting me, a lot of words...she sounded like crazy. (…) It still makes me angry until today and until today we fight. (…) …for instance, if I have made food and she comes home angry she just throws the food away. This is her anger. She cannot control her anger – this is a big thing.

(…) Since I was born, she has not been happy that I exist…she and her friends were insulting me, you know this to be born out of marriage, there is no father for your child, this brought anger. (...) So she did not like me, people were wondering why she did not like me, she was throwing me down and hurting me, she hit me and she was locking me up. She left me there for two days before she brought me to the hospital.

And what did they say at the hospital?
They did not say anything

So, they did not know.
They did not know. Or some people knew…they were saying that about my body…but she was covering it up, saying that I was a naughty child. But there was one day, she locked me up. My uncle came, before leaving that time (he later left Zanzibar), he smashed the door pahhh.. and took me out. He told her: why? what are you doing, why are you hitting him like this? She was hitting me even for small mistakes, but she had her anger you know. You know this anger of her…do you understand this thing…

Yes, I understand...
You wake up with your anger and you go somewhere else and you let out your anger on someone else…this anger of her she came to me and expressed it…you see this is not good it was destroying me. (…) You know sometimes I was afraid of even sleeping at home, so I ran away to sleep outside. I remember one time when I was coming home late she was locking me in, I had my helmet for driving motorbike...she took it ..hitting me..phee!

(…)

Did she hit you with a stick?
Ah…no, if she only was hitting me with a stick…she took whatever was around…like a bottle, she hit me with…whatever she found...sometimes she laid me down.

Ali tells that there was another mother (his mother's sister) that was trying to protect him. She knew and her family knew his mother's problem but according to Ali "they did not manage to interfere", "they could not change her" and his mother "just said that she did not care… she said leave me alone, concentrate on your own life". According to Ali, this physical mistreatment lasted until he became heroin-addicted…" after that she started to be afraid of me".

Ali tells how he systematically was physically and psychologically abused by his mother as a child. He describes traumatization still affecting him as a grown-up. He is aware of how these experiences have built anger inside himself and that he is suffering from this anger, that it has been a challenging part to deal with this anger in his recovery.

Karim: Becoming the victim of sexual abuse

Karim comes from a broken marriage as many of the other informants and ended up poor and in a marginalized position together with his unemployed mother. They had to rely on families and friends to manage and Karim was frequently left alone together with acquaintances of his mother, but who were strangers to Karim. This left him often in situations where he was unprotected and at risk of getting abused. His first experience with sexual abuse was when he was left with his older sister, who his mother had with another father:

We stayed there and I used to sleep with my sister, my older sister…and..then one day she had a friend…I remember they were taking something.. they were laughing at me… I don't know what they were talking about….and then at night, I remember...my sister, took me and she..she.. she did that, the one she did...she took her clothes off and told me to not talk about it.. and she did…she did some kind like, she was masturbating me…and she laid down and she took me to her body, all of her body…and...so I had no idea what to do…but… hivyo, imenda hivyo… (like that…it was like that)… so the next day I woke up, all the time, I was trying to remember...was trying to ask myself what was happening…what am I being used to…and in the morning she was..she was..she was talking to her, her… a friend and they were laughing..and they: "my young brother knows how to do it"…I have never been telling that story to nobody...not even my mum...

So, you kept that to yourself?
Yes…and when I went out…when Ramadan sometimes… I am just hearing…Koran…you know here in Zanzibar the Koran always calls here…you know here…they are saying…" whoever commits sex without marriage they go to hell"…so I was thinking about this. What about me now, I had it with my own sister...so I took myself as a God sinner…and I never got that peace when it came to God…or talking about God again...I neither wanted to talk about God or turning my image to God… I was always… had that fear…to go to hell or…and what do people know about it, maybe I will be rejected…

Karim and his mother end after a short time up in a marginalized situation staying I several shelters in Stone town, he tells how his mother had many men visiting her and how he got sexually abused for a second time:

You know sometimes when I was going home I found somebody in my mother's room. I happened to know what they were doing and everything that so… I didn't like that…I knew that the guy was not my father...and so…

Ok, so there was somebody there with your mother in that room?
Yes…so sometimes…you know that is…that was *our* room so when I hit the door I found her doing something with the guy..(…)..before that…my mother sometimes would travel to Dar Es Salaam or…and so.. she would take me to a different mother…sometimes here, sometimes there, sometimes here, sometimes there.(…)…so one day my mother took me to that mother..to the stranger…she knew them…and then she went to Dar Es Salaam…and one day I was sleeping at night…I remember someone came, I don't remember his face...at night… in the room where I was sleeping…he came and…and took my clothes off and he tried to rape me..and, he, ..he had a knife with him and he said "nitakuchinja"…(I am going to slaughter you)…I will cut you if you are talking...and then he go…I didn't see him or his face…

Ever again...you never saw him again?
Yes, I never saw him again..but I couldn't sleep that day..

Of course, you couldn't...
I didn't sleep,… I whole night… I was in the bed.. awake, waiting for the morning…going to school. And at that time there was no money...to buy anything for days at school…so ..then I came back from school in the evening…at five o'clock in the evening…so I would get a cup of porridge..so at eight I would get some rice..(…)

While you were sleeping, the man who came into your room, did he rape you that time?
Yes, he raped me.

Did you..you didn't tell your mum?
I didn't – I had this fear.

You didn't tell anybody?
I didn't tell anybody.

When was the first time you told anybody about this episode?
One day I was…my first day to drink, I don't know that girl…the first day I was drunk – first time I experienced alcohol…so I was fearing someone to…so…

Who did you tell it to?
Yeah…I talked about it, but I do not know with whom…some stranger

Some stranger?
Yeah….Yeah…but I wasn't talking it clear...

Ok, I understand...that you chose to tell a stranger...
There was a time when I was 15 years I doubted about my ID.. identity… I was struggling with that some time… am I a Gay?…or am I a man?..or so that time. I Ah...I would go somewhere outside there…and never come back to this planet again…

So you were thinking about suicide?
Yeah, suicide…or maybe living outside there…where everything is new….outside Zanzibar or outside Tanzania…Even people in Zanzibar, I cannot tell them this

You cannot tell them?
Yeah, I cannot tell them

Why not?
I am scared...you know here people in Zanzibar they like to point each other fingers…yeah

Do they easily put labels on you?
Yes..

How did this affect your life no then, as a Child?
It did..I was always….eh…I will feel angry….and I will always feel different, from other boys…I will always feel alone….I am all alone. You know feeling different from others it means a lot. I will compare myself with others, I fear to be known… to be rejected…and it cost me a lot...and sometimes…I will miss that family – I really miss that…and I grew up without a role model, my father wasn't there for me…I get through on my own.

Karim is, as many other drug users, left and rejected by his father. Karim is also neglected by his mother, who is leaving him with strangers and exposing him to danger. At least two times he is sexually abused, and this makes life difficult. As a child and later as a young man he is doubting his identity, his sexuality, and his relation to God. As a child, he is scared that God will punish him for having broken at least three tabus; having intercourse with your sister, having intercourse before marriage, and being involved in sexual activity with another man. This is also a classic example of victims blaming themselves. Karim is scared of what people in Zanzibar will say if they get to know this and has to carry the fear that someone will get to know. As a religious child, Karim also has this fear in his relationship to God, he feels that he is responsible to God for his sins. Karim tells that after being an addict he "did whatever was necessary" to get his drugs and survive.

I went to eat in a dump – it was the first time, but it happened again. I would steal – maybe somebody washing clothes, I would steal them, I would steal everything. I got to jail. I got mob justice... If the door was open in a house, I would go in and take whatever in front of me. And sometimes I would do this…eh… Intercourse…you know sometimes eh…in Zanzibar… there

was a house just over there…there were gays…yeah…so the gay comes to you and says fuck me I will give you money…so…I will do it…

So prostitution?
Yes

Did you prostitute yourself?
Yes..

Was that for gays here in Tanzania or for tourist gays?
Whoever…

Karim tells that he was doing this for seven years. He found out about how the market was working, picked up men in bars and parks, this was how he got money for drugs. Karim could not talk to others about what had happened to him and how he got money for drugs. This would make problems for him as all same-sex relations as such, as well as any prostitution, would be a stigma.[19]

The four stories above give us a deeper understanding of how marginalization, stigmatization and childhood trauma contribute to drug use and make recovery difficult. There are often obvious reasons why that some people become vulnerable to drug use and the problem is usually more complex than the addiction as such, there is always more to it, that has to be changed or resolved to be able to live without use of the drugs to ease the pain.

Conclusions and recommendations

This study concludes that drug users who attended the first sober house program in Zanzibar during the two first years of its operation in 2009/2010 were all heroin users. On average they reported being 17 years old when they started drug use and 21 years old when they started heroin use. In our sample, 66% reported having injected heroin. The oldest half of our sample had an onset age of heroin use that was 5,1 years higher than the youngest half. This indicates that during the years from the early 1990s to early 2000s more young people started to use heroin in Zanzibar, it also indicates a general increase in heroin use. Data suggest that injection of the drug became more common during these years.

Informants reported on average to have been drug free in 3,3 years at the time of the interview and had a total drug free time over the ten years of 5,4 years. The *most successful one-third* of the informants (N = 30) had an average total drug-free time of 9,1 years. These had some important characteristics in common like; a higher percentage *avoided injection* of heroin, they *responded positively to the sober house program* at first attendance and a higher percentage *finalized their basic program* in the sober house (83%). More than half (53%) also *finalized their aftercare program*. In this group almost half of them (n = 14) did not relapse during the ten years and they *had more drug-free time in connection with their first stay* in Detroit Sober House. As many as 63 % later *did volunteer work* in a sober house (average was 28%). It seems like the

[19] Khalid, F et. al . 2014 estimater the number of female sex workers in Uguja Island Zanzibar in 2011/2012 to be 3958 and the male sex workers to be 2,157.

combination of responding positively to the first sober house program and engaging oneself in supporting other drug addicts in recovery was important for success.

A significant correlation was found between injection of heroin and total drug-free time ($r = -0.34$, $p < 0.001$), between time spent in the first sober house program and total drug-free time ($r = 0.37$, $p < 0.001$), between drug-free time in connection with the first Detroit Sober House program and total drug-free time ($r = 0.72$, $p < 0.001$), and between volunteering and total drug-free time ($r = 0.61$, $p < 0.001$). People with success in recovery also reported having got more help from the sober house program and their families. The correlation between the self-estimated degree of help from Detroit Sober House and total drug-free time was $r = 0.41$, $p < 0.001$, and respectively for self-estimated family support it was $r = 0.22$, $p < 0.04$.

Different profiles were found while describing the support they got from Detroit Sober House, which also differed concerning recovery success. The more successful would often emphasize the support as *achieving knowledge*, experience *emotional support*, and *behavioral change*. Less successful informants would rather give protection-oriented answers, focusing on access to shelter and basic care like food, medicines, a bath, a bed, and clean clothes.

All together these figures show an impact of the Detroit Sober House program and its importance for recovery success, but the results should also be understood as a result of the entire *community recovery capital* that was built by the movement of young drug users in recovery in Zanzibar and have been present over the ten years. This movement contained many sober houses and other recovery activities, it also influenced the general understanding of drug abuse, addiction, and the policies on drug use and rehabilitation in Zanzibar.

A less expected finding was that *access to a job/income* while leaving the Detroit Sober House program did not seem to affect total drug-free time positively. This would be expected, as a job/income normally is considered an important recovery capital. The character of the jobs/incomes, which often were low pay and temporary could be a part of an explanation to this. It was also found that the workplace itself sometime could be the very context of drug use. Work and drug use could be intervened activities and therefore more of a risk factor than a protective factor.

Another unexpected finding was that the most successful also had more years on heroin before they started the recovery. We found a significant positive correlation between 'years on heroin before recovery' and 'recovery success' ($r = 0.27$, $p < 0.01$). This could be connected to what our informants described as "hitting the bottom", meaning that that reaching the bottom could be a turning point in motivation for quitting drugs and that reaching this point was more likely to happen the longer you had been on the heroin.

There are always underlying factors affecting drug use and recovery. In this study we have highlighted some of these, to show their presence, draw awareness to their existence and how they might affect drug use, addiction, and recovery efforts. As shown, these could be childhood trauma, related to stigma in the past as well as the present, to marginalization in some parts of life or throughout your life. These underlying factors deserve more attention and qualitative studies looking into these factors more in-depth should be carried out.

During the study, it has been impressive to see the contribution of recovering drug users in doing volunteer work at Zanzibar. This effort should be investigated further in terms of its contribution to building the recovery community in Zanzibar. Besides this, a qualitative in-depth study could be conductd, targeting a deeper understanding of the success factors in these people's recovery, like characteristics of their background, user career, motivation, personality, response to the 12 – step program etc.

This study has been concerned with male heroin users. Most of the sober houses has been for males in Zanzibar and most active members in NA and ZRC are males. Only one sober house for women has been established, but this house was closed after some few years of activities. This does not mean that the drug problem in Zanzibar is entirely a male problem, it is present also among women. There seems to be *differences though, in how addiction affects women and men in recovery challenges.* A study should be conducted looking into these differences. What are the characteristics of female drug users in Zanzibar, how are their lives as users and their challenges in recovery efforts? What could be said about the attempt to start a sober house for women in Zanzibar and why did it run only for a short time?

A controversy is present in the recovery community in Zanzibar concerning *defining drug-free* with Narcotics Anonymous and sober houses on one side and methadone assisted treatment on the other. Defining methadone treatment as drug use or not had several implications on defining and measuring recovery success, which is discussed in detail in the study. It would be interesting to investigate closer the relationship between these two *fields of fighting drug addiction* in Zanzibar, to look at conflicts and common grounds, how these fields understand each other and are able/not able to communicate and cooperate.

More research is needed to get a deeper understanding of how a bottom-up movement challenged the heroin addiction problem in Zanzibar, how it is organized, and works. Heroin addiction is an increasing problem in African countries while recovery options are still rare. To any nation looking for ways to meet this challenge, it will be useful to study and learn from the Zanzibar experiences.

Bibliography

Beckerleg, S., Telfer, M. & Hundt, G.L. 2005.The rise of injecting drug use in east Africa: a case study from Kenya. Harm Reduct J 2, 12 (2005).

Beckerleg. S., Sadiq. A., Telfer, M. 2006. Heroin use in Zanzibar: a survey. Drugs and Alcohol Today; Brighton Vol. 6, Iss. 2, (Jul 2006): 42-45.

Bourdieu, Pierre (1977): Outline of a Theory of Practice. Cambridge University Press: Cambridge UK.

Cloud, W., & Granfield, R. 2004. A life-course perspective on exiting addiction: The relevance of recovery capital in treatment. NAD Publication (Nordic Council for Alcohol and Drug Research) 44, 185-202.

Dahoma, M., Salim, A., Abdool, R.,Othman, A., Makame, H., Ali, A.,Abdalla, A., Juma, S., Yahya, ., Shaka, S., Sharif, M., Seha, A., Mussa, M., Shauri, O., Nganga, L., & Kibuka, T. (2006). HIV and substance abuse: the dual epidemics challenging Zanzibar. African Journal of Drug and Alcohol Studies, 5(2), 129-138.

Dell'Osso, Liliana, Rugani, Fabio, Maremmani, Angelo Giovanni Icro, Bertoni, Sara, Pani, Pier Paolo, & Maremmani, Icro. (2014). Towards a unitary perspective between Post-Traumatic Stress Disorder and Substance Use Disorder. Heroin use disorder as case study. *Comprehensive Psychiatry, 55*(5), 1244.

Glassman, J. 2011, War of Words, War of Stones, Racial Thought and Violence in Colonial Zanzibar. Indiana University Press.

Granfield, R., & Cloud, W. 1999. Coming clean: Overcoming addiction without treatment. New York: New York University Press.

Kaskutas, L.A., Borkman, T.J., Laudet, A., Ritter, L.A., Witbrodt, J., Subbaraman, M.S., ... Bond, J. (2014). Elements that define recovery: the experiential perspective. *Journal of Studies on Alcohol and Drugs, 75*(6), 999–1010.

Khalid, F. Hamad, F. Othman, A.,Khatib, A. Mohamed, S., Ali, A., Dahoma, M. 2014. Estimating the Number of People Who Inject Drugs, Female Sex Workers, and Men Who Have Sex with Men, Unguja Island, Zanzibar: Results and Synthesis of Multiple Methods.

Khatib, A; Matiko, E; Khalid, F; Welty, S; Ali, A; et al. 2017. HIV and hepatitis B and C co-infection among people who inject drugs in Zanzibar. BMC public health Vol. 17, Iss. 1, (November 28, 2017).

Nkowane, Mwansa, Rocha-Silva, Lee, Saxena, Shekhar, Mbatia, Joseph, 2004. Psychoactive substance use among young people: findings of a multi-center study in three African countries. Contemporary Drug Problems, 2004, Vol.31(2), pp.329-356.

Matiko, E; Khatib, A; Khalid, F; Welty, S; Said, C; et al. 2015. HIV prevalence and risk behaviors among people who inject drugs in two serial cross-sectional respondent-driven sampling surveys, Zanzibar 2007 and 2012. AIDS and behavior Vol. 19 Suppl 1, (February 2015)

McCurdy SA, Kilonzo GP, Williams ML & Kaaya S (2007) Editorial: Harm reduction in Tanzania: an urgent need for multi-sectoral intervention. International Journal of Drug Policy 18 (3) 155-159.

McCurdy, S & Kaduri, P, 2016. The political economy of heroin and crack cocaine in Tanzania. Review of African Political Economy, 43:148, 312-319.

Mills K, Teesson M, Darke S, Ross J. Reliability of self-reported trauma exposure among people with heroin dependence: a longitudinal investigation. J Trauma Stress.2007; 20 (3): 313–23.

Ratliff, E. A; McCurdy, S.A; Mbwambo, J. K K; Lambdin, B. H; Voets, A; et al. 2013. An Overview of HIV Prevention Interventions for People Who Inject Drugs in Tanzania. Advances in preventive medicine Vol. 2013, (2013): 183187

White, W. & Cloud, W. 2008. Recovery capital: A primer for addictions professionals. Counselor, 9 (5), 22-27.

Expanding addiction recovery resources in East Africa: An interview with Lonnetta Albright, Andre Johnson, Calvin Trent, PhD, and David Whiters, PhD. Posted at:

http://www.williamwhitepapers.com/search/?query=Zanzibar&results=10&search=1

WHO/UNDCP Global Initiative on Primary Prevention of Substance Abuse. Substance abuse in Southern Africa: knowledge, attitudes, practices and opportunities for intervention: summary of baseline assessments in South Africa, the United Republic of Tanzania and Zambia / WHO/UNDCP Global Initiative on Primary Prevention of Substance Abuse. World Health Organization 2003.

https://www.who.int/substance_abuse/activities/en/substance_use_africa.pdf