DETERMINANTS OF HEALTH SEEKING BEHAVIORS AMONG YOUTH INVOLVED IN SUBSTANCE ABUSE IN KINONDONI MUNICIPALITY, DAR ES SALAAM, TANZANIA

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A THESIS SUBMITTED IN FULFILMENT OF THE REQUIREMENTS FOR THE DEGREE OF DOCTOR OF PHILOSOPHY OF THE OPEN UNIVERSITY OF TANZANIA

2019

CERTIFICATION

I the undersigned do certify that I have read and hereby recommend, for acceptance by The Open University of Tanzania, a thesis entitled: *Determinants of Health seeking behaviours among youth involved in substance abuse in Kinondoni Municipality, Dar es Salaam,* in fulfilment of the requirements for the award of the degree of Doctor of Philosophy of The Open University of Tanzania.

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Prof. Hossea Rwegoshora

(Supervisor)

……..

Date

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DECLARATION

I, Ezekiel Henry Mbao, do hereby declare that this thesis is my own original work and that it has never been presented and will not be presented to any other University for a similar or any other degree award.

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……

Date

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DEDICATION

This thesis is dedicated to my family for their love, endless support and encouragement; to my lovely wife Maridhawa Hojaji and my lovely children Lulu, Baraka, Tariq and Harith who have been my motivation and inspiration during the course of my study.

ABSTRACT

This study aimed at identifying and assessing the determinants of health seeking behaviours among youth involved in substance abuse in Kinondoni Municipality, Dar es Salaam, Tanzania. A descriptive cross section study design with both qualitative and quantitative approaches was adopted for this study. The study employed purposive and random sampling procedure and involved 345 respondents. Data was collected through social survey questionnaire, indepth interviews, documentary reviews and focus group discussions. The quantitative and qualitative data were analysed using SPSS version 22 and 'Content Analysis' respectively. The findings revealed that socio-demographic characteristics like gender, education level, income and age were influencial to health seeking behaviours among young people. About 62% of the participants were not aware of the available treatment options for substance abuse, 64% of the participants perceived that substance abuse was a problem and was affecting their health status. The partens that influenced health seeking behaviour included distance to health facilities, time spent to get preferred health services. The study concludes that a combination of personal factors like socio-demographic factors such as education, income, age and gender, awareness of available health services, negative perceptions of own health status and the need to resume normal status, working together in shaping the final health seeking behaviour of individuals including youths suffering from substance abuse problem. The study recommends that, in order to minimize substance abuse among youths, the government and other stakeholders need to consider these determinants in strategizing focused initiatives in substance abuse prevention.

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LIST OF ABBREVIATIONS AND ACRONYMS

AIDS	Acquired Immune Deficiency Syndrome
APA	American Psychiatric Association
CCHS	Canadian Community Health Survey
DCC	Drug Control Commission
DSM IV TR	Diagnostic Statistical Manual IV Text Revised
EIU	Effective Intervation Unit
FGD	Focus Group Discussion
HBM	Health Belief Model
HIV	Human Immunodeficiency Virus
HSB	Health Seeking Behaviour
HSU	Health Seeking and Utilization Behaviours
IDU	Injecting Drug User
MAT	Methadone Assisted Therapy
MDG	Millennium Development Goal
MOHCDGE&C	Ministry of Health, Community Development, Gender, Elderly & Children
NBS	National Bureau of Statistics
NFFI	New Future Fund Initiative
NGO	Non-Governmental Organization
NSGRP	National Strategic for Growth and Reduction of Poverty
SA	Substance Abuse
SAMHSA	Substance Abuse and Mental Health Services Administration
SES	Social Economic Status

SF	Self Form
SPSS	Statistical Package for Social Sciences
SSA	Sub Saharan Africa
STD	Sexually Transmitted Diseases
SUD	Substance Use Disorders
TB	Tuberculosis
TDHS	Tanzania Demographic Health Survey
TPB	Theory of Planned Behaviour
TRA	Theory of Reasoned Action
UNAIDS	United Nations Programme on HIV/AIDS
UNODC	United Nations Organisation of Drug Crimes
URT	United Republic of Tanzania
WHO	World Health Organisation

CHAPTER ONE

INTRODUCTION

1.1 Chapter Overview

This chapter presents the background information, statement of the problem, research objectives, scope of the study, significance of the study, and the limitations of the study.

1.2 Background to the Problem

Studies have shown that, among different disorders, individuals with substance abuse problems have complex pathways towards seeking available health services due to the stigma attached to their condition (Aromaa *et al*., 2011; Conner *et al.* 2010). This is also the case in Kinondoni, the centre of this study. This stigma may reduce access and use of available treatment and services and make the problem of substance abuse difficult to eradicate. Despite the various efforts of providing needed services, the substance abuse problem has been on the increase especially among the youth (Blanco, 2015; Rubio *et al.,* 2014). Health Seeking Behaviour (HSB) helps individuals to abstain from substance abuse, prevent relapse and allow victims to live active lives within families, workplaces, and the wider community (Blanco *et al.*, 2014; Bladshaw *et al.*, 2012). This study focused on assessing the determinants of health seekindg behaviours among young people involved in substance abuse in Kinondoni Municipality in Dar es Salaam.

The occurrences of any health problem among individuals within a society usually create demands for treatment and initiate actions towards seeking available health

services by concerned individuals. This is also known as individual's health seeking behaviours (Downie *et al.,* 2010; Pasareanu *et al.,* 2015). Scholars have described health seeking behaviour as all the sets of activities undertaken by individuals who perceive themselves as having a health problem, for the purpose of getting appropriate therapy for both actual and potential problems (Batten & Dutton, 2011; Schoen *et al.,* 2012).

The choice of therapeutic options is usually determined by socio-demographic characteristics, awareness of available treatment options, individual culture, type and severity of a health problems, individual perceptions, psychosocial factors and the preparedness of the care from various health services (Downie *et al.,* 2010; Garner *et al.,* 2014 & (Rubio *et al.,* 2014). Generally, Health Seeking Behaviour (HSB) entails what people do when they are sick or have symptoms of illness including delays in seeking treatment and proper management. Moreover, HSB predicts individual health outcome(s).

Many individuals of all ages worldwide are affected by substance abuse problem, but youth are the most affected by this problem (Blanco, 2013; Rubio *et al.,* 2014). The impact of substance abuse among individuals with substance abuse problem varies significantly. For instance, substance offenses are the leading causes of incarceration with half of federal inmates reporting illegal substance use in the month before their offense (Mumola *et al.,* 2004). Alcohol consumption ranks third among preventable causes of death Worldwide (Mokdad *et al.,* 2004). Substance abuse can result in serious threats to health and well-being, substantial family distress, and to massive

societal economic burden (Blanco *et al.,* 2015; Compton *et al*., 2007; Hasin *et al*., 2007; Rubio *et al.,* 2014, 2013). Economically, illicit substance use and abuse account for nearly two hundred US billion dollars each year in healthcare, lost productivity, incarceration, and drug enforcement costs (Rubio *et al.,* 2014). Substance abuse has also been associated with high prevalence and numerous adverse health consequences (Blanco *et al.,* 2014; García-Rodrígueza *et al.,* 2014).

Globally there are various treatment options for substance abuse such as attending to mental health clinics, body detoxification, and replacement therapy such as use of methadone, rehabilitation of substances users, naltrexone maintenance, psychological treatment and cognitive behaviour therapy (Blanco *et al.,* 2015; SAMHSA, 2015).In Tanzania, particularly Kinondoni Municipality services like mental health clinics, methadone assisted therapy, soberer houses, detoxification and counselling are all available (DCC 2011; Yusuph, 2016). However, very few youths seek the available treatment options (Blanco *et al*., 2015; Elliot and Larson, 2004). For instance, according to McMillen & Raghavan (2009), the global trend of substance abuse among youth peaks while their use of available substance abstinence service declines. It is estimated that in developed countries, approximately one in six problematic drug users receives treatment for substance abuse disorders each year, whereas, in developing countries like Latin America, only 1 out of 11 and only 1 out of 18 in Africa receives treatment (SAMHSA, 2015). There is therefore, variation between countries mainly due to factors such as lack of resources such as facilities and personnel (WHO, 2010; World Drug Report, 2017).

Globally, there is limited access to health care for individuals suffering from substance abuse problems compared to the general population (Garcia-Rodriguez *et al.,* 2013). Evidence from high income countries reveals some variations towards access to health care ranging from satisfactory level (O'Brien *et al*., 2015) to poor (Brain, 2014; Riley *et al.,* 2002; Sohler *et al.,* 2007). Low service utilization among substance abusers is common and has been associated with poverty, frequent mobility, unstable housing, and other factors that often characterize marginalized groups (Galea, 2002; Martinez *et al.,* 2014, Brain, 2014). For example, a study conducted in Brazil revealed that only 27 % of substance abusers had utilized some type of health service in the month previous to the interview for a study (Brain, 2014). Several barriers were expressed by Brazilian substance abusers including limited service resources, lack of needs-specific professional skills among health providers, bureaucratic obstacles, and stigma (Santos *et al.,* 2013). These barrires might be applicable in the Tanzanian context.

The level of access to health care among individuals with substance abuse in Sub-Saharan Africa (SSA) is still very low (World Drug Report, 2016). For instance, study findings from South Africa, point out that, institutional practice and clinical experience show that youth hardly seek any kind of substance abuse treatment and that, when they do so, they often drop out early (Slesnick, 2007). This leads to a range of persistent substance abuse problems including lost productivity, security challenges, crime and lawlessness, increased health care costs, and a myriad of negative social consequences such as to persue education difficulties, health related

problems, and poor peer relationships (Bradshaw *et al.*, 2012; World Drug Report, 2016).

There is evidence of a growing burden of substance abuse and established treatment services (Mbwambo *et al.*, 2012). But the level of access to the available health care services among individuals with substance abuse is still limited (MoHCDGEC, 2014). Consequently, poor access to health services may result in poor health outcomes among individuals with substance abuse problems. This may also increase the cost of medical care to sufferers and the health system as a whole. It is, therefore, necessary to understand the determinants of health seeking behaviours among the concerned group of individuals in order to strategize better to improve their health conditions.

Substance abuse, especially among youth is one of the major social concerns in Tanzania. Available data by DCC (2013) shows that the problem is growing and is now deep rooted. The effects are evidently seen in terms of economic, physiologic, mental, and social conditions of the abusers. This scenario is depicted by Kazimoto (2014), as well as Mbatia and Kilonzo (1996). In order to address the scourge, the government of Tanzania embarked on various measures to supply and demand reduction of the vice, notable being the law- Prevention of Illicit Trafficking in Drugs Act, No 9 of 1995, and establishment of the comprehensive treatments in the year 2011 for individuals with substance abuse coordinated under the Drug Control commission. Despite all the efforts to solve the problem of substance abuse, in Tanzania, the problem is still deep-rooted and the common abused substances in the

country includes tobacco, Cannabis, Khat, heroin, alcohol, inhalants and Cocaine and this is mainly because of availability and accessibility of substances (DCC, 2013).

Substances like cigarrate, alcohols such as wine and beer are readly available they can be obtained in most of the shops and supermarkets in the street and they are available for the range of prices for example a cigarrate can be obtained for a price of Two hundred shillings, alcohols can be obtained from a price of Five hundred shillings to Two thousands Tanzanian shillings which seems to be affordable to most youths Heroin use is also done through smoking andinjecting in most part of the country and it has aprice which is relatively affordable to youth as it can be available for a price of at least One thousand Tanzanian Shillings. Substance abuse became an increasing public health and social concern in the past decades worldwide (UNGASS, 2010).

Table1. 1 Drugs seized in Tanzania from 2005 – 2013

Type of Drug	**2005**	**2006**	**2007**	**2008**	**2009**	**2010**	**2011**	**2012**	**2013**	**No of Arrested Persons**
Cannabis (Tones)	151	225.3	60	76	56.2	4.03	17.3	48.7	85.6	**30,155**
Khat (Kg)	1.122	5.145	2.2	53	22.909	3.69	126	6.216	12,500	**4,090**
Cocaine (Kg)	0.42	4.13	6.6	3.5	4.3	62.9	126.3	151	4	**1,351**
Heroin (Kg)	9.9	91.7	16.2	3.7	9	185.8	264	260	36	**1,575**
Mandrax	-	11.47	3.05	0.53	0.1	-	-	-	-	**25**
Morphine	1.4	37	0.94	-	0.619	1.5	-	-	-	**107**

Source: Drug control commission report [6]-2013

The above data from the drug control commission provides that there is a serious problem of substances abuse in Tanzania that needs critical address to rescue youth from consequences of abusing the substances.

Researchers have found that people who inject drugs (PWID) in Dar es Salaam are a disproportionately high disease burden with an estimated HIV prevalence of 42%–50%, hepatitis C prevalence of 56–76% and an active pulmonary TB prevalence of 4%–11% (Ubuguyu *et al.,* 2016). Another study in Dar es Salaam revealed that prevalence of substance use was found to be 17.2%. 8.7% and 0.8% for alcohol, tobacco and cannabis, respectively (Mbatia *et al.*, 2009).

Various efforts on substance abuse treatment have been employed in the country among them has been the introduction of comprehensive treatment for substance abuse (SA) established in 2011, comprising of Methadone assisted therapy (MAT), Counselling, Psychotherapy, Mental health clinics, rehabilitation, detoxifications and sober houses (DCC, 2011; Yusuph, 2016). The introduction of these treatment options offers various benefits to affected individuals including reduction of the intensity of substance abuse desire, improve functioning and wellbeing of the affected individuals, and prevention of future harm by decreasing the risk of complications and reoccurrence (Pasareanu, *et al.*, 2015; UNDOC, 2016).

In the Kinondoni Municipality, efforts towards helping individuals with substance abuse problems are available (DCC, 2015), and some of them includes, mental health clinics, methadone assisted therapy, psychosocial interventions and community-based outreach to substance abusers as an initiative that was introduced in 2010

through the synergy of four community-based organizations (CBOs) located in Kinondoni District. (DCC, 2015), This initiative was carried out using three basic approaches: firstly traditional outreach workers, basically social workers, or health professionals. Secondly, storefront drop-in centers. These centers provide information, education and communication (IEC) concerning HIV and substance abuse; they provide training on syringe cleaning kits; psychosocial services for individuals, families and groups, provide livelihood and capacity building, and nutritional support. Thirdly, there are two mobile units offering HIV testing and counseling (HTC) in drug using communities in Dar es Salaam (Lambdin *et al.,* 2013). However, the determinants of HSB for substance abusers are not well known in the Kinondoni Municipality.

Individuals with substance abuse problem particularly youths need health care services to abstain from drugs problem and enable them to have socially acceptable and productive lives within families, workplaces, and communities (Blanco *et al.,* 2015; Greenfield *et al.,* 2007). The pathway for individuals with substance abuse problem towards seeking and utilizing available treatment options remain elusive. Therefore, the current study focused on assessing the determinants of health seeking behaviours among youth involved in substance abuse in Kinondoni Dar es Salaam. In order to better strategize to save the young people from the vice and enable them to return to society mainstream as law abiding and productive social beings.

1.3 Problem Statement

Studies on health seeking behaviour have focused on illnesses such as malaria (Sekule, 2012); TB (Tarimo, 2012), diabetes (Nguma, 2010) but few studies are

available on the health seeking behaviours among individuals with substance abuse problems. Many, studies on substance abuse have focused on the cause, effects and remedial measure of substance abuse (Matowo, 2013), prevalence of alcohol consumption and harzodous drinking (Mbatia *et al.,* 2009), knowledge, attitude and practice of psycho active substances (Masibo, 2013), drug trafficking use and HIV risks (Mbwambo *et al.,* 2012) HIV infection among injecting drug users (Msami ,2004). However, very little is known about health seeking behaviour among individuals with substance abuse problems, especially the youth, in Kinondoni Municipality. Therefore, this study tried to bridge this gap of knowledge by assessing the determinants of health seeking behaviours among youth involved in substance abuse in Kinondoni Municipality, Tanzania.

1.4 Objectives of the Study

1.4.1 General Objective

This study aimed to assess the determinants of health seeking behaviours among youth involved in substance abuse in Kinondoni Municipality.

1.4.2 Specific Objectives

The specific objectives of this study were to:

i. Assess social-demographic factors associated with health seeking behaviour among youth involved in substance abuse in Kinondoni Municipality.
ii. Assess the level of awareness on available treatment options in Kinondoni Municipality

iii. Explore the perceptions of substance abusers on their health status in Kinondoni Municipality

iv. Examine the utilization pattern of substance abstinence services among youth involved in substance abuse in Kinondoni Municipality.

1.5 Research Questions

This research endeavoured to answer the following research questions:

i. What are the social-demographic factors influencing health seeking behaviours among youth involved in -substance abuse in Kinondoni Municipality?

   The variables involved are: Age, gender, education, marital status, income, occupation, family size, source of income, expenditure, social networks.

ii. To what extent do youth in Kinondoni Municipality are involved in substance abuse are aware (knowledge) of available treatment options for the vice?

   The applicable variables are: availability of treatment options, type of service sought, information regarding treatment options, source of information, reasons for not being treated, treatment options preferred and reasons, fear of treatment consequences

iii. What are the perceptions of substance abusers on their health status in Kinondoni Municipality?

   Variables: perception on the victims' health status, importance of their health, concerns about their problem

iv. What patterns do substance abusers use in seeking available treatment options in Kinondoni Municipality?

Variables: treatment sought, preference of treatment, time taken to reach health facility, time taken to start treatment and restriction given relating to the substance.

1.6 Scope of the Study

The scope of this study was to cover the determinants of health seeking behaviours among youth who were involved in substance abuse in Kinondoni Municipality in Tanzania as follows: -

The study focused on youths' social-demographic characteristics like age, gender, education level, marital status, and occupation/income inorder to find out how they influence their health seeking behaviour following substance abuse. The study looked at the awareness of the substance abusers on the available treatment options and how the options influenced their decision to seek the treatment options.

The study focused on the perceptions of substance abusers on health status and the petrceptions influence individuals in seeking available treatment options. The study also assessed the perception of substance abusers in relation to available treatment options and how the perceptions influence their decision to seek available treatment options. The study also examined the use patterns of available treatment options and how the treatment influenced their decision to seek health services.

The study was focused on Kinondoni Municipality, which included the following wards during that time; Manzese, Mwananyamala, Kimara, Magomeni Ndugumbi, Tandale, Sinza and Kigogo. The study managed to extract information from 345

respondents. In different capacities including substance abusers, health and social workers and other key informants.

1.7 Significance of the Study

This work contributed to the body of knowledge through both quantitative and qualitative components of the study with the aim to better understand the determinants of health seeking behaviour among youth involved in substance abuse in Tanzania. This study is significant to social work practice as it deepens the level of understanding of issue of substance abuse and health seeking behaviours including adding new knowledge to this field of social work. The knowledge added to this field may promote social change among youth who are involved in substance abuse in the society and all other persons that could be at the risk of getting involvedin substance use and abuse.

The contribution of this study to social work practice includes increasing knowledge and skills in dealing with youth having substance abuse problem and hence promoting their health. In so doing, the role of social work as a profession may become more visible nationally and internationally towards alleviating substance abuse and other social problems. This study also reveals that social workers have a key role to play in helping individuals with substance abuse problems by empowering people surrounding these individuals to understand their responsibilities and strengthen the role of social workers in managing substance abuse problems in Tanzania.

The study is a reference for researchers, academicians, policy makers and health stakeholders in understanding determinants of health seeking behaviour at individual level and developing patinent more effective control measures. In this regard, the study is not only relevant to substance abuse but also to other health problems which require health seeking behaviours. The current study is important to policy makers as the recommendation provides information which helps in formulation of new policies that are evidence-based according to the social life of youth involved in substance abuse. This means that policy formulation and enforcement mechanisms should rely on evidences that are generated through research. Moreover, this study will inform policy makers to strengthen existing policies related to health seeking and utilization behaviours among youth involved in substance abuse.

Needless to reiterate butthe, the fight against substance abuse among youth is a contemporary global agenda linked to poverty alleviation, youth empowerment, peace and security. Thus, this study contributes to global efforts in understanding and enhancing health seeking behaviours. At micro level, the findings will assist health planners and other health collaborators to formulate appropriate strategies and interventions to improve health seeking behaviour among substance abusers; The findings will provide some information supporting strategies on how to achieve the National health policy goals, as well as various global and national commitments as reflected in the relevant targets of the Sustainable Development Goal 3.5, which emphasizes "strengthening prevention and treatment for substance abuse, including narcotic drug abuse and harmful use of alcohol", as well as Tanzania Vision 2025 which focuses on transforming Tanzania into a middle income economy, especially

through industrialization and improved training of the labour force and through the National Strategy for Growth and Reduction of Poverty (NSGRP).

1.8 Limitations of the Study

The limitations of this study are due to different factors including access to information and space and resources available. Concerning access to information, for most of the time, the youth who abuse substances are found in hiding places and risky geographical locations. Obtaining information from individuals involved in substance abuse problem is a big challenge. In order to overcome such a hurdle, the concerned youth were assured that the researchers were not a threat to them and cooperation with the local leaders and people who were friendly to them was sought and involved. The local leaders did provide escort and ascertained security to the researcher. Another challenge relating to access to information was the language of the study. Individuals with substance abuse problem had their own informal language and terminologies which had to be learnt quickly, in order to cope and match the information collected with research objectives during the interview process. The researcher managed to learn some terminologies used in the language used by youth during the pre-test. Some common Swahili words such as "*kuyoyoma*" meant to them the actual taking of drugs; Cannabis (*ganja* in Swahili) chasing, the actual taking of heroin. Heroin is "*sukari guru*" in Swahili. *Arosto* denotes withdrawal which means the client is in need of some more heroins to curb the craving and pain, red eyes which showed that they have used cannabis. Also, the drug abusers used expressions such as "*Noma Uione wewe*" meaning they do not feel shy, (shyness is on the side of the observer), and therefore they could do anything they wished without fear of being

arrested and/or punished. Other limitations were that the research was not able to access variations in other regions in Tanzania because the study was conducted in only one district. Some doubts relied on the study that it would only capture the circumstances that prevailed at the time of the interviews, the tendency which is normal to most such studies. The researcher sometimes doubted that some respondents did not provide their true opinions during the interview or focus group discussion because of fear of the rules and policy regarding the issue of substance abuse. However, careful considerations were taken on board and thoughtful efforts were made to make the study as scientific, systematic and as objective as possible so as to encounter the identified limitations.

Finally, the study was limited in terms of resources available. The sample of the study could have included more respondents and more areas would have been covered if resources were available. However, despite the above-mentioned limitations the researcher was able to make necessary arrangements such as probing for more information and sharpening the guiding questions which enabled the collection of required information from the selected respondents in the study.

CHAPTER TWO

LITERATURE REVIEW

2.1 Chapter Overview

This chapter discusses the existing literature relating to health seeking behaviours among youth involved in substance abuse. The review narrates what is already known about the research problem with the hope to identify relevant theoretical and conceptual framework needed for defining the research problem.

The chapter lays the foundation for this study, inspire new research ideas, and identify existing gaps or inconsistencies in the relevant body of research (Cresswell *et al.*, 2007). This section begins with definitions and theoretical discussions that are related to health seeking behaviour among youth involved in substance abuse disorders followed by empirical studies on health seeking and health services use behaviours among youth who are involved in substance abuse. The study presents a conceptual framework and a review of relevant policies and ends with identification of the gap in literature that this study intends to bridge.

The literature review was undertaken through consulting books and journal articles using different search engines and websites such as google scholar to mention a few, also the researcher used key words such as health, health seeking behaviour, substance, substance abuse, and substance use disorder. The study was guided by the health belief model, the theory of planned behaviour and the social learning theory which helped in generating the variables and the conceptual framework.

2.2 Conceptualization of Key Terms

a*) Health seeking*: Refers to an act by people who perceive having a health problem or being sick and embark on looking for appropriate therapy (Wade and Halliban 2004). In the context of this study, health seeking behaviour shall be considered as any efforts shown or applied by individuals with substance abuse problem trying to use available formal treatment options in order to stop or reduce the use of those substances.

c) *Substance abuse:* refers to any substance that, if taken by a person, modifies his or her perception of one or more of the five senses (sight, hearing, taste, touch and smell) It also modifies mood, cognition, behaviour and motor functions. Drugs include licit substances such as nicotine and alcohol and illicit substances such as cannabis, heroin, and cocaine. In the context of this study substance abuse is considered as any substance chemical (drug) or non chemical (glue, petrol, gasoline) which are allowed, for use by persons like nicotine and alcohol, and those which are not allowed by law like heroin, cannabis cocaine, and mandrax.

d) *Youth:* as defined by WHO (1993) refers to person falling between the ages 10-24 years. There are different definitions of the concept, and differ from country to country, culture to culture and even context. In some societies the concept can be used to denote persons age and before puberty or immature age. This study adopts the definition propounded in the Tanzania National Youth Development Policy-2007, that is, “young men and women from the age group of 15-35 years.” In the

context of this study Youth are considered as, young men and women who are out of schools and their age ranging between 18-35 years.

2.2.1 Theoretical Literature Review

Theories are ideas and concepts that when considered together, help to explain a certain particular phenomenon and allow people to predict behaviour and other events (Mabeyo, 2014). Theories differ from other types of knowledge because they allow one to organize knowledge and put it into practice on a particular issue. Without theories, knowledge about human behaviour and social issues would remain static and people would not be able to make connections among related facts and information to form new ideas that could help to advance knowledge about human behaviour and social issues. In order to assess the determinants of health seeking beviours among youth involved in substance abuse, this study was guided by two theories and one model which are; Theory of Planed Behaviour, Social Learning Theory and the Health Belief Model. These helped to explicitly so as to explicitly explain the phenomena of health seeking behaviours among youth involved in substance abuse in Kinondoni Municipality. This section discusses the theories and the model and how they guided the current study.

2.2.2 The Theory of Planned Behaviour

The center of attention in this theory is on factors which direct reason to take a particular action or meaning of a particular behaviour. In the Theory of Planned Behaviour (TPB), Behavioural meaning is determined by belief of other people

towards behaviour, attitude, perceived behaviour control, i.e. ability to perform, and social-demographic characteristics.

The Theory of Planned Behaviour

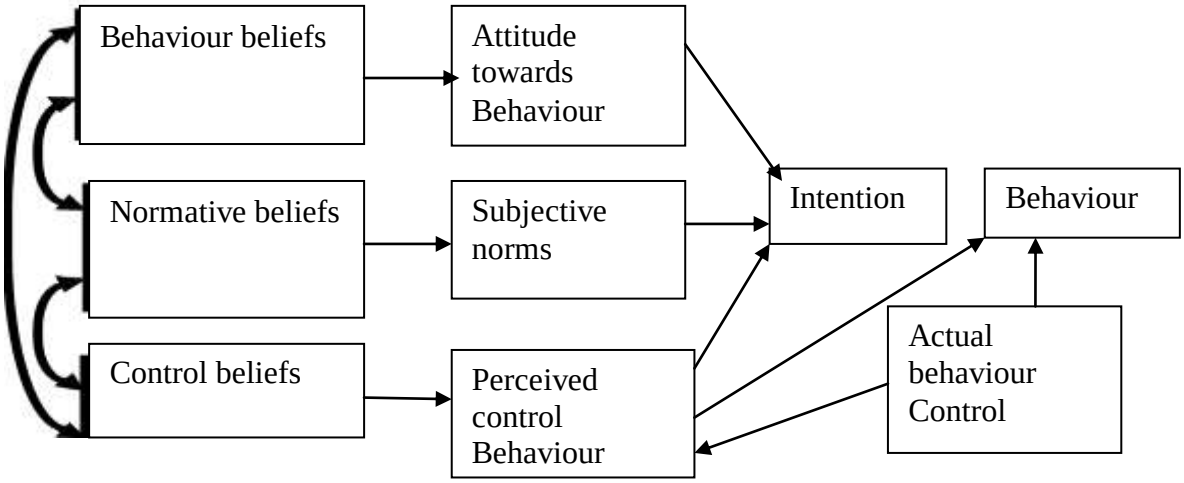

Figure 2. 1: The Model for the Theory of Planned Behaviour

Source: Ajzen (1991).

This theory has the following assumptions; first, attitude towards a certain behavior is determined by the belief that a specific behaviour will have consequence including the evaluation of this consequence. Second, the theory assumes that personal conviction toward certain behaviour depends on whether other significant people will support one's behaviour and personal motivation to accomplish the expectations of others. Third, the perceived personal behavioural control is determined by the conviction of access to the resources needed in order to act successfully. Fourth, individual behaviour is a function of socio-demographic characteristics, social network support and individual personality and character which condition attitudes, guides subjective norms and controls perceived behaviour (Hausmann-Muela *et al.*, 2003).

The theory of planned behaviour had its significance in this study by ensuring that it considered social demographic characteristics (age, sex, educational level, income and marital status) of youth involved in substance abuse. During data analysis the assumptions helped to integrate perceptions of health status against the available treatment options among youth involved in substance abuse. Individuals with substance abuse seem to have complex path to utilize the available services as they fear that they are not accepted by the majority of members in the society. This theory therefore helped to guide the determination of the factors that promote or hinder youth in the use of available health services.

Although it can be adapted to incorporate individuals involved in substance abuse dimension, the theory of planned behaviour does not explicitly consider individual perception of the health status, patterns of utilization and awareness of available treatment options to youth involved in substance use. The shortfall of this theory was complemented by the use of Social Learning Theory and the Health Belief Modal (HBM).

2.2.3 Social Learning Theory

Bandura's Social Learning Theory suggests that humans are social beings and hold a need or desire to interact with other people and they usually learn from one another, via observation, imitation, and modelling. Bandura's Social Learning Theory suggests that humans are social beings and hold a need or desire to interact with other people and usually learn from one another, via observation, imitation, and

modelling. The theory has often been called a bridge between theories of behavior and cognitive learning because it includes attention, memory, and motivation. People learn by observing other people's behaviors, attitudes and outcomes (Akers 1985).

Individuals learn to make connections and increase the likelihood of committing the same behaviour (e.g., abusing substances or looking for the available treatment options to alleviate or relieve one from substance abuse problem) (Akers 1985). The social learning theory derives from a more behaviourist standpoint that further examines social factors (differential association, differential reinforcement, definitions, and imitation) influential in reward-seeking behaviours. The first construct, that is the differential association, is based on the norms developed through peer interactions with primary relationships, such as with significant others, close friends, families and/or parents. In this regards the concerned individuals are those with substance abuse problem, whether they are continuing to abuse the substances or are using available services to reduce or elleviate the problem (Akers, Krohn, Lanza-Kaduce, & Radosevich, 1979).

The second construct, namely, differential reinforcement, according to Akers (1985), is the perceived benefits and consequences of behaviour. Behaviour that is positively reinforced is likely to develop from rewarding outcomes or encouragement while negative reinforcement is likely to occur when an individual seeks to remove or avoid a distressful event. In the context of the youth involved in substance abuse, a perceived benefit of using available treatment options could improve the life of individuals with substance abuse problem and their academic performance for those

who are in schools, while a perceived cost or consequence could be developing as an addiction (Peralta & Steele, 2010).

The third construct of social learning theory is definitions, which can be thought of as rationalizations or justifications for a certain particular behaviour (e.g., abusing substances or deciding to seek available treatment options so that they can improve in health"). Definitions refer to the meanings and attitudes connected to behaviours (Akers, 1985). The more positively one views behaviour, the more likely he/she islikely to engage in the given behaviour (Akers, Krohn, Lanza-Kaduce, & Radosevich, 1979).

Lastly, imitation is the construct that is most similar to that of modelling or observational learning (Akers 1985). Just like modelling, imitation occurs through the reciprocal interaction between an individual and their environment (e.g., friends, family, etc.). Therefore, when a behavior is rewarded, the imitation or modelling of behavior is likely to repeat, as opposed to when the behavior is punished, decreasing the likelihood of repeated imitation/modelling of behavior (Akers, Krohn, Lanza-Kaduce, & Radosevich, 1979). In line with this theory, it is likely that individuals with substance abuse problem will always tend to hang around with friends who explicitly endorse the behaviour of abusing substances. However, if they associate with individuals who utilize available treatment options they will eventually tend to see the benefits that are associated with utilizing available treatment options. Furthermore, deviant or risk behavior, such as engaging in substance abuse, can be learned from associations one has with their intimate social groups (Akers, 1985).

These four constructs comprise the social learning theory, including differential association, differential reinforcement, definitions, and imitation. This theory finds its relevance in this study by determining the behaviour of youths depending on the people in their association are surrounded by substance abusers they will continue to abuse the substances and vice versa. Most human behavior is learned by modeling observationally: by observing others, one forms an idea of how new behaviors are learned, and later this coded information serves as a guide to future action (Bandulla, 1977). In terms of continuous reciprocal interaction between cognitive, behavioral, and environmental influences, social learning theory explains human behavior. The shortcomings of the social learning theory have been accommodated by the HBM and the TPB.

2.2.4 The Health Belief Model

The Health Belief Model has been adopted by Sheeran & Abraham (1995) and the definitions used for the variables are those of the original authors of the model namely (Hochbaum, Rosenstock and Kegels 1950).

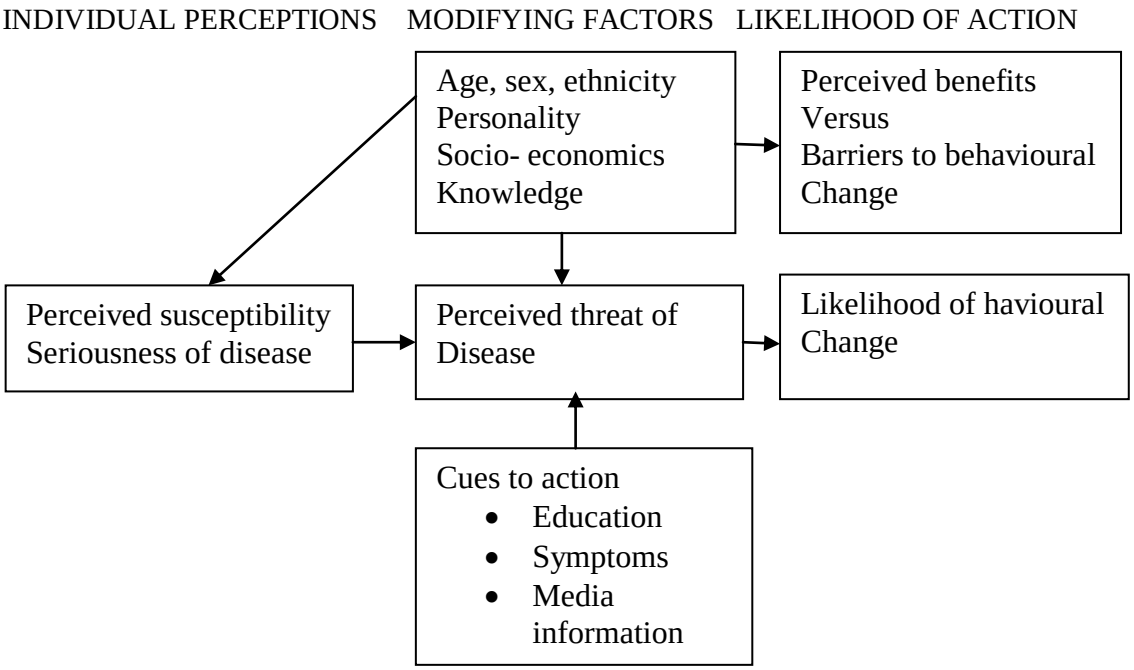

Figure 2. 2: The Health Belief Framework

Source: Hochbaum, Rosenstock and Kegels 1950

The HBM argues that people's beliefs about the severity of a health problem (Perceived Severity), the probability of experiencing the health problem (Perceived Susceptibility), the advantages of taking preventive and/or health promoting behaviours/actions (Perceived advantage), their evaluation of the barriers to adopting preventive and/or health-promoting behaviors/actions (Perceived Barriers), and immediate pushing factors which may be internal such as pain, or external such as information from close friends (Cues to action) act together to determine whether or not a particular person will engage in the preventive or promotional health behaviors (Rosenstock, 1974).

In other words, the HBM claims that, in order for individuals to engage in preventive or health promoting behaviors, they must have a minimum knowledge of health as it

relates to the particular condition, believe that the condition is serious and/or life-threatening and that they are in danger of contracting or succumbing to the condition, and finally, they must believe that engaging in the proposed preventive and/or health promoting behaviors will neutralize their vulnerability to the condition, while also foreseeing no significant barriers to engaging in these behaviors. To the extent that an individual's subjective appraisal of their index illness and related factors may be so important in determining their choice of their behaviour whether seeking the available services for overcoming the potential or actual problem (Cockerham, 1992),

The HBM applies to the current study as follows: (1) individual perceptions of their current health status will inform health-seeking behaviors (2) individual perceptions about susceptibility to problem of substance abuse will inform health-seeking behaviors (3) beliefs regarding barriers to some health care options such as not being aware of the available treatment options, higher cost of care, availability, and distance to health facilities will inform health-seeking behaviors, and (4) previous experience with different care options and observation of treatment outcomes of other people who are close to them from different care options will inform health-seeking behaviors for current and future illnesses (cues to action). Self-efficacy was not considered as a construct of interest in the present study because the present researcher did not find it significantly aligned with the purposes and scope of the current study, where the focus is on modulating factors such as age, gender, educational and income levels, and how these factors influence health-seeking behaviors in the context of the selected constructs, namely perceived severity of

illness, perceived susceptibility, perceived benefits, perceived barriers and cues to action.

The HBM is significant to the current study as it tests the perceptions of individuals with substance abuse problems on their health status and how it does influence their behaviours towards seeking available treatment options. Although this model fails to allow any understanding of what motivates peoples' decisions for either adopting or not adopting health behaviour, this was rectified by the use of The Social Learning Theory and the Theory of Planned Behaviour. Thus, the use of SLT, TPB and HBM allow consideration of all variables involved in the current study.

Table 2. 1: Summary of Theories and their implications

S/NO	Name of Theory	Implication to this study
1	Social Learning Theory (SLT)	The HSB depends on the reciprocal interaction with significant others like peers, families and friends through observations
2	Theory of Planned Behaviour (TPB)	HSB is associated with belief one has on significant others on approving a certain behaviour and the social demographic characteristics
3	Health Belief Model (HBM)	HSB is associated with the perception of ones current health status and the income, education, gender.

2.4 Empirical Literature Review

In this section, several empirical studies related to the current study were examined. Several studies have been conducted to find out what promotes the utilization of health services, and what forces people to behave differently in relation to their health. There are many studies which emphasize health care seeking behaviour the 'end point' which is utilization of the formal system, or; secondly, there are those which emphasized the 'process' or steps which are taken from symptoms recognition which is illness response, or health-seeking behaviour (MacKian, 2001`).

The current study shall combine both approaches. Health-seeking and utilization behaviour which involves the' pathway to utilization of the available formal health system for treatment of substance abuse including to facilities visited, health care workers visited, and treatment process, in addition to use of any other treatments before and during utilization of the formal health care system. In this study, the social demographic characteristics, awreness of the available treatment options, perceptions of health status and the pattern of utilization of the available treatment options were used as bases for examining the Health seeking behaviouirs among youth involved in substance abuse in Kinondoni Municipality.

2.3.1 Health Seeking Behaviour in Sub Saharan Africa

Klein (2007) conducted a study on HSB in rural Benin. He found that the most common form of treatment for illness was self-treatment (67%), of which 37% used biomedical pharmaceuticals from unlicensed drugs sellers and 30% gathered herbs from the bush or bought them from informal vendors. Village health centres and

local indigenous practitioners were both visited in 11% of all incidences, with formal biomedical institution only being visited in 5% of recorded cases, of which the majority were private not government facilities. Klein argues that low utilisation of government health facilities is linked to the behaviour of staff, lack of privacy, lack of language skills and waiting times to be attended, rather than because people were rejecting biomedical health traditions, or because they were experiencing poor access.

The study conducted by Janzen (1978) attributes some aspects of HSB to belief, however, in his study of health-seeking in Zaire (now Democratic Republic of Congo). Janzen records a distinction between natural illnesses that come from God and unnatural illnesses that are caused by man. He outlines the belief that natural illnesses can be treated by biomedical interventions and sometimes by traditional healers, but that unnatural illnesses require treatment by traditional healers and cannot be treated with orthodox western medicine. The researcher does emphasise however that therapy managers move back and forth between health systems, utilising biomedical therapies initially and then traditional therapies if no results are seen or vice versa.

Cavender, (1991). highlights similar patterns in Zimbabwe, where orthodox medical intervention is sought for illnesses considered ‘normal’ and traditional medicine sought for illnesses deemed ‘abnormal’ Anita Spring found there to be a distinction between ‘illness’ and ‘disease’ in her study of northwest Zambia with diseases being treatable by both traditional and orthodox therapies but illnesses being best treated by

traditional medicine. Illness in that context included barrenness, ‘weak penis’, ‘rotten sperm’ and ‘madness’ (Spring 1980). Spring concludes that whilst expediency, financial resources and hopelessness do play a role in HSB, the primary factor that drives therapy choice is belief in the system and its pharmacopoeia. She argues that people accept biomedical services because they see good results but maintains that people would not forego ritual, herbal and proscriptive aspects of traditional medicine which are perceived to address underlying causality (1980).

Taffa *et al*., (2005) conducted a study in Nairobi, Kenya and identified that factors like lack of money was most important in deciding not to attend biomedical health clinics in Nairobi, whilst Ngugi, (1999) found that people were willing to pay for treatment as long as the service was decent.Thus they increasingly used private facilities that were more costly but offered better quality service. The picture here appears rather conflicting, with each study finding different determinants of HSB to be the most influential. This serves to indicate that each context is different and despite the utility for policy-makers of models that seek to offer universally applicable conclusions, it is necessary for each country, or even each region, to investigate HSB in their own locality. The literature outlined above, does however, allow us to build a picture of the potential factors that influence HSB in Tanzania, including quality of service cost of care and belief in efficacy of therapies.

Rosenblum *et al.,* (2011) studed the types of barriers or determinants which lie between patients and services. Again, there are as many categorizations and variations in terminology as there are studies, but all tend to fall under the divisions

of geographical (e.g. distance and physical access), social (e.g. age and sex), economic (e.g. cost of care), cultural (e.g. status of women in the community) and organizational factors (e.g. perceived quality of service). There are also studies that attempt to categorize the type of processes or pathways at work. Such studies develop pathways to care models identifying stages where decisions are made, and delay may be introduced, towards adoption of 'modern care'. This approach offers an opportunity to identify key junctions where there may be delays in seeking competent care and is therefore of potential practical relevance for policy development.

Merrill *et al.,* (2002) & Singh, (2012) studies on Health seeking and utilization behaviours have been connected with several socio-demographic characteristics such as age, marital status, gender, and socioeconomic status. One of the main factors associated with health seeking and utilization is that of "health services need," as measured by individuals' health status (Borra 1994). Poor interactions of clients with service providers has also been pointed out as one of the main reasons for youth addicts avoiding care or limited access to these health services as they have reported discrimination from a variety of service providers

Studies conducted in Asian countries (Prasad 2009; Perron *et al.,* 2009) have revealed that, external challenges are influenced by the overall approach of the government toward health. Health services also depend on availability of trained doctors, nurses, and other health personnel. At another level, the external barriers relate to larger issues of human development, gender and caste stereotyping,

economic growth and equity, poverty and systems of governance and corruption, which, in turn, reinforce certain internal barriers. Together these factors affect the health-seeking and utilization behaviour of men and women. In the case of substance abuse, there are added dimensions of stigma, discrimination, lack of insight and insensitive treatment and denial in healthcare at the personal level

In a study done by Chirmulay, (1997) in India, among 3,000 households in five Indian states that assessed the factors affecting health seeking and utilization of curative healthcare services, the key indicators for sickness were inability to move and work and loss of appetite or interest in the surroundings. The reasons that were found to influence health seeking and utilization of health services were perception of "health" and perceived quality of services provided by health care providers. Private practitioners were preferred compared with government health services because of the longer waiting periods involved to get service, the attitude and behaviour of the staff, and lack of medicines (Prasad, 2009; Shen, Mc Lallan & Merill, 2009). The numbers of factors need to be taken into consideration before describing the health seeking and utilization behaviours of a certain population.

It has also been reported that some service providers are unable to provide effective services due to lack of education regarding issues surrounding youth using drugs (Lally *et al.*, 2008). Thus, whenever young people face health concerns, they often seek health care informally. In other words, they do not refer to health professionals or to formal health services first. Instead, they seek help from people close to them including parents, friends or others they trust (Pommier *et al.*, 2001; Booth *et al.*,

2004). Therefore, a study that will also assess the determinants of health seeking and utilization behaviours among youth involved in substance abuse In the Tanzania context might be useful to explain the behaviour.

Substance abuse is cited as one of the key factors responsible for risk behaviours which have detrimental socio-economic, political and health consequences on society. Substance abuse has profound health, economic, and social consequences. The negative consequences of substance abuse affect not only individuals who abuse substances but also their families and friends, various businesses and government resources. Substance abuse has serious consequences for existing social systems, affecting crime rates, hospitalizations, child abuse and neglect, and rapidly consuming public funds (Hoffman and Goldfrank, 1990). Despite the magnitude and the consequences that young people get as a result of abusing substances young people tend to find it difficult to use the available health services and the reasons do vary from one individual to the. Therefore, a study which shed more light on barriers to health seeking behaviour is important.This is one of the needed studies.

Stephen, *et al.,* (2013) Reports that the health and wellbeing of many young people worldwide today is seriously threatened by increasing use of illicit drugs like cocaine, heroin, bhang, etc. The use of illicit substances has serious consequences in homes, schools, and communities These serious consequences in turn affect the quality of life of these people and worse they do not utilize the health services and as a result their health conditions become worse with increasing mortality rate. So

studies which will shed more light on the barriers for health seeking and utilization is important especially to young people already affected with substance abuse.

Literature review shows that there are strong links between the risk of using illicit substances and family breakdown, economic and emotional poverty, neglect, abuse, violence, unsafe sexual behaviour and lost opportunities (Nsimba, 2013). The health, social and economic costs of illicit drug use-related problems among young people impose a substantial burden on society. The use of illicit substances is currently being reported to be on increase in Tanzania and other developing countries (Stephen, *et al.,* 2013, Nsimba *et al.,* 2010). It has been observed that in daily life the use of illicit substances has more complications compared with the substances like alcohol where people who consume beer have fewer consequences when compared with those of heroin and cocaine abuse.

2.5 Socio Demographic Characteristics

Social Dermographic characteristics discussed under this subheading include income, employment, gender, age and marital status.

2.5.1 Income/Employment

Problems with substance abuse often have serious implications for employment prospects of people affected. Zabkiewicz and Schmidt, (2007) conducted a study in the United States and followed a sample of welfare recipients over a six-year period and examined the effects of behavioral health problems and a range of psychiatric disorders, including substance abuse, on the ability of participants to find and maintain employment. The study found that ‘hostility, interpersonal sensitivity,

psychoticism and heavy substance abuse' heavily undermined chances of gaining a job (Zabkiewicz and Schmidt, 2007).

A study by Zabkiewicz and Schmidt, (2007) showed thatpersons with psychosis symptoms were 70 percent less likely to be employed than those without such symptoms. In terms of maintaining employment, the researchers found that participants with behavioural health problems kept their jobs for, on average, only 13 months, compared to others who maintained their jobs for 20 months or more. Similarly, a European study that looked at the impact of schizophrenia upon employment, in the UK, Germany and France, found that simultaneous substance abuse increased the likelihood of unemployment (Marwaha *et al.*, 2007). These findings were obtained from developed countries parallel studies in developing countries like Tanzania are important.

Henkel, (2011) conducted a study examining the impact on employment of substance abuse issues. The researcher provided evidence that female drug users may experience both greater mental health problems and greater barriers to employment than their male counterparts. Looking more closely at the differences in employment barriers between the sexes, the researchers argued that this was not necessarily due to gender but to mental health disparities Focusing on the perception of barriers to employment, the researcher reported that the more individuals perceived barriers to employment, the more likely they were to be impacted (Henkel, 2011). The authors argued that female participants may have greater barriers to employment because they also experience more mental health problems than male participants..

2.5.2 Gender

Youth health seeking behaviour has been shown to be influenced by gender, in that males are less likely to seek help than their female counterparts (Perkins *et al*, 2016), who appear to recognize the need for help more readily (Perkind *et al.,* 2016). Females hold more positive attitudes towards substance abstinence and (Aboagye *et al.,* 2013), place greater confidence in service providers. The literature suggests that health-seeking behavior patterns related to gender among young people are consistent with early childhood learning experiences. Using a sample of 213 students in second, fourth and sixth grades, (Henkel, 2014) showed that, beginning in early childhood, girls view health seeking to be more acceptable and appropriate than boys. These researchers also show that gender biases may affect how useful children expect help resources to be. For example, children preferred to ask fathers for support on tasks involving spatial-relationship skills, technical abilities, or energy, but declined to seek help from mothers on tasks involving writing, reading, attending to injury, or validating feelings.

Abongile, (2010) & Lin *et al.,* (2010) studies argued that historically, gender also appeared to affect how parents respond to children seeking help; in that previously, parents were found to be more likely to encourage dependence in female children by responding quickly to requests for help and were more likely to promote independence in male children by ignoring requests for help or providing' hints' that would enable male children to find solutions on their own. These findings suggest that boys and girls, due to family socialization patterns, develop different attitudes and beliefs regarding health seeking from early in childhood.

Several researchers (Adler et al.,2010) suggest that child-rearing practices and gender roles teach boys to see health seeking as incompatible with male norms; thereby preventing boys from embracing the' soft role' that is often associated with seeking help and suffering from substance abuse issues. Vogel, Webster, and Larson (2007) suggest that traditional male gender roles lead males to have stronger convictions than females about their need for autonomy and personal control. Hence, men may have stronger barriers based on beliefs than women.

Adler & Stewart (2010), Oluwatuyi, (2010) studies indicate that during adolescence, social pressures to act in gender-appropriate ways intensify and have been shown to be related to female tendencies to reveal problems and male tendencies to conceal problems. Because health seeking can be considered a' dependent' behavior, people may see health seeking to be more consistent with traditional and stereotyped female roles. Based on the predominance of gender stereotypes in cultural groups, it may help to determine how and whether families are seeking help for children and adolescents. For example, Rogler and Cortes argue that women are more likely to mobilize help resources and address disease issues in families that emphasize gender roles and are more likely to share in helping families seek responsibilities. Western society has long been recognized as having a tendency to socialize men to be independent, self-reliant, and achievement-oriented while socializing women aimed to make them cooperative and dependent (Abongile, 2010).

2.5.3 Education level

Empirical evidence shows that education is a significant health determinant (Albert

& Davia, 2010) Higher education levels are associated with improved health outcomes (Chou, Liu, Grossman & Joyce, 2010), youth health (Viner *et al*., 2012), and reduced mortality and morbidity (Baker, Leon, Greenaway, Collins & Movit, 2011). For example, the widely cited Marmot Review reported that obtaining a tertiary qualification is associated with increased health and longevity in health. Their study in England found that an estimated 202,000 premature deaths could be prevented if a degree was achieved by the entire population. (Marmot, 2010a).

The literature cites a pronounced gradient of education in health, suggesting that as education levels increase, the likelihood of positive health outcomes also increases. (Zimmerman, Woolf & Haley, 2015) Therefore, schooling can be recommended to be an important component in enhancing demographic groups ' life trajectories while increasing health inequalities arising from gaps in health-seeking behaviour. The dominant finding in Sub-Saharan African literature is that education is an important determinant of health-seeking behavior with lower levels of education associated with a reduced likelihood of seeking care (Anselmi *et al.,* 2015; Njuki et al., 2014; Zyaambo *et al.,* 2012). In contrast to this view, a study by Frie, Eikemo and Von Dem Knesebeck (2010). The health-seeking behavior of people in developed European countries was examined and the opposite effect was found. In other words, lower education levels were indicative of increased in activity related to health.

A Zambia-based study linked education to increased awareness of ill health, how to recognize symptoms, and increased awareness of where to go when sick. In addition, education is a proxy for socio-economic status, as education generally leads to better

employment and income, enabling individuals to have a wider range of health care choices. (Zyaambo *et al.,* 2012). The above reasoning might explain why this was the dominant finding in the literature. A study carried out in Burkina Faso, a low-income West African country; found that increased educational achievement improved the likelihood of a formal health care provider visiting (Beogo *et al.,* 2014). A possible explanation for this was provided by Caldwell *et al* (2014) who found that misconceptions and myths deterred seeking treatment from the formal healthcare sector as uneducated groups tend to perceive western medicine to be too severe for treating their infants, and believed that government health clinics only catered for the reproductive needs of females resulting in distrust and avoidance.

2.5.4 Age

In their study of age differences in heath-seeking behaviors, Ahern and Galea (2007) suggest that older adolescents are more likely than their younger ones to seek professional help many researchers refer to the transitions that take place as children enter adolescence to explain this finding. For example, emerging patterns of self-awareness and self-monitoring can make it easier for young people to recognize mental health issues and stress signs (Picket and Wilkinson, 2015). Consistent with this, Boldero and Fallon (1995) found that older adolescents (15-18 years old) perceive themselves as having serious problems more often than younger adolescents (11-14 years old). (Picket and Wilkinson, 2015) suggest differences in health seeking behaviours of older and younger adolescents may also reflect younger adolescents' tendency to believe that professional help will not be effective; this has been found in some research studies (Aboubakar, Holding and Mwangoma, 2011).

Mabuto *et al.,* (2014) reported the tendency of older adolescents to seek help more frequently than younger adolescents by stressing the newly discovered sense of autonomy of younger adolescents, which may deter efforts by Smetana, Villalobos, Rogge, and Tasopoulos-Chan (2010) Theseresaechers report that young people in early adolescence are more likely to limit self-disclosure to parents and other adults in order to place greater emphasis on peer affiliation and striving for independence. Teenagers may view help seeking as a challenge to their independence during this period. Youth, however, tend to regain a sense of closeness to parents and other adults later in life while maintaining due relationships with peers (Mabuto *et al.*, 2010; Kendall, 2008).

Adler and Stewart (2010) have demonstrated that older adolescents report fewer barriers to help seek autonomy as a result of reduced perceived needs and believe that prior mental health care has been helpfulOverall, the cognitive and perspective-taking skills acquired during adolescence enable young people to engage in the more complex thinking processes needed to reflect on alternative approaches, consider cost-benefit analysis of seeking help, and think more critically about resources that might be helpful (Abongile, 2010). Individual beliefs about how their condition is treated and the effectiveness of the treatment options available constitute a cure-control component that can be divided into perceptions of how much treatment, such as medication, is likely to help their condition and how one's own behavior can influence the course of the disease. (Oluwatuyi, 2014).

Researchers have indicated that decisions by adolescents to give up professional health assistance may result from beliefs that treatment will not help or that people

seeking help are weak. (Curtis, 2010; Komiti, and Judd *et al.,* 2006). This is illustrated by (Yap *et al.,* 2011), who examined the help young people (12-25 years old) provided to persons thought to be developing a substance abuse problem or in a mental health crisis. In the study participants took part in telephone surveys in which one of four vignettes involving depression, alcohol abuse depression, social phobia and psychosis were randomly read. The gender and age in the vignette was chosen to match the participant's gender and age; For example, participants aged 12 to 17 were reading versions of vignettes depicting a person aged 15 years and in high school.

The results suggest that the decision of young people to offer help or encourage professional help seeking was affected by the condition mentioned in the vignette; so that social phobia was associated with higher scores of stigmatizing perceptions of' poor not ill,' suggesting the impression that people with social phobia did not need treatment because they were' bad' or could control their behaviour. Overall, the findings show that the ability of young people to appreciate the severity of problems with substance abuse and to respond in a supportive way is not optimal. In general, if they considered the person with the substance abuse problem to be' bad,' the willingness of young people to identify the need for professional assistance was hampered. (Yap *et al.,* 2011)

The most powerful predictor of health-seeking behavior may be the perception of youth of what it means to seek help. For example, researchers have found that young people who associate inferiority with substance abuse and mental health problems are more likely to have negative attitudes to help seek and forget help (e.g., Chrandra

and Minkovitz, 2007). In a sample of 451 Canadian high school students (14 to 19 years old), Stanhope, Menna, and Newby-Clark (2003) found that adolescents' primary barrier to seeking informal or formal help for a stressful problem was the belief that one should be able to handle the problem independently. Similarly, youth have been found to be less likely to seek help when they believe they contributed to the problem, feel the problem is unique to their experience, or fear being seen as inferior or dependent on others (Nadler, 1991; 1997).

Additional factors that influence parental attitudes to seek professional help for adolescent difficulties. Benjamin et al. (2009) conducted eight focus group discussions in a qualitative study with parents who had concerns about the emotional health or behavior of their child (age 2 to 17 years). The results suggest that the attitudes of parents towards seeking help are affected by their understanding of adolescent issues, their ability to cope with adolescent problems, their mental health awareness, and the availability of resources.

Parents also recorded attitudes that may be inconvenient to help search (e.g., limited available appointment times, appointments perceived to be too short in duration), led to feelings of embarrassment or blame, may result in children being labelled, and in extreme circumstances may result in having children removed from the family home setting. Negative attitudes towards seeking professional help seemed to be mitigated by parental expectations that practitioners were involved in children, good contact with clinicians, quality of treatment (e.g., long-term relationships with the general practitioner) and trust in a general practitioner. (Benjamin *et al*.2009).

In addition to psychological and social changes, young people undergo significant physical changes during puberty, rapid growth and development, and sexual maturation. This often leads to problems of personal identity, self-awareness and emotional independence. They may engage in behaviors that are considered experimental and risky in an attempt to cope with the complex changes and development challenges (Breinbaucher, 2005). As a result, during these years, several important public health and social issues either begin or peak, including homicide, suicide, substance use and abuse, sexually transmitted infections, and teenage and unplanned pregnancies.

One of the most common problems in adolescents and young adults is preventing the successful development of young substance abuse. In fact, abuse of substances is genetic (Rivers *et al*., 1997). Substance use disorder is on the rise among youth and it is a public concern as it results in health and social problems that have negatively affected a significant number of people. According to (UNODC, 2008). 205 million individuals are involved in substance misuse worldwide. Of these, 25 million people are estimated to be problem drug users, many of whom are unable to stop without treatment. That is why this study aimed at looking to health seeking behaviours among youth involved in substance abuse in order help them to stop from abusing substances.

The World Drug Report (2017) revealed that in recent years the use of illicit substances has increased throughout the world. The study further notes that the rising accessibility of many types of drugs to a growing socio-economic spectrum of

customers is a major trend in the world. The report argues that opiates (particularly heroin) continue to be the main problem drug at global level, followed by cocaine. Of example, opiates were the main problem substance for most of Europe and Asia, accounting in 62% of all care in 2003. Statistics from a total of 95 countries revealed that drug seizures increased fourfold in 2003, of which more than half were of marijuana.

Substance abuse not only hinders the economy, as supply management and demand reduction are costly undertakings, but it is also a blow to the country as its youth become less competitive. Substance abuse, including smoking and drinking alcohol, places substantial costs on patients and their families, taxpayers, the national economy and the society as a whole, according to the Ministerial Council on Drug Policy in Kenya (2005). International studies indicate that half of the long-term smokers die prematurely. (Doll, 2004). A significant proportion of adolescent populations use substances or alcohol to the extent that they are adversely affected by their health, interpersonal relationships or school performance (Johnston et al., 2003). The studies also suggest that smokers are four times more likely to suffer a heart attack before age 40 than non-smokers. (Mahonen, 2004). Moreover, the earlier youth begin to smoke, and the more they smoke throughout their lives, the more likely they are to suffer from smoking-related diseases. The phenomenon of substance abuse and its effects is worldwide and is not unusual for Tanzania.

Substances widely used by adolescents and young adults are cigarettes and alcohol, with marijuana use accounting for 90% or more of the illegal use of substances in

North America, Australia and Europe (Alexander, 2001, Canadian Centre for Substance Abuse 2002). In the context of Tanzania there are also some studies which have also been conducted and According to Joseph Mbatia in their study done in Dar es Salaam revealed that prevalence of substance use was found to be 17.2%. 8.7% and 0.8% for alcohol, tobacco and cannabis, respectively (Mbatia *et al.*, 2009). These findings are pointing out similar trends of youth abusing mostly alcohol and tobacco and cannabis is mostly abused illegal substance and this may be explained by their availability, accessibility and affordability among youths worldwide.

There is substance abuse by young people from different socio-economic backgrounds. This is evident from research in urban and rural areas (Madu & Matla, 2003; Plüddermann *et al.*, 2007), It indicates that substance abuse exists not only among poor families, but also among wealthy families. Drug and alcohol use initiation is most likely to occur during puberty, and some older adolescents experiment with drugs is normal. For example, the results of the survey of the future (2010).

A national survey on drug use rates in the United States, found that at some point in their lives 48.2% of 12th graders reported using illicit substances (Johnson *et al.,* 2011), suggesting that substance abuse is a common problem among young people than adults Many researchers have revealed that young people are beginning to use substances and alcohol for a number of reasons: improving their mood; receiving social rewards; reducing negative feelings; and avoiding social rejection. (Kuntsche, Knibbe, Gmel, & Engels, 2005) A study by Terry *et al.*, (2009), revealed peer

pressure and other social factors as reasons for initial use of substances during teen years. Similarly, evidence from the developing world shows that sex, type of family, lack of parental guidance, faith and poor academic performance were associated with substance abuse among the youth (Fatoye, 2003).

2.6 Awareness of Available Treatment Options and health seeking behaviours

Knowledge of substance abuse and resources for health research has been consistently recognized as a barrier to curb substance abuse and mental health problems (Carolyn *et al*., 2010). For instance, not being aware of where to go to get help getting help (Jones, Simon and Singleton, 2010) or not knowing of the importance of an individuals' behavioural changes have been reported as barriers to obtaining professional services. Given the opportunity to identify reasons for not seeking professional assistance, approximately 8% (n=58) of CCHS participants indicated that their lack of knowledge of professional resources had prevented them from obtaining the assistance they thought they needed (Galdas, *et al.*, 2005). In general, young people (aged 12 to 19) in CCHS were found to be more likely than adults to identify a lack of knowledge as an obstacle.

Statistics Canada, (2009) & Galdas uses a questionnaire to measure youth barriers. (2005) It was found that high school students most frequently attributed their lack of professional assistance seeking insufficient time, beliefs that families and peers provided sufficient assistance, and not knowing where to get professional assistance. Females were found to be less likely than males to report a lack of knowledge as a

barrier (Koopmans and Lamer, 2006). Young people with previous professional resource experience were least likely to report a lack of knowledge as a barrier to health seeking behaviour (Koopmans and Lamer, 2006.)

Health seeking behavior models suggest that lack of knowledge may hinder, if not stop, efforts seeking help. Recognition of an issue is based on the awareness of adolescents about the symptoms of distress and the level of personal insight of adolescents. This means that youths must have access to the knowledge necessary to assess whether or not they have known symptoms. Understandably, adolescents with undetected or minimized problems may not consider seeking available treatment options.

In addition, the health-seeking process can be terminated prematurely if the knowledge of young people does not sufficiently prepare them to anticipate the difficulties associated with waiting, negative health-seeking experiences and the time required detecting therapeutic benefits. Thus, the knowledge of young people may not only prevent them from realizing their need for help, but may lead them to abandon the process of seeking help if they fail to prepare themselves adequately for the barriers ahead (Noel *et al.,* 2006). Successful search for health requires young people to know enough to appreciate what is unknown, what can be known, and where information can be obtained.

Prasad (2009) used focus groups with 48 adolescents aged 14 or 15 years to explore youth awareness of substance abuse information. Overall, the results suggested that

the knowledge of adolescents about substance abuse services was limited to general practitioners ' abilities (e.g., family doctors). Compared to adults, adolescents are found to be more likely to think that general practitioners are not suitable professionals to copie with substance abuse problems and may be too judgmental and close to parents to provide adolescents with tolerance and confidentiality in supporting sources (Jain *et al.,* 2006.);

Other researchers have replicated this finding (Holmes *et al.,* 1996). Most participants were unsure of their right to consult with general practitioners in the absence of a guardian. Adolescents were also uncertain about what information should be kept private and rarely understood what the term "confidentiality" meant. Many adolescents also reported concerns about sharing their personal health information with their parents. Ultimately, the uncertainty of participants about consumer rights and available sources of support led to substantial delays in getting suitable.

Thuan et al. (2008) found that the accessibility of service and the characteristics of the parents of adolescents (e.g. mental health knowledge) were prominent factors associated with the use of adolescent service. That is, health services aimed at attracting young people have consistently attracted a larger proportion of young people and have been more successful in addressing comprehensive healthcare needs compared to services intended for the general public. In addition, parental education was positively associated with references to specialty services by adolescents, such as child psychiatrists. The awareness by teachers and parents of adolescent substance

abuse problems or the existence of comorbid conditions (e.g., anxiety and depression) also seemed to increase the likelihood of adolescents finding and using medical services (Gernal *et al.,* 2014).

According to a study conducted in India, it was noted that inadequate education and lack of awareness of the services and entitlements available and lack of family support for women reinforcing low self-esteem; hopeless poverty that drives health to a low priority; and the prevalence of culturally influenced activities that may be detrimental to health in certain circumstances are among the key factors. (Prasad, 2009). These factors might be applicable to youth with substance abuse because most of youth who abuse substances, do not get support from their families and they might not consider health as a priority to them. Most governments, especially in the developing countries do not put much emphasis on the substance abuse and mental health. However, the findings from this study will shed more light as to whether these findings are applicable to this group and this context.

In general, managing the overall quality of service and the quality of public administrative services requires full awareness of the differences between the expectations of consumers and perceived values as part of management, supplying organizations and customers. According to Pasareamu *et al.,* 2015, the biggest gap is between customer service prospects and their perceived value in the service delivery system. To be sure, the expectations of users are influenced by their past experience and purchases, as well as those of other clients, and even the engagement of service providers. The lack of awareness and health facilities in rural areas, in turn, results in

a high incidence of sexually transmitted diseases / respiratory tract infections (Hausmann, *et al,* 2014). This finding might also be true in town settings and to youth with SUD as it is logical that if somebody is not aware of an existing health facility and the services that are offered by that facility the chances of using the services will be minimal.

Research on barriers to Chinese access to health and rehabilitation services among substance abusers has identified one of the barriers including communication difficulties and knowledge gaps among substance abusers (e.g. misunderstanding what services are available, including the important role of primary health care as a first point of contact) (Edlund *et al.,* 2012). However the study did not focus much on youth and was done in Asia. Therefore the current study focus more on youth and is relevant to Tanzania.

2.7 Youths perceived health status and Perceived Need for Substance Abstinence services

This section focuses on youths, families and friends and their perception of adolescents' mental well-being, ability to face day-to-day demands, and psychological distress (Aboubakar, Holding and Mwangoma, 2011). While many factors deter adolescents from seeking professional help, increased psychological distress has been found to increase adolescents' willingness to seek professional help (Abongile, 2010).

Youths have been recognized to seek professional help more when they perceive increasing levels of symptom and problem severity. In this way, distress is thought to

motivate adolescents to overcome barriers to professional help that they may have previously been unable to overcome (Sheffield *et al*., 2010.). For example, Zwaanswijk *et al.,* reported that approximately six percent of adolescents sought help when they perceived themselves as having minor emotional or behavioural problems, but approximately 18 percent of the adolescents sought help when they perceived that their problems were serious.

The CCHS assessed participants' perceived need for professional help using self-report measures of health status, stress, and impairment to daily functioning. The results revealed that 88 percent of individuals aged 12 years of age or older (n=125,493) indicated excellent or good health and 74 percent of the sample considered their life to be 'a bit' stressful at most (Sareen *et al.,* 2005). A small minority of the sample reported having to stay in bed or cut down on regular activities for all or most of the day.

Overall, only 12 percent of respondents perceived a need for substance abuse treatment (Katung *et al.,* 2001). Despite this, measures of distress revealed that approximately 20 percent of CCHS respondents needed substance abstinence services; suggesting that a significant number of people failed to recognize a need for help. CCHS researchers attribute the noted discrepancy to the possibility that participants were unaware of early signs of substance abuse problems or had a higher tolerance for distress than research suggests one should tolerate without seeking professional help (Sareen *et al*., 2010).

When compared to older age groups (i.e., 25 to 44 years, 45 to 64 years, and 65 years and over), respondents aged 15 to 24 years were found to have highest rates of substance abuse problems (Bergeron *et al.,* 2005), indicating that they may be more likely to tolerate symptoms and are at a higher risk for failing to recognize substance abuse problems at early stages. Respondents who were aware of their needs for professional services were more likely to have co-occurring conditions, and thus, greater levels of psychological distress (Urbanoski *et al*., 2008).

The nature and perceived severity about the index illness have also been cited as important determinants of health-seeking behavior (Kanungo et al., 2015). In a recent study, Peppa, Edmunds, and Funk (2017) explored health seeking behaviors among individuals with influenza-like illness in an internet based cohort; they found that individuals with fewer symptoms were less likely to seek medical care, while those with more severe and protracted symptoms were more likely to seek care. As cited by Okwara (1999), individuals with "non-serious" disease such as "fever" are more likely to ignore the problem altogether, or to resort to self-medication at best, while those whose conditions are severe enough to interfere with routine activities of life or pose an imminent threat to life, are more likely to seek the services of professionals for diagnosis and treatment.

2.8 Pattern of health seeking behaviour

Studies from North American have revealed the role of geographic locations of services (Rosenblum *et al.,* 2011, Schimitt, Phibbs and Piette 2003) and patient's lack of confidence or trust in the health system as key access reason or barriers

(Mayosi *et al.,* 2014). Substance abusers not considering themselves as ill or lacking or have less motivation for treatment (Sexton *et al.,* 2008), and culturally unsuitable service contexts, are additional reasons for not accessing treatment (Neale, Sheard and Tompkins, 2007).

Studies from Nepal pointed out that members of one's social network highly influence a sick person's ability to access health care. Research participants in a study in the Saptari District of Nepal emphasized the importance of social capital in accessing health care. The use of social networks through friends, family and relations, were shown to be critical in gathering information and support relating to health care, services, and financial help (Dedenhardt *et al*., 2010). One-way support can be provided by taking over the sick person's chores, work, or housework. Spouses mainly take over this responsibility, however, other family members, such as parents and children, also help in this capacity. Less often, one's neighbors and friends take part in helping to alleviate the burden of work of an ill person (Harris *et al,* 2011).

Studies from Europe, Asia and America have suggested that the major barriers to accessing health services among drug addicts include concerns about confidentiality and embarrassment in disclosing their health issues (Elliot, 2004,) In addition a study conducted in Canada to examine the experiences of drug users attempting to access health care, their finding indicated that drug users encountered many barriers when attempting to find care, including lack of system resources, discrimination,

lack of communication with service organizations, insufficient financial resources, and poor social support networks (Lang *et al.*, 2011).

These findings might also be applicable in the Tanzanian setting as most people with substance abuse may have similar characteristics. However the findings from this study will shed more light on the barriers for health service utilization among youth with substance abuse in the Tanzanian context are. Families of youth with drug problems revealed being too embarrassed to address anyone about the concern and of feeling that they should be able to 'sort things out themselves (Johns *et al.*, 2010). Stigma also has a big impact on recovery once in treatment. The low self-esteem of people in treatment prevents a belief in recovery.

Health seeking behaviour can be seen as generally positive or negative views of a person (e.g., mental health professional), place (e.g., mental health centre), thing (e.g., medication), or event (e.g., therapy) encountered in the help-seeking process. Adolescents with favourable attitudes toward professional help seeking are more likely to seek professional help than those with unfavourable attitudes (Myers *et al*., 2004). Examples of such positive attitudes include having confidence that service providers will be able to help alleviate ill health problems (Myers *et al.,* 2004) and believing that help seeking can facilitate future independence (Abongile, 2010).

Evidence around the globe suggests that there are small proportions of substance abusers who receive social or health services including treatment. For example, data from North American suggest that only limited proportions of substance abusers

receive health services (Loyd *et al.,* 2010) and receive targeted interventions only or services for key health risks, such as sexual transmitted diseases (STD) risks or problems (Mumola *et al*., 200.4). A mixed range of barriers for substance abusers not seeking and utilizing available services have been recognized. In Latin-American the barriers that were reported in accessing substance abuse treatment include: lack of treatment professionals and services; excessive costs; perceived stigma; insufficient or lack of treatment or medication options; long queues associated with long waiting times or limited working and opening hours; geographic distance or lack of transportation options (da Silva *et al*., 2009).

2.9 Extent of the Problem of substance abuse in Tanzania

The extent of substance abuse is the area of interest for this study. To date there is no proper records of substance abusers in Tanzania.However, a MOH report shows that there were more than 200,000 heroin users who were in need of treatment in year 2011 (MoH, 2011). The study conducted by the Drug Control Commission (DCC), which is one of the most recent, and relatively comprehensive, estimates the number of PWUD (hard drugs) across regions in Tanzania were: 5,190 in Tanga, 3,300 in Mwanza, 2700 in Arusha, 1,539 in Pwani, 1,500 in Morogoro, 1,096 in Dodoma, 820 in Mbeya, 563 in Kilimanjaro, 319 in Shinyanga, 108 in Geita, `100 in Kigoma, and 65 in Mtwara. The estimated number of PWUD was 540 in Tanga, 300 in Mwanza, 297 in Morogoro, 230 in Arusha, 164 in Pwani, 133 in Dodoma, 107 in Kilimanjanro, 64 in Mbeya, 25 in Shinyanga, 7 in Mtwara, 3 in Geita, and 0 in Kigoma (DCC, 2015).

The report from the drug control commission (2015) further points out that, across all regions illicit drug use was increasing; with Heterogeneity in the magnitude and type of drug use epidemic across regions. Cannabis was the most common illicit drug used, followed by heroin. Drug use hotspots were more numerous in regions with major roadways, and commonly located near bus stops or intercity bus stands within municipalities and along main roads. Indeed, drug use is also a deep-rooted behavior in Tanzania where the commonly abused substances in the country includes tobacco, cannabis, khat, heroin, alcohol, inhalants and cocaine. Heroin use is commonly through injecting in most parts of the country. Drug use became an increasing public health and social concern in the past decades worldwide (UNGASS, 2010).

The majority of People Who Use Drugs (PWUD) are engaged in smoking "cocktail" which is a combination of cannabis dust, tobacco and heroin and few PWUD injected or had ever injected drugs. Those who were identifies as PUID appeared to have injected heroin. Within all regions several primary and secondary key informants could not distinguish heroine from cocaine by name, but instead referred to both as "unga", a slang term that describes white, brown or khaki – coloured drugs in powder form. In all regions needle sharing was high among the small number who engaged in injection drug use. Risk sexual behaviours (e.g. sex without condom, multiple sex partners and transactional sex) also appeared high among PWUD (DCC, 2015).

The study also depicts that individuals believed in that the use of drug to use drug was often stigmatized by community members. Community members did not trust

drug use individuals and often referred to them with derogatory terms such as “teja” (addict). Teja refers only to those who use unga; Members were more prone to accepting those who smoked cannabis or used khat. Also, data from the DCC for the year ended 2013, (Taarifa ya Hali ya Dawa za Kulevya ya Mwaka 2013) indicates that in 2013, 127 hectors of cannabis and 1,107 sacs as well as 3,445 kilograms of cannabis were destroyed in Arusha, including the netting of more drug dealers than the previous years. Also, 85 tones of cannabis were netted compared to 48 tons in 2012, 12.8 tones of khat were also netted compared to 5.2 tons for the year ended 2012 which attests to the fact that the problem is growing.

Substance abuse has played a major role in the spread of HIV/AIDS in many countries. The high level of HIV infection among substance abusers is a major health problem of international concern today (Degenhardt *et al,* 2010). A survey of 4042 HIV-infected people in United States reported 45% of participants had a history of substance abuse and of these, 20% had injected drugs (Chander & Moore, 2006). The Tanzanian Participatory Poverty Assessment recognized the linkages between poverty and overall ill health but did not explicitly consider the role of illegal substance use, which may be crucial in linking economic and social development and research on these linkages, may assist effective interventions (URT, 2004).

2.10 Policy Review

The Government of the United Republic of Tanzania (URT) has seriously considered the problem of substance abuse and trafficking and has been upgrading narcotic and psychotropic substance control legislations. I t enacted the Drug s and Prevention of

Illicit Traffic in Drugs Act, No. 9 of 1995. The Act consolidated and repealed the previous laws, strengthening control over substance abuse considerably enhancing the penalties particularly for trafficking offences. This legislation provides for various offences related to drug trafficking and abuse accompanied by stiff penalties. For serious drug trafficking offences, there is no bail for the accused and upon conviction they may be sentenced to life imprisonment. The law also provides for the forfeiture of properties derived from and or used in illicit drug trafficking and recognizes and provides for the treatment of drug addicts and other drug reduction activities.

The drug problem, which was perceived to b e a criminal action and dealt by law enforcement, has now been a multisectoral issue. The Act established the Drug Control Commission with the role of defining, promoting and coordinating multisectoral responses on drug control.

The URT, in realizing the problem of drug abuse and trafficking has ratified the following conventions.

- The Single Convention on Narcotics Drugs, 1961 adopted by the United Nations Conference at New York in March 1961.
- The United Nations Conventions on Psychotropic Substances, 1971 adopted by the United Nations Conference at Vienna on February 1st, 1971.
- The United Nations Protocol amending the 1961 convention on Narcotic Drugs Adopted by the United Nation Conference at Geneva in March 1972.

- The United Nations Convention against Illicit Traffic in Narcotics Drugs and Psychotropic Substances adopted at Vienna on 19th December, 1988.
- The Protocol on Combating Illicit Drug Trafficking in the Southern Africa Development Community (SADC) Region, 1996.

2.11 Research gap

Research gap implies a lack of empirical studies ,either from a certain theoretical perspective or methodologica approach. Moreover, a research gap can be determined by a sense of the lack of clarity of the relationship between the variables of the unexplored phenomena or a research gap can be an area in which previous researchers are silent (Grant and Pollock ,2011). Muller-Bloch and Kranz (2015) identified research gaps as a fundamental goal of literature review . In the current study, after a review of literatures, some gaps have emerged, First ,it has been noted that despte a large and rapidly expanding literature on substance abuse such as (Yusuph, 2016, Mbatia et al 2009, Masibo 2013, Mbwambo 2012, Msami 2004), there is limited information that any empirical study has been conducted to assess the deteminants of health seeking behaviours among youths involved in substance abuse in Tanzania. Previous empirical studies have focused on examining the prevalence(Mbatia et al 2009) , cause, effects (Matowo, 2013, Msami 2004) , drug traficking use and HIV risk (Mwambo et al 2012) Knowledge attitude and practice of psychoactive substances (Masibo 2013) Factors predisposing youths into substance abuse (Nsimba et al 2012). On the other hand previous studies on health seeking behaviour have focused on illnesses such as malaria (Sekule, 2007), Tuberclosis TB (Tarimo,2010) , Diabetes (Nguma,2010). However, very little is known about health seeking behaviour among individuals with substance abuse problems, especially

youth, in Tanzania. Therefore, this study tried to bridge this gap of knowledge by assessing the socio-demographic characteristics, awareness, perception of heatlth status and pattern of using substance abstinence services among youth involved in substance abuse in Tanzania.

Conceptual Framework

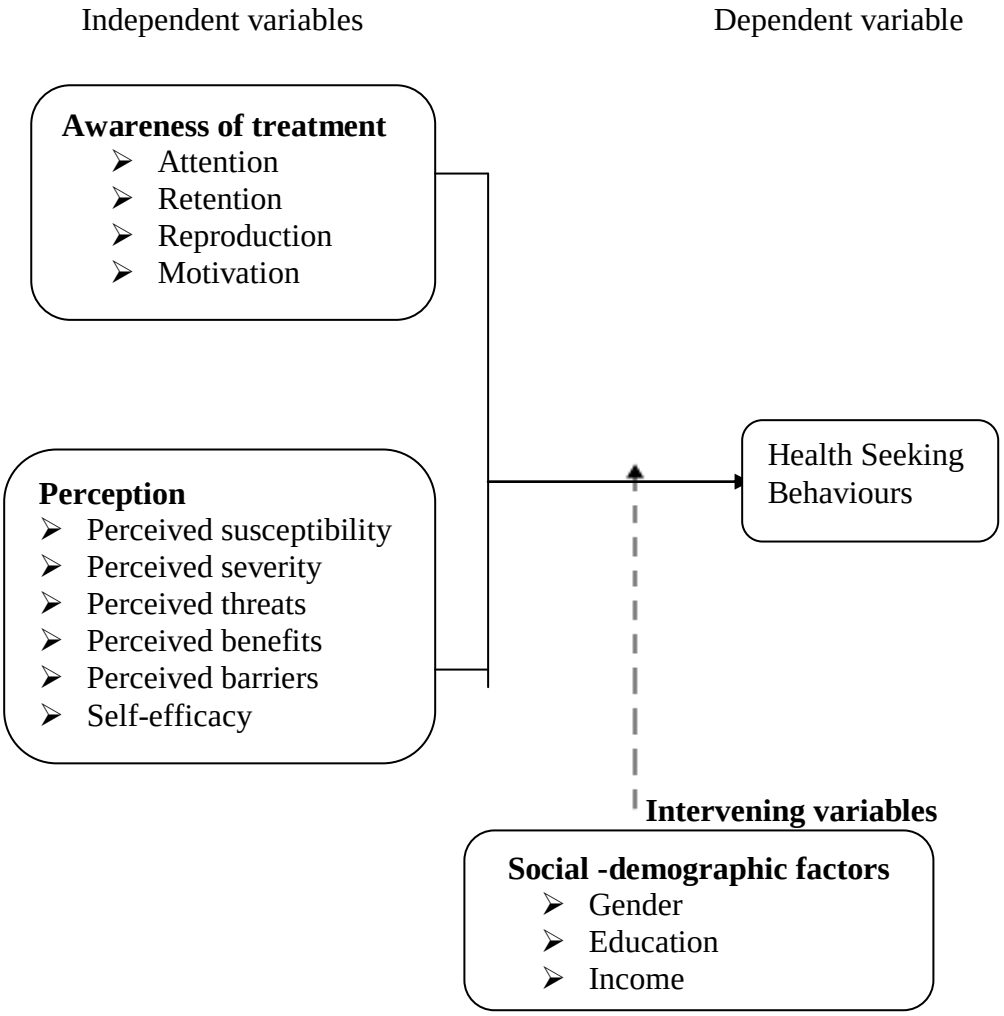

Figure 2. 3: The Conceptual Framework of the Study

Source: Adopted from Health Belief Model, TPB and Social Learning Theory by the researcher (2017)

This conceptual framework indicates that for an individual with substance abuse problem to seek and utilize the available treatment options he/she has to be aware of the available treatment options, and aware that the substance abuse problem can be treated successfully with the available treatment options. The individuals with substance abuse problem need also to have a positive perception regarding the available treatment options and their health status need to be perceived that it needs a special kind of attention from the available treatment options and is even facilitated by the income, education and gender of that individual with substance abuse problem.

2.12 Dependent Variable

The outcome/dependent variable is the health seeking behaviour. This variable is measured as a dichotomy: checking whether there are positive health seeking or. Negative health seeking behaviours among the youth.

2.12.1 Independent Variables

The independent variables included: social- demographic characteristics, awareness and perceptions. Each of the study variables was measured as follows:

a) **Social demographic characteristics**: The study classified the participants according to their social dermographic characteristics and their health seeking behaviours.

b) **Awareness of the available treatment options:** The awareness variable has to do with the extent of information youths had regarding available treatment options within Kinondoni Municipality.

c) **Perception of youth's health status:** The perception variable has to do with how youths with substance abuse problem perceives their current health status

d) **Patterns of health seeking:** The patterns variable refers the characteristics like distance, means of transport and time taken to reach available services

CHAPTER THREE

METHODOLOGY

3.1 Chapter Overview

This chapter provides the research methodology for this study. Methodology in research refers to how a researcher goes about practically finding out whatever he or she believes can be known (Antwi and Hamza, 2015). This chapter discusses the following: the research philosophy, research design, area of study, target population, sample and sampling procedure, research instruments, validity and reliability of instruments, data collection, data analysis procedure, ethical considerations and procedures followed to ultimately produce a comprehensive research report.

3.2 Research Philosophy

Research Philosophy is an important part of research methodology. It guides the collection of data in an effective and correctly manner (Johnson and Christensen, 2005). Yin (2009) defined research philosophy as a belief about the ways in which data about a phenomenon should be collected, analysed and used. In reality, failure to understand the philosophical issues in a study can gravely affect the quality of research because it is the research philosophy that helps the researcher to clarify develop the relevant research design. Knowledge of research philosophy helps to recognize which research design will work and which one will not work for a given research problem.

In other words, the research philosophy provides the researcher with knowledge to make decision about a specific research design (Thorpe *et al* .2002). In this study a

pragmatic research paradigm was adopted. Paradigm refers to the modes of thinking about the conduct of research on any social reality (Omari, 2011). The model, according to McBurney and White (2007), consists of a set of laws, concepts, methods and implementation that form a tradition of scientific research. Pragmatism is not devoted to theory or truth in any one framework. It applies to mixed research methods, since investigators freely draw on both quantitative and qualitative assumptions when engaging in research. (Creswell, 2007). Researchers have the freedom of choice for collecting and analyzing data that best meet the defined needs and purposes rather than subscribing to only one way.

This study embraced the qualitative research approach where views, feelings and opinions of the targeted population relating to health seeking behaviours among youth were gathered. The study also used quantitative approach with the aim of producing quantifiable data where frequencies, percentages and averages were used to establish the pattern of behaviour being studied. Cohen *et al.,* (2007) asserts that the use of two or more methods of data collection attempts to map out or explain fully, the richness and complexity of human behaviour by studying it from more than one stand point. In the present study the use of qualitative approach was used to increase the depth of the researchers' understanding and accuracy of the findings.

3.3 Research Design

A research design is a blueprint or road map which addresses all the necessary areas in the research project. It gives information of what the study is all about, its particular purpose, where the study was conducted, what kind of information was

required, where to obtain the required information, the time taken for the study, techniques used for data collection, how data was obtained, analysed and reported (Kombo and Tromp, 2006., De Vaus, 2013).

Descriptive cross-sectional study is a study in which the phenomenon of interest or condition and potentially related factors are measured at a specific point in time for a defined population (Creswell, 2007). This study used the descriptive cross-sectional research design with both qualitative and quantitative approaches. The research design was used because it is appropriate for the nature of the study and useful in providing quality data that can inform this study. It is both relevant and effective in generating data at a particular point in time. It was designed and carried out by developing procedures and tools that help to capture respondents' perspectives about issues. It also played the role of sketching out research processes for the research objectives and research questions to data collection, analysis and interpretation of the findings (Kothari, 2004). In this study youths with substance abuse problems who were found in the hang outs were screened by administering a seven item questionnaire and those who scored three and above questions out of seven were given the consent form and those who consented were given the main questionnaire which was guided by the researcher's assistant.

On the other hand, the community leaders, health workers, social workers and influential people like religious leaders were solicited and involved in in-depth interviews and focus group discussion to solicit their experiences regarding substance abuse by youths in their respective areas. This design was selected because

it is flexible and helps to obtain a lot of information in the course of the research (Polit *et al.,* 2004). Through this design the researcher examined a common set of features on several cases expressed in numbers. This design also involved the collection of data at one point in time, utilizing a combination of activities including extensive literature review, consultations with experts and respondent communities to provide socio-economic oriented findings (Bryman, 2008). The cross-sectional design enabled the researcher to determine the HSB and the associated determinants. Also, through analysis of data from the survey questionnaires the researcher managed to establish the patterns of behaviours involved in the area of study.

Table 3. 1: Framework of Research Objectives, Design, Data Collection Method and Their Analysis.

Study aims, designs, samples, analysis and publications					
Study aims,	Designs, approaches	Data collection methods s	Study period	Data Analysis approach	Paper
Socio-demographic characteristics of substance abusers	Quantitative	Sample survey questionnaire to 300 substance abusers	October 2016	Logistical regression	
Awareness of the available treatment options	Quantitative and qualitative	In-depth interviews and Six FGDs for substance abusers, health workers, social workers, community development officers, community leaders and key opinion leaders	October 2016	Content analysis, cross tabulation	

Perception of drug abusers of their health status	Quantitative and qualitative	Sample survey questionnaire to 300 substance abusers In-depth interviews to 12 substance abuse Six FGDs to substance abuser, for health workers, social workers, community development officers, community leaders and key opinion leaders	October 2016	Content analysis, cross tabulation	
Patte rn of use of available health services	Quantitative	Sample survey questionnaire to 300 substance abusers	October 2016	Content analysis, cross tabulation	

Source: Field Data 2016

3.4 Research Approach

The study used a mixed methods approach which combined both quantitative and qualitative data collection and analysis into one empirical study. The methods involved integration of philosophical assumptions, using both quantitative and

qualitative approaches in the study. It is thus more than simply collecting and analyzing both kinds of data concurrently. It also involved the use of both approaches in tandem with the overall strength of a study making it greater than either one of the two approaches (Creswell, 2009 and Creswell, 2014). A major advantage of using the mixed methods in the present study was to enable the researcher to answer confirmatory questions relating to the research problem in question through the administration of both open and closed ended iterms in questionnaires, interviews, focus group discussions and also field observation schedules.

In this study the reseacher employed the concurrent mixed method approch which had four variants namely; convergent model, data fransformation model, validating quantitative data model and mult level model (Creswell & Plano Clark, 2011). The convergence model according to these authors, invoves separate collection and analysisof qualitative and quantitative data on the same phenomena. In the data transformation model, collection and analysis of quantitative and qualitative data are also handled separately.

The reseacher employs different procedures to transform one type of data into another form. The process is known as qualifying quantitative data or quantifying qualitative data (Tashakkori & Teddlie, 1998) in addition, validation of quantitation of quantitative data model occurs when the reseacher wants to validate and expand the quantitative findings from a survey by including open ended qualitative questions. The same survey instrument is used to collect both qintitative and

qualitative data. Multilevel model employs different levels within a system. The findings from each level are merged during the overall interpretation of data to make multiple inferences (Tashakkori & Crswell 2007)

Concurrent mixed method approach in research

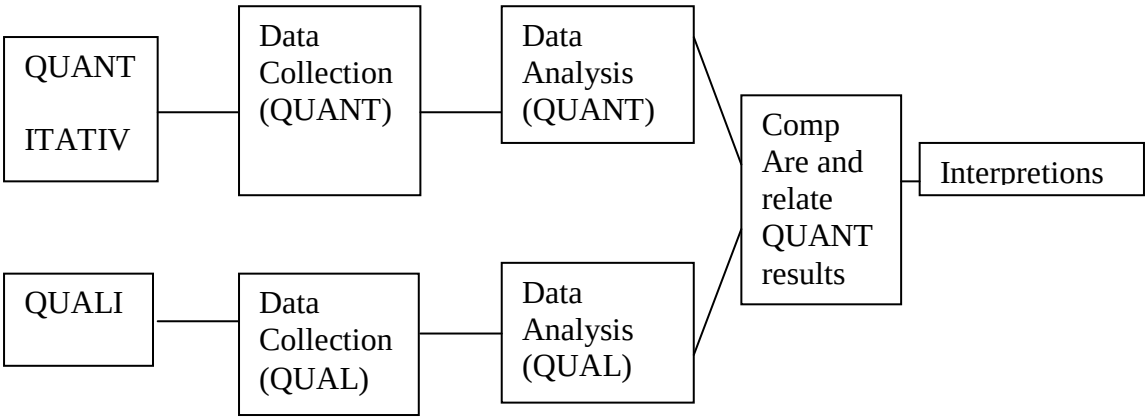

Figure 3. 1: Concurrent mixed method approach Adopted from Creswell, 2014

3.4.1 Qualitative Approach

This study used qualitative approach in the form of phenomenological design that tried to study a lived experience of a certain phenomenon in its natural environment (Cohen, 1987). This approach was concerned with meanings, which the informants attributed to social interactions and situations. Thus, it was helpful in describing and understanding the essential lived experiences of youth with substance abuse problem (Creswell, 2007), and understanding the determinants of their health seeking behaviours. The act of getting out into the field using phenomenological inquiry

enabled the researcher to gain a deeper understanding of behaviour of youth involved in substance abuse. Another rationale of using phenomenological design was associated with the nature of the main research participants who were mainly substance abusers and people who are associated with them in one way or another.

3.4.2 Quantitative Approach

Quantitative approach was also used in the form of survey with structured questionnaires which were easier to conduct and cost effective. This helped to determine the awareness, social demographic factors, perception, and patterns of health seeking and utilization behaviours among youth involved in substance abuse in Kinondoni Municipality.

This study employed cross sectional research design for determining linkages between factors by observing all parameters at the same time. It is one of the research methods commonly used within the social science under this research design variables of interest in a sample subject examined once, and the relationship between them determined (Bryman, 2004). It utilizes different groups of people who differ in their varied of interest, but share other characteristics such as socio-economic status, educational background and ethnicity (Bailey, 1990).

3.5 Area of Study

The study was conducted in Kinondoni Municipality in Dar es Salaam, Tanzania. Dar es Salaam region was chosen due to its cosmopolitan nature. It is the commercial capital of Tanzania and has cultural diversities due to in/out migration of people from

panterritorial urban and rural settings. It was also one of the regions that are mostly affected with substance abuse and has well established services for individuals affected with the problem of substance abuse. Kinondoni Municipality was chosen purposely among the three Municipalities of Dar es Salaam Region. The reason for selecting the study area of Kinondoni was that was the mostly affected district in Dar es Salaam and has a well-established treatment system for substance abuse (DCC, 2008 TAYOA, 2014).

3.5.1 Location

Kinondoni Municipality is located in the Northern part of Dar es Salaam. The other Municipals are Temeke to the far South East, and Ilala to the South. In the East is the Indian Ocean and to the North and West is the Coastal Region of Tanzania

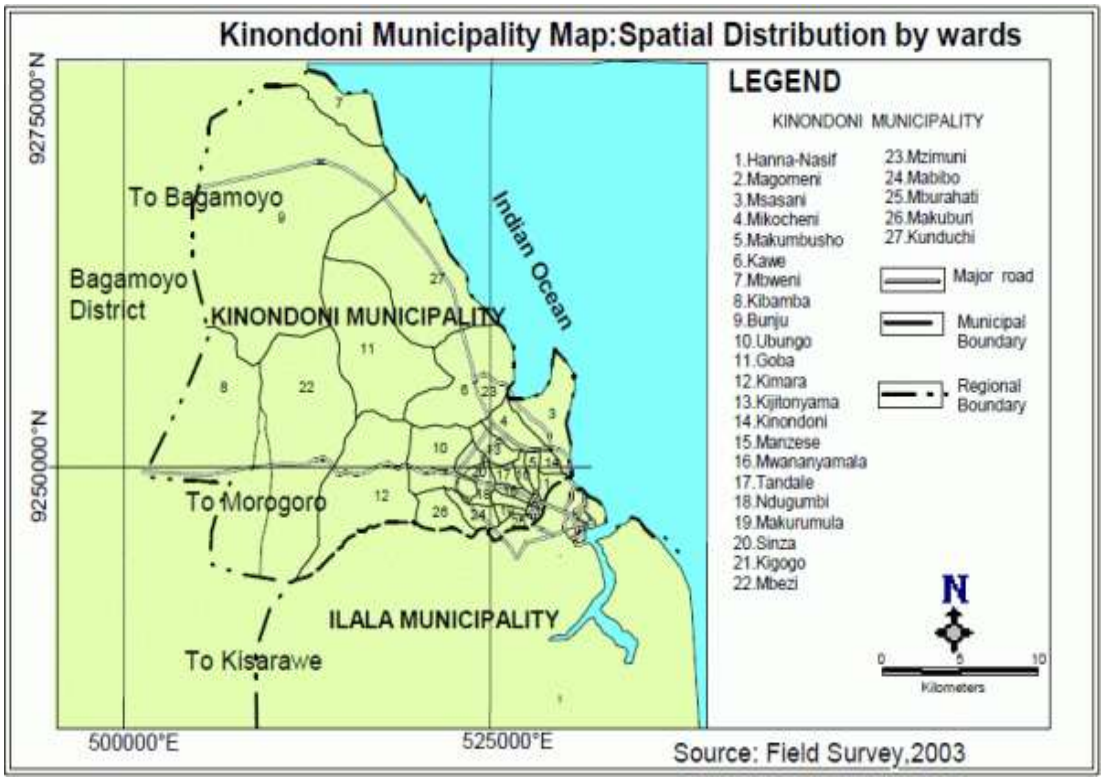

Figure 3. 2: Map of Kinondoni Municipality

3.5.2 Population

Kinondoni Municipality covers an area of approximately 531 square kilometres. The Census of 2002 showed that the population of KinondoniMunicipality was 362,111. The Census of 2012 showed that the population had risen to 983,199 (Census, 2002-2012). The current estimate population is 1, 083,913 people (DCC, 2014).

3.5.3 Main Economic Activities in Kinondoni District

The main economic activities of residents of Kinondoni include; trading, farming, fishing, small manufacturing industries, tourism, transport and communication, urban agriculture, mining and quarrying, construction, public service and financial services (DCC, 2014).

3.5.4 Health Services

The provision of health services in Kinondoni District is under the Department of Health and Cleaning. Among the responsibilities of the Department of Health and Cleaning is to offer health services to members of the community through the main health facilities of Mwananyamala Hospitals, health centers and through numerous dispensaries located in various wards of the Municipality (DCC, 2014). The Municipality has two government hospitals, namely Mwananyamala and Palestina. There are also the Tandale Health Centre, Magomeni, Health Centre, Kimara healh Center and at least one dispensary to each ward. All these are government owned facilities and many other private health facilities which have health professionals also exist and can provide services at some level including referral services including for treatment of substance abuse.

3.6 Study Population

A research population refers to all members involved in issues or events having the same characteristics that are of interest to researchers (De Vaus, 2013, Rick and Hancock, 2006). It is a group of cases or items such as individuals, events, or objects. This population should possess the characteristic of interest in a study (Castillo, 2009). The population for this study included youths aged between18 to 35 years found in the community and are out of school, and are involved in using substances or have either used substances in the past. The second category of persons was ward executive officers (WEO), street executive officers, members of ward councils (ten-cell leaders) community development officers (CDO), health care providers (HCP),

social workers (SW) and other key opinion or influential leaders like religious leaders.

Table 3. 2: Category of Participants and their Areas

Respondents/participants category	**Area**	**Number of participants**
Substance abusers	Wards	300
Health workers	Health facilities	10
Social workers	Social welfare office/health facilities/ward offices	10
Ward Executive Officers/Street Executive Officers	Ward offices	12
Community Development Officers	Ward offices	6
Religious/influential readers	Wards	7
Total		**345**

Source: Field data 2016

3.6.1 Criteria for the Selection of Respondents/participants

Substance abusers: are the victims of substance abuse and are aware of all the challenges they face or face by their colleagues who have the same problem. Health workers constantly interact with youth who have substance abuse problem and have a scientific understanding of substance abuse problem. Social workers are aware of the problem of substance abuse and the theories which explain the problem and how to explain why it happens and how to help youth with substance abuse problem. They are also experienced with challenges which are faced by youths especially with substance abuse problems. Ward/street Executive Officers: are people who constantly address the challenges in the community including the problems caused by individuals with substance abuse problem. They constantly interact with the affected persons and have vast experiences with the challenges faced by youth

including their health seeking. Community development officers were selected for the study because they are always interacting and working with various groupsof people including youth in the community. Religious/influential leader: are people who are accepted by many people in the community and spiritually help youth with challenges including substance abuse.

3.7 Sampling Procedures

Sampling is the method of selecting a sub-set of individuals or social phenomena to be observed from the wider perspective and may be representative or non representative of the study population (Kothari, 2004). Sampling procedure facilitates or helps the researcher in selecting units to be included in the sample. There are two types of sampling technique namely, probability and non-probability sampling techniques. The researcher used these two sampling techniques to choose the research sample for this study.

3.7.1 Multistage Cluster Random Sampling

Multistage cluster random sampling technique was used to get the representative gangs *(maskani)* and substance abusers were sampled as follows; the first stage involved the selection of wards from Kinondoni Municipality. A list of all the wards in Kinondoni Municipality was obtained. There was a total of 34 wards out of which, seven (7) were randomly selected. All thirty-four (34) wards were listed and by using secret ballot seven (7) wards were picked. These included Manzese, Tandale, Magomeni, Mwananyamala, Kimara, Kigogo and Sinza. The second stage was the selection of streets. Each of the selected wards had its streets listed down. Out of the

seven wards, the researcher randomly selected four streets using the secret ballot method as done in the previous stage.

A total of 28 streets were selected. The third stage involved the selection of gangs from each street. In this stage, the researcher listed down the gangs belonging to each of the sampled streets as obtained from the streets excutive officer with the help of streets executive officers. For each street, the gangs were written on separate pieces of paper and folded. For each street, the papers were mixed out of which three pieces were picked and the names listed. In this exercise, 84 gangs were identified for the study. In each gang the whole cluster of youth with substance abuse problem wasfound, each gang had on average 5(five) to 10 (ten) youths all of those who were found were included in the study as long as they met the criteria and agreed to participate in the study.

3.7.2 Purposeful Sampling

The researcher adopted purposeful sampling as the process in which researchers chose participants arbitrarily to their unique characteristics or their experiences, attitudes, or perceptions (Cooper and Schindler, 2008). It is a technique that allows a researcher to use respondents who have the required information and experience with respect to the objective of the study (Mugenda & Mugenda, 1999).

This study used purposeful sampling technique because the researcher needed to select respondents who conform to the required characteristics. In addition, the researcher used this technique because it has power in selecting information rich-

cases for in-depth discussions related to the central issues being studied. This confirms the idea put forward by Patton (2009) that qualitative traditions use interviews to elicit in-depth data that is rich with experience that informs the researcher on the grassrootsissues about a phenomenon, in this case the health seeking behaviour among the youth in Kinondoni Municipality.

3.8 Sample Size

According to Latham (2007), a sample involves taking a representative selection of the population and using the data collected as research information. It is crucial because of its major impact on time and money that must go into data collection. The size of the sample is needed before the survey starts and goes into operation. The sample size is also necessary for this study because it is impossible to have the entire population as research respondents. The sample choice reasoning is to use a subset of the population that is theoretically considered to be able to highlight a phenomenon of interest. This technique is sometimes called technique reasoned choice by what is called logical reasoning (Grawitz 2005).

According to Dawson (2009), the correct sample size in a study is dependent on the nature of the population and the purpose of the study. In addition, sample refers to the number of randomly (each being given an equal chance of being picked) selected members of the entire population for use in the study. It is a sub group for observation from a large population in order to make inferences about the characteristics of the large population, since it would not be convenient for the researchers to study the entire population.

The sample size representative of the youth with substance abuse in this study was 321. It was determined based on the Krejcie and Morgan's sample size calculation which is thesame as using the Krejcie and Morgan's sample size determination table. The Krejcie and Morgan's sample size calculation was based on p = 0.05 where the probability of committing type I error is less than 5 % or p *<0.05.*

s=X2 NP(1-P) ± d2 (N—])+X2 P(1—P) (3.1)

where,

s required sample size.

X2 the table value of chi-square for 1 degree of freedom at the desired confidence level *(0.05* = 3.841).

N the population size. (1905 number of individuals with substance abuse in kinondoni municipality attending to health facilities)

P the population proportion (assumed to be 0.50 since this would provide the maximum sample size.

d the degree of accuracy expressed as proportion (0.05)

The current study consisted of of 300 substance abusers from various wards in Kinondoni Municipality

Qualitative: The sample size was determined by the saturation principle. This means that there were no new themes coming up from the respondents.

3.8.1 Sampling Frame

The researcher established that respondents who are informative, or possess the required characteristics are handpicked. Respondents who were picked through this

technique were the substance abusers, ward executive officers (WEO), street executive officer, ten-cell leaders, community development officers (CDO), health care providers (HCP), social workers (SW) and other key opinion leaders in the community like religious leaders and other prominent figures like businessman.

3.9 Types and Sources of Data

For the purposes of this study, both primary and secondary data was collected in order to capture the qualitative and quantitative information. Primary data was the data which were collected fresh for the first time, thus was original in character. These primary data, particularly data concerning health seeking behaviors of youth with substance abuse problem was obtained through a structured questionnaire given to participating clients who had met the inclusion criteria and had consented to participate. These were youth involved in substance abuse (300) and also involved people who were working or interacting with these youth involved in substance abuse. Secondary data was obtained through various published and un-published materials and reports available that related to the study so as to add value to the information obtained from the field.

3.10 Data Collection tools and Methods

In conducting this study, various methods of data collection were used including questionnaires, interviews and focus group discussion (Rwegoshora, 2014; Babbie, 2004). These methods were used in awareness that varying methods have different magnitude of strengths and weaknesses. Hence using several methods would help to

complement each other. The three techniques used for primary data collection were as follows.

3.10.1 Interview

According to literature an interview was defined as a conversation between two or more people where questions are asked by the interviewer to elicit facts or statements from the interviewee. It can be done as a face to face interview or through phone, videoconference etc. (Cooper and Schindler, 2008).

Qualitative data from respondents was collected by using interviews. The guide used consisted of questions about the youth's awareness and experience on health seeking behaviours, and their perceptions on the quality of their health status and the services for treatment of substance abuse. One interview session per day was conducted so that insight gained from each interview after preliminary analysis could be used in the next session. An interview guide was used in exploring and gaining deeper understanding of factors contributing to health seeking behaviour. Youth with substance abuse were interviewed until saturation point was attained

The researcher invited a limited number of respondents, after survey, to participate in semi structured interview during the research. At the beginning of interviews, the researcher created rapport with participants by starting with general questions to make respondents feel relaxed in answering questions. This approach was used so as to establish a cooperative environment and give enough confidence to respondents to provide information about themselves, expressing details of daily life on sensitive matters as described by Sharrif (1991); Dean and Eichhorn (1969); Wax (1971).

Such an opportunity enabled the researcher to get reliable and valid information from the respondents experiencing substance abuse problems, their treatment and challenges involved.

A total of twenty-five (25) in-depth interviews were conducted. Ten with substance abusers (10), four with community leaders (4), four with community development officers (4), three with health workers (3), two with social workers (2) and two with the key opinion leaders or influential people in the community (2). These respondents were obtained purposively as they had rich information on the factors that influence health seeking behaviours among youth involved in substance abuse. These people normaly interact with youth and normarly help in solving various problem that youth with substance abuse problem normaly incounter.

3.10.2 Questionnaires

The researcher adopted the definition that, questionnaires are instruments delivered to the respondents via personal (intercept, phone) or non-personal (computer delivered, mail delivered) which are completed by the participant (Cooper & Schindler, 2008). Quantitative data was collected using structured questionnaires. The questionnaires had questions on demographic characteristics, awareness of the available health services, perception of substance abusers on their health status and the available treatment options for managing youths with substance abuse problem. They also gathered information regarding their health seeking and utilization behaviours to the available treatment options (appendix III).

Moreover, there were seven items in the questionnaire adopted from the Diagnostic Statistical Manual Text Revised fourth version (DSM IV TR). The questionnaire which had seven items aimed to detect a person with substance abuse if he/she answered yes to three items out of the seven (appendix I). In this study questionnaires were structured into close- ended questions for quantitative with possible answers to choose from among alternatives; and the open-ended questions for qualitative data which gave the respondents an opportunity to give their opinions regarding the problem of substance abuse.

Before being used as a major means of data collection tool, questionnaires were pre-tested with some colleagues so as to satisfy the researcher that they would yield information which is required to meet the objectives of the study. They were then piloted to some selected individuals who were not part of the selected area of the study. Problems and ambiguities were identified and rectified before the final version underwent mass production. The final questionnaires were administered to the sampled respondents for data collection.

This instrument was preferred by the researcher because it could be self-administered by large groups of respondents at their own convenience. They could answer questions in their order of preference, skip questions, take several sessions to answer the questions, and write in their comments as described by Brown, (2001). The idea of using questionnaires is recommended by Brown (ibid) that the cost and time involved in using such instrument is less as compared to the use of interviews. On

the other hand, Taylor Powell (1998) emphasized that questionnaires are suitable in collecting data related to knowledge, beliefs, attitudes and behaviours.

The questionnaire was adopted from previous studies on health seeking behaviours among various populations in different areas of Tanzania. The big part of this questionnaire has been adopted from the following studies Nguma, 2010, Sekule, (2007), Tarimo, (2010). The questionnaire however was modified to suit the context of the current study. The psychometric properties of the adopted questionnaires were within the accepted standards for instance the Cronbatch alpha of above 0.9 and had some objectives which were related to the current study though they were adrresing a different health problem like Diabetes, TB, and malaria which could be related to substance abuse. That is why the researcher decided to adopt and modify the questionnaire so that they could only meet the objectives and the context of the study.

Eethical considerations in adopting the questionnaire were taken care of by the researcher in adopting and using part of qustionnaires from different authors. These considerations include citation of author sources, non violation of copyright of resources, using open access resources, paraphrasing of original sources and adaptation of the questionnaire to suit the cultural context of the study. The researcher also observed other ethical issues in dealing with respondents such as confidentiality, autonomy, consent and doing no harm during the research to participants.

3.10.3 Focus Group Discussions

According to Bryman & Bell (2011), focus group discussion (FGD) means an in-depth field method that brings together a small homogeneous group (usually 4 to 8 persons) to discuss topics on a study agenda. In this study, the FGDs were conducted with health workers, social workers, community development officers, of the selected sites, leaders of the streets and wards. Selected substance abusers were also involved, bearing in mind that the instrumentwas bound up with the use of qualitative research in general being scheduled by listening/observation discussions of the homogenous group where the observer keeps track of the information flow (Babbie, 2004).

Data from the respondents was collected through focused group discussions (FGDs), Six focus group discussions with five (5) to seven (7) people each were conducted; one FGD with youth who had substance abuse problems asking them about their awareness and perception of availability and experiences of use of services. Similarly, one FGD was held with health workers, one FGD with social workers, working in some of the health facilities selected in Kinondoni Municipality which provides treatment for substance abuse. One FGD was also held with community leaders, one FGD with key opinion leaders or influential people from the selected wards at the study site and one FGD with community development officers. All such groups were asked questionsregarding their experiences and challenges that youth with substance abuse were facing on seeking and utilization of available health services for treatment of substance abuse.

The discussions were led by a trained facilitator in cooperation with a research assistant and involved the researcher who was there to note down issues raised by participants. The discussion was conducted using FGD guide to monitor and regulate the discussions. The FGDs consisted of five (5) to seven (7) participants. The supervision was done by the facilitator and observed by the research assistant who was involved in planning the sessions and assisted the researcher to take notes and compile data. Such discussions enabled the researcher to gather the required data much more quickly from respondents without wasting time. The FGDs enabled the researcher to get a better understanding of the awareness, perceptions, attitudes, experiences, and beliefs on health seeking and utilization behaviours among youth who are involved in substance abuse. It also facilitated to gather additional information for the study; and was also useful to improve validity and reliability of data collected through triangulation of approaches.

Focus group discussions were preferred, as they socially captures a real-life data, are flexible, have high face validity and expedited results, and are of low costs (Kruger and Babbie, 2004). This method was found convenient for a group of people who were found together and who perform similar work. It allowed direct interaction with the respondents; and gave an opportunity to obtain large and rich information (data) using respondents‟ own words, (Krueger and Casey, 2000). It also allowed the respondents to react and build upon the responses of other group members.

A total of seven FGDs were conducted comprising substance abusers (1), ward executive officers (1), street executive officers (1), social workers (1), health workers (1), influential people (1) and community development officers.

Quantitative data was collected with the aid of two trained researcher assistants. The researcher or principle investigator (PI) trained and supervised the research assistants in administering the questionnaire to reduce errors in the data collection process. Interviewer administered questionnaire were filled personally by the research assistants.

3.11 Data analysis and interpretation

Data analysis aims at discovering the patterns in the data that point to theoretical understandings of a social life (Babbie, 2004). This entailed reflecting on the collected data and taking steps to understand what such data represented; its significance and then interpret the broader meaning of the data (Creswell 2007).

Qualitative data analysis refers to all non-numeric data or data collection processes that have not been quantified and can be a product of different research approaches (Saunders *et al.,* 2009). It attempts to interpret social reality of profile of youth who are involved in substance abuse in Kinondoni Municipality. According to Silverman (2001), researchers who are interested in exploring people's lives, histories or every day's behaviour must use qualitative instead of quantitative research strategy. This helps to capture the ideas, concerns, feelings and experiences of the determinants of youth involved in substance abuse. The investigative study employed the qualitative research approach to emphasize the dynamic, holistic and individual aspects of youth's experiences and to capture the entire aspects within their context.

Qualitative research allows the subjects being studied to give much richer answers to questions put to them by the researcher and may give valuable insights which might have been missed by any other method (Creswell, 2007) Not only does it provide valuable information to certain research questions in its own right but there is a strong case for using it to complement quantitative research methods. It also enables the building of a complex and holistic picture through the analysis of words, to reporting specific views of the informants and to conduct the study in a natural setting. The qualitative design enabled the researcher to reveal the complexities of the livelihoods of youth who are involved in substance abuse in Kinondoni Municipality. This research paradigm was useful in understanding social realities. Qualitative research may also help the researcher to understand the findings of quantitative research in developing theory from data analysis and interpretation (Saunders *et al*., 2007).

Data analysis was done by using content analysis method. The researcher read the transcripts and the notes and came up with meaningful units, categorizing them, and constructing an indexing broad themes.The videotaped in-depth interviews and focus group discussion were transcribed verbatim and translated from Swahili to English by a researcher who was bilingual (English and Swahili). The transcripts were scrutinized for discussions of values and experiences of youth, and the role of family and community influential leaders related to utilization of formal health services. Themes, sub-themes, categories and the study unities were developed. The themes were supported by quotes from the English transcripts; these themes helped to illustrate participant's attitude, emotions, views and opinions.

Table 3. 3: Stages of Content Analysis

Phase	Description of the Process
Phase1: Becoming familiar with the data	After collecting data from the focus group and indepth interviews in a verbatim manner, the transcriptions were read and re-read in order to become thoroughly familiar with it, and to immerse in the data (Braun & Clarke, 2006; Cohen *et al*., 2007).
Phase2: Generating initial codes	Coding interesting features of the data in a systematic manner across the entire data set. Collating data relevant to each other.
Phase 3: Searching for themes	After generating initial codes, the codes were collated into possible categories and sub-themes, gathering all data relevant to each potential theme (Braun & Clarke, 2006).
Phase4: Reviewing themes	Checking the themes worked in relation to coded extracts and the entire data set. Generating a thematic "map" of the analysis.
Phase5: Defining and naming themes	Ongoing analysis to refine the specifics of each theme and the overall story the analysis tells, generating clear definitions and names for each theme.
Phase 6: Producing the report	Selection of vivid, complelling. Final analysis of selected extracts, relating back of the analysis to the research question and literature. Producing report of the analysis.

Quantitative approach refers to the systematic empirical investigation of phenomena, their properties and relationships. It is concerned with counting and measuring things, producing in particular estimates of averages and differences between groups. It emphasizes on collection of numerical data, which is a deductive approach (Bryman and Bell, 2003). Quantitative analysis provides a relation between empirical observation and mathematical expression of quantitative relationships. In this study, this was based on already decided and well-structured questions, whereby all the respondents were asked the same questions. Open questions were used to give the respondent the flexibility to answer from different perspectives. Frequency tables,

percentages and charts were generated to summarize the data from where patterns of responses were determined. In order to achieve the research objectives.

Quantiatative data was entered and analysed using the Statistical Package for Social Sciences (SPSS) version 22. This is a popular statistical application developed by IBM, to analyze data. This software was appropropriate for conducting descriptive and inferential statistical analysis and addressing the research questios in the quantitative data sets in the study (Creswell, 2014). Descriptive statistics such as frequencies and percentages were used to describe the characteristics of the study sample while inferential statistics extended the scope of descriptive statistics by examining the relationships within a set of data.

The study also used logistic regression analysis to predict the likelihood of sociodemographic characteristics to HSB. The logistic regression analysis was used as follow:

Logit Regression is used to capture the dependency of the dependent variable (Y_i) on independent variable (X_i). The dependent variable Y_i is taken as a function when there are several explanatory variables (social dermographic characteristics)

$$\boldsymbol{Y_i = \alpha + \beta X_i + \varepsilon_i}$$

$Where:$ $\boldsymbol{Y_i}$ = The binary dependent variable

$\boldsymbol{\alpha}$ = The Y_i intercept

$\boldsymbol{\beta}$ = The Slope

$\boldsymbol{X_i}$ = The independent variable

$\boldsymbol{\varepsilon_i}$ = The random error

If $E(Y_i) = \alpha + \beta X_i = \Pi_i$ is the expected value of Y_i, and Y_i can take only the value of 0 and 1 (binary) while the error (ε_i) is dichotomous (not normally distributed)

If $\boldsymbol{Y_i = 1}$ which occur with the probability $\boldsymbol{\Pi_i}$

$$\mathbf{1} = \boldsymbol{E(Y_i)} + \boldsymbol{\varepsilon_i}$$

$$\boldsymbol{\varepsilon_i} = \mathbf{1} - \boldsymbol{E(Y_i)}$$

$$= \mathbf{1} - (\boldsymbol{\alpha} + \boldsymbol{\beta X_i})$$

$$= \mathbf{1} - \boldsymbol{\Pi_i}$$

Alternatively if $\boldsymbol{Y_i = 0}$ which occur with the probability $\boldsymbol{\Pi_i}$

$$\mathbf{0} = \boldsymbol{E(Y_i)} + \boldsymbol{\varepsilon_i}$$

$$\boldsymbol{\varepsilon_i} = \mathbf{0} - \boldsymbol{E(Y_i)}$$

$$= \mathbf{0} - (\boldsymbol{\alpha} + \boldsymbol{\beta X_i})$$

$$= \mathbf{0} - \boldsymbol{\Pi_i}$$

$$= -\boldsymbol{\Pi_i}$$

The dependence of Y_i on X_i for the Expected value of Y_i $\equiv\equiv>$ $E(Y_i)$ is given by:

$$\boldsymbol{E(Y_i) = Odd} = \boldsymbol{\Pi(Y/X)} = \frac{\text{Probability of the event}}{1 - \text{Probability of the event}} = \frac{\Pi_i}{1 - \Pi_i} = e^{(\alpha + \beta_1 X_1 + \beta_2 X_2 + \cdots \ldots \beta_k X_k)}$$

$$\boldsymbol{Logit\ E(Y_i) = Logit\ \Pi_i(Y/X) = ln\ \frac{\Pi_i}{1-\Pi_i} = \alpha + \beta_1 X_2 + \beta_2 X_2 + \ldots\ldots + \beta_k X_k}$$

3.12 Reliability and Validity

3.12.1 Reliability of Research Instruments

According to Mugenda and Mugenda (2003) reliability refers to a measure of the extent to which a research instrument yields consistent results after repeated trials. Therefore, reliability is the proportion of the observed variable's variance which is attributable to the effect of unobservable variable such that, the higher the variance

of an indicator error the lower will be its reliability. It was noted that, the covariance between an unobserved variable and its indicator is the product of the item loading multiplied by the factor variances.

In attaining the reliability of data, the findings were tested if they are consistently the same if the study is done over and the total population under the study is referred to reliability and if the results of the study can be reproduced under the same methodology, the research tool is considered to be reliable (Golafshani, 2003). Reliability is conceived as the assessment of the degree of consistency between multiple measurements of a construct; and this is referred to as a measure of stability of the proposed measure(s) to be used for a given research.

According to Golafshani (2003), there are three types of reliability in quantitative research namely, the degree to which a measurement given separately remains the same, the stability measurement over time, and the similarity of measurement over time or stability of measurement over a variety of conditions. This means that, the use of test-retest method which implies that the same scale or measure can be administered to the same respondents at two separate points in time. In this study, data was collected at one time and then analyzed to generate conclusion and make recommendations.

Based on the above arguments, in order to ensure that data collection tools were reliable, the researcher conducted a pilot study before the main survey so as to make sure that the instruments used were capable of capturing the content variable. The

tools were translated into (Kiswahili), which is familiar to all the respondents and hence increased the suitability of data collection instrument. But it was also, the English version that remained valid and used for those who were comfortable with this language.

To enhance reliability and objectivity, all measures in the construct were repeated and the findings were free from researcher values. Internal consistency was used to assess reliability of the data, and this yielded acceptable Cronbach's Alpha of .916 for all 56 items in the data collected (see Table 3.4). Furthermore, the researcher used composite reliability to judge the internal consistency of the variables. Internal consistency is widely used to measure the appropriateness of the instruments and to determine how well a set of items measure a particular behavior of characteristics within the test (Ndekwa, 2017).

Table 3. 4: Reliability Statistics

Cronbach's Alpha	Cronbach's Alpha Based on Standardized Items	N of Items
.916	.902	56

Source: Field Data (2016)

In the analysis, a composite reliability (CR) above 0.5 was considered significant while the coefficient that ranged from 0.6 and above was considered more acceptable. In this study, the CR above 0.7 in Table 3.6 indicates that the data and instrument were reliable and met the criteria of being accepted.

3.12.2 Validity of Data used in the Study

Validity involves assessing the measurement instruments and assesses what they aim to measure (Drost, 2012). In this study, to ensure that measurement instruments measured what they aimed to measure, quantitative instruments were employed. Construct Validity test was used to ensure that the actual data collection conforms to the theory which is being studied and hence is used to test validity of the results in order to validate their investigation (de Vause, 2009).

An aggregate of 340 questionnaires was distributed to youths with substance abuse problem at their hang out places (maskani). About 312 duly completed questionnaires were returned. This comprised a response rate of 93.5% while 7 (seven) questionnaires were not returned by the respondents. Out of 312, five (5) questionnaires from the respondents were eliminated due to excessively missing data leaving 308 (97.1%) questionnaires which were used for further analysis. The names for both respondents and entities were not included in this analysis for ethical reasons. In the current research, the collected data was coded in preparation for a subsequent analysis. The coded data was merged into one SPSS file and checked for completeness and consistency.

This ensures that another researcher taking the same root will come up with similar conclusions and the results can be confirmed by other researchers doing a similar study (Nimako, *et al,* 2012). The analyses of the pilot information ensured that the study instruments were valid and address the study objectives. According to Green (2008), a test is said to be valid if it measures what it claims to measure. There are

different kinds of validity namely, content validity, construct validity, and criterion validity which are used by various researchers to measure validity in their studies.

Content Validity

Content Validity refers to whether or not the items on a given test accurately reflect the theoretical domain of the latent constructs they claim to measure (Morse, et al., 2002). Content validity helps to identify whether the tools appear to be measuring what they say they measure. To ensure content validity a pilot study of survey was done in Ilala Municipality so as to test the survey instruments to see whether they accurately reflect the theoretical domain of the latent variable.

Construct Validity

Construct measure of validity is directly related to a variable's theoretical relationship to other variables. In testing for construct validity, the scale used through convergent, discriminatory and nomological validity testing should be examined (Cohen, 1979). Convergent validity is concerned with whether a test is similar to those with which it should theoretically be similar. To ensure convergent validity, a loading in measurement model must be at least 0.5 of the variances in the variable (Falk and Miller, 1982). In this study, measurements model loaded not less than 0.5 (see Table 3.6). It said that the value loaded above 0.5 demonstrates adequacy when using Average Variance Extract (AVE) in testing the convergent validity of the model.

Table 3.6 shows that AVE value ranges from 0.587 to 0.923 which ensures adequate convergent validity. In testing constructs validity, discriminate validity was assessed with a view that a given scale can be distinguished from others which measure

different concepts or traits. Discriminate validity was assessed by comparing the AVE of each individual construct with the shared variance between the individual construct and all the other constructs. As suggested by Fornell and Larcker (1981), a high AVE than shared variance for an individual construct suggests a discriminate validity. In this study, a comparison of all correlations and square roots of the AVEs on the diagonal indicated adequate discriminate validity.

Further, nomological validity was tested by relating measurements to a theoretical model that leads to further deductions, interpretations and tests which require all standardized coefficients values of greater than 0.2 (Spiro and Weitz, 1990). In this study all measurement models had standardized coefficients with significant value of greater than 0.2.

Table 3. 5: Composite Reliability (CR), Convergent and discriminant Validity

	CR	AVE	MSV	MaxR(H)	PT	PU	PR	BO
PT	0.960	0.923	0.149	0.962	**0.961**			
PU	0.946	0.898	0.158	0.977	0.370	**0.948**		
PR	0.747	0.587	0.210	0.978	0.386	0.398	**0.622**	
BO	0.741	0.591	0.210	0.980	0.223	0.165	0.458	**0.769**

Source: Field Data (2016).

Data in Table 3.6 show that all variables had Composite Reliability (CR) of greater than 0.74 and scored an Average Variance Extract (AVE) of more than 0.58 which was recommended by Falk and Miller (1982), such that an internal consistence of any variable should score at least composite reliability of 0.60.

Criterion Validity

The validity of a criterion provides evidence of how well the scores on a new measure compare with other measures of the system or are close to the underlying structures that should be logically connected (Kimberlin and Winterstain, 2008). In predictive validity and simultaneous validity, the criterion validity test is sought. Concurrent validity uses existing and well-accepted tests that can be contrasted with the new measure. To ensure simultaneous validity, by considering strong validated literature, data collection instruments were drawn and developed.

3.13 Rigour and Trustworthness of the Qualitative Data

According to Al-Dossary (2008) reliability and validity checks are agreed performance assurance standards for quantitative research. The naturalistic investigative method, however, was criticized on the basis of the question of trustworthiness. It is recognized that qualitative methods result in investigative subjectivity. Again, the prejudices of the investigator may not require accurate evidence to be generated. As a result of subjectivity valid knowledge may not be generated. The naturalists have objected these attacks. They have made efforts to fix certain standards to check the trustworthiness of the investigation. Lincoln and Guba (1985:289-31) suggested the use of different criteria, namely: credibility, transferability, dependability and confirmability in the evaluation of qualitative research. De Vous *et al.,* (2011) said that the qualitative aspect of research needs to meet the criteria for rigour and trustworthiness. More details for these terminologies are explained as follows:-

a) Credibility

According to Lincoln and Guba (1985) credibility is the measure of the degree of consistency of the findings and interpretations, which is in turn comparable to internal validity in a quantitative research. Credibility is concerned with testing what it actually intended to measure. Triangulation of research instruments was the techniques used to ensure credibility in this study (Lincoln and Guba, 1995). The use of multiple sources of data such as District social welfare officers, District community development officer, substance abusers, health workers and street and wards executive officers was meant to ensure credibility. Furthermore, credibility

was ensured through multiple data collection methods including interview, focus group discussion and observation methods (Frankel and Wallen, 2000).

In addition triangulation of methods was embraced when the focus group discussion was applied to seek more experiences that could not being captured by the two methods. This is the best way to improve the reliability of the research as the results come from multiple methods (Patton, 2009). In addition, the reliability of the research was attained when the current researcher triangulated sites where Sinza, Manzese, Tandale, Magomeni and Mwananyamala areas were used to get experiences and opinions on the health seeking behaviours among youth in Kinondoni Municipality. This increased the result and limited the researcher in relying on the single site for the information on the investigated topic. Hence the reliability of this research was rigour and credible as it involved the triangulation of participants, methods and sites. This discussion is in line with what is recommend by Patton (2009) Bogdan and Bicklen (1998) on the best ways to increase and attain reliability of research data.

b) Transferability

Transferability is the calculation of how applicable or generalizable the findings of a study in one setting may be in other settings. For quantitative research, transferability is equivalent with internal validity. Lincoln and Guba (1985) argued that the researcher's major task is to provide thick description of the phenomena and not to decide whether the findings can be generalisable. The authors argue that it is the reader who can decide whether or not to generalize the findings to other contexts.

Transferability was achieved in the present study by presenting detailed descriptions of the study context, methodology and research design characteristics. Through the detailed descriptions the reader may decide if the findings can be generalized for other settings.

c) Dependability

According to Sheraton (2004) dependability relates to the reliability issues that, if the research was repeated in the same context, with the same methods and participants, then similar results would be obtained. In other words, consistency refers to the fact that one study's findings could be the same if the same study was repeated with different participants somewhere else in a similar context. Dependability in quantitative research is comparable with reliability. In the present study, reliability was addressed by detailed reporting of the research's methodological procedures, thus enabling a future researcher to repeat the work, to gain similar results. Reliability has been achieved by keeping records of methodological decisions and various types of personal notes / memos used as important tools for the future during the study.

d) Confirmability

Confirmability is similar to objectivity in quantitative research and can be described as the degree the findings of one study can be confirmed by another independent researcher (Lincoln and Guba, 1985). In other words, the research findings are the results of the experiences and ideas of the informants, rather than the characteristics and preferences of the researcher (Sheraton, 1994). According to Miles and Huberman (1994) a key measure for confirmability is the extent to which the

researcher recognizes the shortcomings in the study's methods and their potential effects. In the current study, the researcher acknowledged and clarified the grounds for supporting the research design chosen. Conformability was achieved by ensuring that study conclusion is grounded in the data.

3.14 Ethical Consideration

According to Alston and Bowles (2003) "research is never value free. Ethics is a vital part of every research project ". Strydom (2005:57), asserts that ethics is a set of moral principles suggested by an individual or a group, which is subsequently widely accepted, and offers rules and behavioural expectations about the most correct conduct towards experimental subjects and respondents, employers, sponsors, other researchers, assistants and students.

The New Social Work Dictionary (2004:22) refers to ethics as a set of rules and prescriptions, based on social work ethics, regarding the actions and accountability of a social worker in professional situations. In fact, it is accepted that social research must meet some ethical criteria in order to be considered. These principles have been accepted not only because most researchers wish to conduct ethical research, but also because of the demands for a 'fair go' from the people being researched. Ethical issues that were considered in this study were permission to collect data, debriefing, voluntary participation, informed consent, confidentiality and the protection of participants (Berg, 2001; Kerlinger & Lee, 2000; Newman, 2000; Patton, 2001).

3.14.1 Permission to conduct the study

Ethical clearance to conduct the study was sought from the Open University of Tanzania Research and Publication Committee. Permission and approval for data collection was obtained from the Municipal Medical of Health Kinondoni Municipality.

3.14.2 Debriefing

Before conducting data collection, the researcher explained the purpose and procedures of the study. Participants were informed about all the procedures that were to be followed in this study. Details about dates and venues for the study were clearly explained to participants. An attempt was made to remove any misconceptions that the participants may have about the study (Kerlinger & Lee, 2000).

3.14.3 Voluntary participation

Before conducting the interviews, participants were made aware that their participation in the study was voluntary, that they may withdraw from the study at any time if they wish to do so (Kerlinger & Lee, 2000; Newman, 2000; Patton, 2001; Seidman, 1998). The participants were also informed that their participation was important for this study and that it will contribute to understanding the determinants of health seeking behaviours among youth involved in substance abuse.

3.14.4 Informed consent

Informed consent was obtained from each participant who was willing and agreed to participate in the study. Informed consent was also obtained from the health workers,

social workers and community leaders. The consent was ensured in writing. Informed consent slips were signed by both participants themselves and is when an individual understands what the researcher wants her or him to do and agree to partaking in the research (Berg, 2001; Kerlinger & Lee, 2000; Liamputtong & Ezzy, 2005; Newman, 2000; Patton, 2001). In addition, participants were informed that no financial gain would be obtained by participating in the study. In addition, the respondents were informed that the study was for academic purpose only. They were also informed about the purpose of the study and asked for their willingness to participate.

It was also clearly stated both orally and in the written consent form that, acceptance or refusal to participate in the study had no untoward consequences and that they were free stop at any point whenever they felt doing so or not to participate in the study at all. They also got the address/contacts of the researcher as well as the contacts of the Director for Research and Publication Committee from OUT for communicating issues regarding the study if need arose. Written informed consent was also sought from all the study candidates. All the study participants were 18 years or above. The participants were given the consent form to read and then were required to sign if they agreed to participate in the study. Participants were also informed that they were free to ask questions and if not willing to participate were free to leave.

3.14.5 Protection of participants

Participants were told that the study did not present any known risks. (Kerlinger & Lee, 2000; Liamputtong & Ezzy, 2005; Newman, 2000; Patton, 2001). Efforts have

been made to ensure that the participants are protected against any harm or discomfort that may result from the study. In addition, participants were informed that arrangements were made with health facilities, health workers, and social workers to assist them after the interview if they needed treatment, counseling, or debriefing. Permission was obtained from the participants.

3.14.6 Confidentiality

Participants were assured that all the information they gave would be treated as confidential. This means that data will only be used for stated purposes and no other person will have access to the data from the interviews. The respondents were informed not to write or mention their real names/titles in the questionnaires or interviews so as to ensure their confidentiality of any information given and that numbers would be used to identify respondents (Kerlinger & Lee, 2000; Liamputtong & Ezzy, 2005; Newman, 2000; Patton, 2001). The participants were also assured that all documents would be deleted if their anonymity was to be compromised. This was done to avoid participants ' biased responses. In case there were concerns about them at a later date, data were kept safe. Audio files have been locked away. Computer data was protected by a password. At the end of the whole process, all documents will be shredded and tapes will be erased. (Liamuttong & Ezzy 2005). Data will be destroyed after completion of the degree and when the data is no longer required by the university

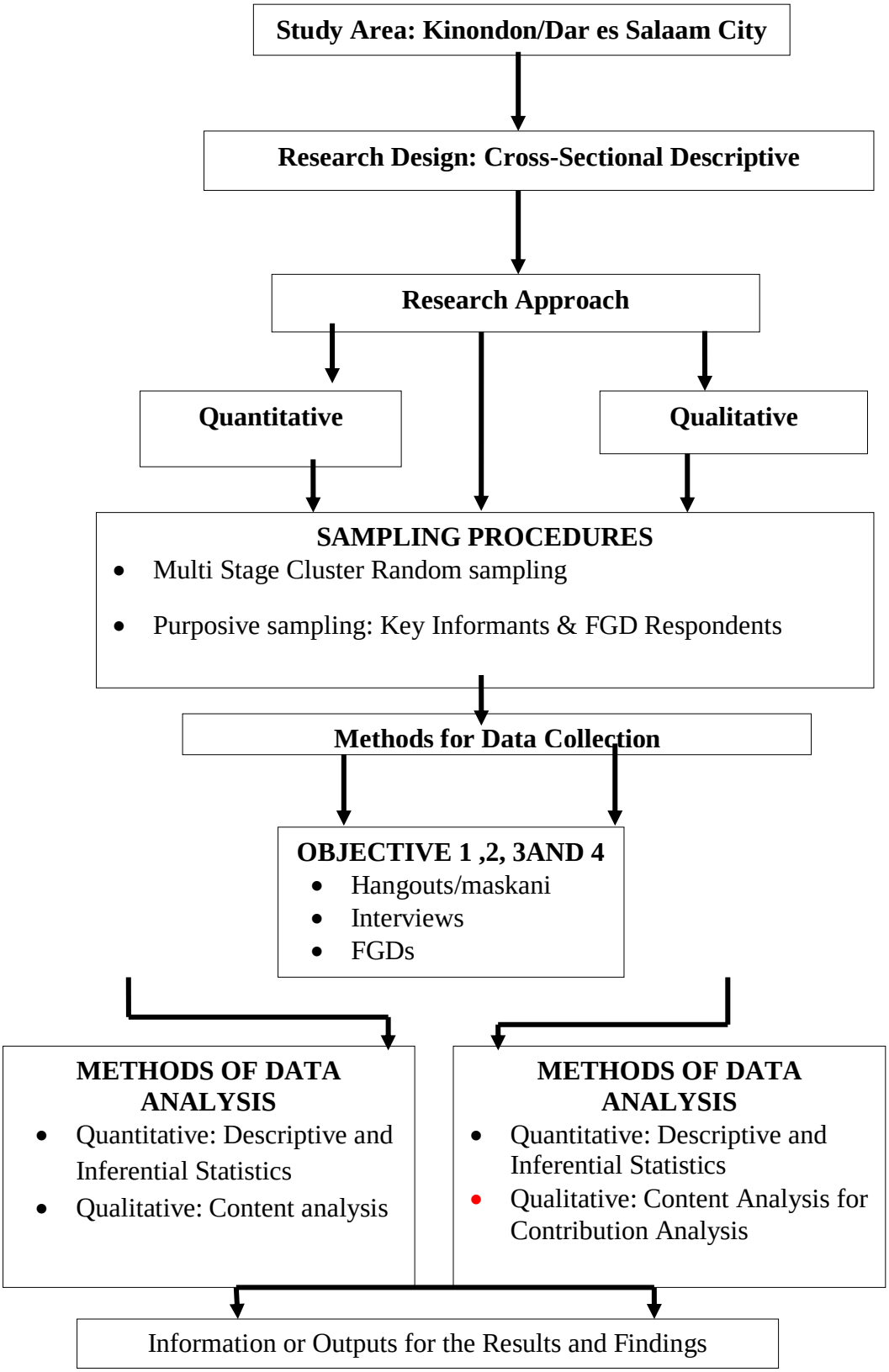

Figure 1 : 3.4: Methodological Flow Chart

CHAPTER FOUR

RESULTS AND DISCUSSIONS

4.1 Chapter Overview

This chapter presents and discusses the results of the study. It is organized into five sections arranged chronologically according to the ealier research objectives. Section one (4.1) is the overview of the study and section two (4.2) represent the socio-demographic characteristics of the respondents and link them with the health seeking and utilization behaviours of youths involved in substance abuse. Section three (4.3) reflects on the awareness of the respondents on available treatment options and their Health Seeking Behaviours (HSB). Section four (4.4) addresses the objective and answers the research question on the perception of substance abusers on their health status and their HSB. Section five (4.5), presents and discusses the findings on the use pattern for available treatment options and their relationships with the health seeking behaviours of young persons.

4.2 Social Demographic Characteristics of the respondents

The respondents‟ characteristics provide their background of the respondents and their suitability for this inquiry. The main characteristics of the respondents considered in this study were gender, age, education level, marital status and occupation (Table 4.1). These characteristics usually influence health seeking behaviour of an individual. The results are presented and discussed below.

Table 4. 1: Socio-Demographic Characteristics of Respondents

Variable	Frequency	%
Age		
18 -22	97	32.3
23-27	103	34.4
28-32	56	18.6
33-37	44	14.7
Gender		
Female	78	26
Male	222	74
Marital Status		
Single	225	74.9
Married	75	25.1
Education level		
Uneducated	19	6.3
Primary education	169	53.7
Secondary education	113	37.7
College education	7	2.3
Occupation		
Employed	16	5.3
Unemployed	265	88.3
Business	16	5.3
Students	4	1.1

Source: Field Survey, 2016

4.2.1 Gender

Gender refers to the socially constructed characteristics of women and men – such as norms, roles and relationships between groups of women and men. They can vary from society to society. While most people are born male or female, certain expectations and attitudes are learned – including how they should communicate within families, societies and workplaces with others of the same and opposite sex. If individuals or groups do not "suit" existing gender norms, they often face discrimination, discriminatory practices, and social exclusion, all of which have an

adverse health impact. It is important to be receptive to different identities that do not necessarily fit into the categories of binary male or female gender.

Gender norms, roles and relations influence people's susceptibility to different health conditions and diseases and affect their enjoyment of good mental, physical health and wellbeing. They also have a bearing on people's access to and uptake of health services and on the health outcomes they experience throughout the life-course. (Upleker *et al*., 1999, WHO 2018). Moreover, gender plays norms a role in decision to seek medical treatment for any ailment.

The results presented in Table 4.1 show that large a proportion 229 (74%) of the respondents comprised male, and very few 78 (26%) were female. This difference in percentage between male and female might be explained by the fact that the majority of female substance abusers are not usually found in places like "*maskani*" where most male clients are found most of the time. This phenomenon is explained by African culture which does not support the idea of women sitting in public areas, this is why it was difficult to access a big number of female substance abuser during the study. The large proportion of males does not mean that females are not involved in substance abuse.

This calls for the need to emphasize on equality in information sharing regarding health seeking behaviour among youth involved in substance abuse for both males and females. These findings finds support from previous studies which ascertain that though its difficult to find female substance abusers in the streets, female substance

abusers are more likely than male to seek and use health care or services (Galdas, Cheater, and Marshall, 2005). According to Richard (2004) it was indicated that gender has an influence on health seeking and utilization behaviours, with men's having a tendency of late presentation to health services leading to higher levels of potentially preventable health problems among men than their conterparts hence less chances to attend and obtain available treatment options.

The possible explanation could be that, women are more open in discussing health-related issues, are more sensitive to health and ill health issues, are more sensitive to symptoms, and are more responsive to health concerns experienced by members of the household. Moreover, the studies reaching the above conclusion also found that females have a higher response rate than males, which provides further empirical support for the proposed explanations (Ahs, Burell & Westerling, 2012; Beogo *et al.*, 2014; Thompson *et al.*, 2016; van der Hoeven, Kruger & Greef, 2012; Zyaambo *et al.*, 2012).

These findings are also supported by qualitative data which was obtained from the Focus Group Discussions where it was reported:

> *"It is realy strange because one can easily believe that the problem of substance abuse is a problem of males because it is difficult to see females with substance abuse problem in the street. However, if you visit the methadone clinics you will find a lot of women taking the treatment".*

Through FGD it was reported:

> *"If you just stay in the street you can easily imagine that the substance abuse problem is related to males. But if you get a chance to go to hospital then you*

will wonder after seeing a number of females taking the treatment for substance abuse problems"

This study showed that, though the number of females was leow 78 (26%) compared to males they were more likely to seek available treatment options. Female youths were found to be significantly more likely to recognize and seek the treatment options for substance abuse; this being consistent with findings from previous research (Raviv *et al*., 2009). In contrast, male youths were found to be significantly more likely not to seek treatment options (Farrand *et al.*, 2007; Raviv *et al*., 2009; Rickwood *et al*., 2005). Previous research has shown that males are not only more likely to rely on themselves rather than seek help but are also more likely to deny the existence of problems altogether (Offer, Howard, Schonert, and Ostrov, 1991).

Rickwoodand *et al.*, (2005) assert that men tend to be socialized in order to seek less assistance from formal and informal sources, while women tend to be socialized throughout their lives in need of support from others. These findings are supported by other results which asserts that, the behaviour of using drugs is a predominantly male phenomenon, although anecdotal evidence suggest an increase in the number of female users both in rural and urban areas (Mc Curdy, *et al.,* 2010). But, the tendency of looking for support is more likely to be pursued by female more than their male counterparts.

This finding is not inline with studies which assert that, more females than their counterpatrs had started with home remedies at the onset of ill-health symptoms. On the other hand, most men started the treatment from the qualified private service

providers that had implications on timely diagnosis (Spleen *et al.*, 2014: Xua *et al.*, 2004). Women autonomy has always been an issue of concern which has been reflected in other studies too (Nakagawa *et al.,* 2001: Shaikh and Hetcher 2004: Spleen *et al*., 2014) Women in our study were dependent on family members in seeking health care. More women than men had cited financial constraints in doing this. Women had no alternative but to resort to home remedies or medicines from nearby shops without prescription.

Under-reporting of TB in women has been attributed to barriers women face in accessing TB care (Crampin *et al.,* 2004: Hedelson, 1996). These differences in gender health seeking behaviours might be explained by the difference in the disease pattern and the stigma that is associated with those health problems. In this study the problem of substance abuse was the focus while the other findings were reffering to Tuberculosis which is believed to be a naturally occurring disease when compared with substance abuse which most people do think is a disease that is not natural and people think that one is responsible for the problem and there is a lot of stigma attached to substance abuse as compared to TB.

The results were further supported by findings from studies in Europe, which indicate that, morbidity and mortality data show that men are over-represented in statistics on cardiovascular diseases (CVD) and non-gender specific cancers. Interestingly, these health inequalities are evident between men living in different countries, as well as in male populations living within the same country (European Commission, 2011). Although male mortality and morbidity from some long-term

conditions seen today are related to biology, what is apparent is that biological explanations alone cannot fully explain these statistics. A biological view overlooks the complex interplay of the wider determinants of health, which include socio-economic, cultural, psychological and behavioural factors (Courtenay, 2000b).The findings from this study and else where in the world consistently support that men are more likely and more easly to bond to become victim to a particular health problem but on the other hand it is hard for them to seek medical treatment to elviate that problem..

4.2.2 Age

The age of an individual has influence on health seeking and health service utilization behaviour for available treatment options. Differences have been found in the nature and extent of health seeking behaviours among older people compared to young people, possibly due to increased concern over health issues with age (Parrott *et al.,* 2004; Weaver *et al.,* 2010). In addition, age determines the labour availability for various economic activities in any given community.

The results on age in Table 4.1 indicate four major age categories in the study area: (18-22 years), (23-27 years), (28-32 years) and (33-37 years). The results show that on average more than half (66.7%) of the respondents were aged between 18 and 27 years with very few (14.7%) falling between 33 to 37 years of age. The results show that there were many youths between 18 to 27 years of age engaged in substance abuse. The possible explanation of large number of youths in this age category being engaged in substance abuse is due to the fact that youth are prone to substance abuse

and their vulnerability is related to different lifestyles (Mohasoa, 2010). The youth state of extensive experimentation, poverty as a result of having no employment and poor income predisposes them to different kinds of vulnerabilities including substance abuse (Kadalie & Thomas, 2013; Parry *et al.*, 2012).

The results from the qualitative part also support the findings as presented by a social worker during their FGD

> *"Youths with substance abuse problems and who are older than 30years seem to be more positive with available treatment options when compared with those who are less than 20 years of age"*

The results imply that most of the youth engaged in substance abuse fall in the economically active age group. Hence when affected with substance abuse and do use the available treatment options, then it became difficult to bring them to the normal health status, and hence their economic productivity is lost. The results agree with the findings from (Parrott *et al.,* 2004) that a large number of youth experiment with legal and illegal substances out of curiosity and consequently rendering them socially and economically unproductive.

Moreover, youth consider smoking and drinking "safe" habits that make them look more adult like (Craig & Baucum, 2001). Other reasons for youth abuse of substances include coping with stress, peer group pressure and following the example set by adults (Donald *et al.,* 2007). Therefore, the youthful time promotes self-centeredness and a sense of vulnerability, motivating young people to take risks (Williams, 2004; Visser & Routledge, 2007). Youths (age 18) were more likely to

have negative impact in seeking help than older personsof years 28 and above. This is consistent with previous research findings that have shown that younger adolescents believe that professionally given medical resources will not be helpful (Jorm, Wright, & Morgan, 2007).

In the present study, young age was also associated with indifference to stigma, suggesting that youths with age 18 to 25 years were more likely to feel guilty, ashamed, or embarrassed as a result of their substance abuse problems. Researchers have accounted for this in highlighting the fact that youths of age below 25 years appear to have a heightened sensitivity to threats of autonomy relative to older youths (Schonert- Reichl, & Muller, 1996; Wilson & Deane, 2010). The cognitive and perspective-taking abilities acquired during late adolescence have been proposed to allow older youth to engage in complex thought processes required to think more critically about the costs and benefits of seeking the available treatment options (Pruitt, 2000; Spear & Kulbok, 2004; Steinberg, 2001).

Youths aged 28 years and above were found to seek available health services as compared to their counterparts who were less than 28 years old. This trend could be attributed by youth who were 28 year and above being more aware about the importance of maintaining a healthy state than the youth, who had less than 28 years. This was substantiated by a South African study by Otwombe *et al.*, (2014) whose sample only included adolescents. The study found that only 27% sought out medical care in the past six months of which the majority of the sample went to clinics, with the smallest proportion seeking help from homeopaths or traditional healers. This

scenario is attested to by the DCC (2015) study which identified that (people who Use Drugs) PWUD were predominately male, aged 20 to 39 years, suggesting that drug use was concentrated among people of working age.

4.2.3 Education Level

Education level is an important factor which influences individuals' general understanding on available treatment options and health seeking behaviour. People who are educated are more likely to understand the effects of substances abuse on one's health, social life, education, economy and the community at large Zimmerman, Woolf and Haley (2015) observed that the level of education influences health seeking and medical utilization behaviour all associated with knowing the advantages of health and the consequences not seeking and using available health services.

The profile of education level of the respondents is presented in Table 4.1. The results show that almost half 169 (53.7%) of the respondents had primary education, followed by 113 (37.7%) who had secondary education and very few 7 (2.3%) had college education. These results also show that a large proportion of the respondents had primary and secondary education. The possible explanation for most of the substance abusers having primary and secondary education is likely to be that those who had failed to continue with further studies due to various reasons got involved early in substance abuse, due to peer group pressures Biancorosa *et. al.,* (2004) observed that in most cases youth start to indulge in substance abuse when they are below 19 years of age. This makes it difficult for them to continue with further

education due to the effects of the substances such as laziness, tendency to drop out of school and lack of concentration on any matter including studies.

The findings are supported by qualitative data which was obtained during interviews with the Manzese Ward Executive officer, who pointed out that

"*the majority of youth who engage in substance abuse are mainly those who fail to continue with further studies due to such reasons as poor school attendance, peer pressure lack of proper guidance from parents and engagement in substance abuse."*

Monazza and Greta (2010) support these results when they observe that educations were positively related to attitudes toward health. Another study which was conducted in Zambia linked education to increased knowledge about ill health, how to recognize drug symptoms, and increased awareness about where to go when sick. Furthermore, education is a proxy of socio-economic status as educational attainment generally results in better employment and income which allow individuals a broader spectrum of choices when it comes to health care (Zyaambo *et al*., 2012). The above reasoning could offer an explanations on why drug use was strongly associated with poor health seeking behaviours in this study.The implication of the results is that the majority of substance abusers had primary to secondary education and that their low education level was likely to contribute towards low tendency of health seeking and utilization behaviour.

Carolyn *et al*., (2010) observed that low educational level influences delay in seeking and using available health services when they are having ill health symptoms. This is

contrary to the educated which had a quick response when they observe the ill health symptoms. The study results agree with the findings in the International Journal of Collaborative Research on Internal Medicine and Public health, (2012) which found that when youth who had low education level mixed with peers who had bad morals and bad manners and had limited knowledge, they could not differentiate good or bad, hence ended up in drug abuse and drug trafficking to earn quick money.

4.2.4 Marital Status

Marital status is strongly associated with individual's health seeking and utilization behaviour and consequently their improved health outcomes (Eikemo and Mackenbach, 2012; Perkins *et al*., 2016). Married individuals have higher chances of seeking and using available treatment options when they encounter particular health problems compared to unmarried individuals (Dupre, Beck and Meadows, 2009). This is because marriage enhances well-being through healthier lifestyle including avoidance in substance abuse (Lewis and Butterfield, 2007). According to Nystedt (2006) married individuals are less likely to indulge in substance abuse and more likely to quit substance abuse.

The study results in Table 4.1 show that a large proportion of 225 (74.9%) of the respondents were single and very few 75 (25.1%) were married. The fact that the majority of the respondents were single suggested that they tended to be involved in substance abuse. These were mainly youth without the sense of commitment to a family, hence spend most of their time in gangs (Maskani) (Eikemo and Mackenbach, 2012). This implies that the majority of substance abusers are single

and spend most of the time in the gangs, engaging in substance abuse and without having a close and personal relationship to motivate them toward seeking available treatment options. A possible explanation for this is that being in a partnership, whether cohabiting or married, offers more economic, social and psychological opportunities than if never married (Perkins *et al*., 2016). Although economic support is mainly derived from being married due to legal laws that protect both partners, in terms of assets and monetary resources, monetary support would mainly benefit marriedindividuals rather than those who are cohabiting or in no relationships (Carr & Springer, 2010).

4.2.5 Occupation/Income

Being unemployed increases the likelihood of substance use mainly due to the fact that in most cases unemployed individuals mitigates the discomfort of being unemployed by engaging in substance use. According to Paul and Moser (2009) unemployment increases substance use because of the increase in distress associated financial strain, depression, identity crises and loss of social support. The results in Table 4.1 show that large proportional 265 (88.3%) of respondents are unemployed, about 16 (5.3%) are employed, approximately 16 (5.3%) engaged in small business and about 4 (1.1%) are students. During the survey of the study area it was revealed that employed respondents involved in substance use were mainly those working in small scale industries found around the area. It was also observed that students who engaged in substance use were primary school pupils and those who dropped out of secondary school.

The results indicate that large proportion 265 (88.3%) of the respondents were unemployed. The possible reason for this observation is that due to lack of employment most young people tend to stay in gangs “Maskani” and in most cases mitigate the challenges of lack of employment and income by engaging in substance abuse. The results imply that, the majority of respondents involved in substance abuse lost social support and did not have reliable source of income. This is likely to demotivate them to seek and utilize available treatment options. This calls for various efforts from government and non-government organizations and community at large to take necessary actions to remove young people from this viscous cycle of substance abuse.

These results are in agreement with previous studies which report that, substance abusers face a variety of obstacles when to looking for employment, of which most are deeply entrenched. These include poor self-confidence and mental health problems, physical health problems, a lack of edequate education, training and skills, ongoing substance abuse, receiving treatment whilst working and stigmatisation by employers. Most of the obstacles highlighted, such as a lack of education and training and ongoing substance abuse, have the possibility to be removed by the individuals if they have the support and motivation to devote needed time and effort.

However, other barriers may prove harder to overcome and require broader societal intervention. The reported reluctance on the part of employers to take on individuals with a history of substance abuse, or with criminal convictions, is an obstacle that is rooted in social attitudes and therefore, much more difficult to alter (Bradshaw,

2012). The socio-demographic characteristics of health seeking behaviors included gender, education level, income, and health status (as their p value was less tha 0.05). Other associated factors were age, marital status, place of residence and occupation. As it is indicated in (Table 4.2).

Table 4. 2: The Logistic Regression of the Socio Demographic Characteristics of the Respondents

Variable	B	S e	Wald	Df	Significance
Age	-.145	.056	6.735	1	.009
Gender (1)	-2.507	.859	8.513	1	.004
Marriage	-.107	.267	.162	1	.687
Education	-2.142	.616	12.100	1	.001
Income	-3.217	.526	37.451	1	.000
Occupation	-.204	.779	.069	1	.793
Family	.093	.495	.035	1	.851
Head of family	-.278	.799	.121	1	.728
Occupation of Head	-.228	.829	.076	1	.783
Source of income	-2.867	1.279	5.023	1	.025
Shelter	.071	.414	.029	1	.864
Expenditure	-.646	.341	3.587	1	.058
Health Status	-1.197	.473	6.388	1	.011
Connection	-.083	.859	.009	1	.923
Placeof residence	-.107	.267	.162	1	.687

Source: Field Data, 2016

The Health Belief Model (HBM) had an assumption that the social- demographic profile of individuals has a role to play in shaping behaviour especially when it comes to health seeking and utilization of the available treatment options. In this study it has been shown that gender, education and income of and individual had influence on seeking the available treatment options. These findings are also supported by the HBM which says that, effects of demographic variables on health behaviour patterns and are amenable to change through educational intervention. The model could be applied to a range of health behaviours and so provided a framework

for shaping behaviour patterns relevant to public health especially to a problem like substance abuse which is one of the prominent health problems in the society and it affects the most sensitive population. Futhermore, the social learning theory (SLT) and the Theory of planned behaviour (TPB) supports that social dmogrphic characteristics are a function of behaviour formation of an individual and that can be achieved through reciprocal interaction by observing what others are doing either abusing substances or using the available treatment options to overcome their substance abuse problem.

4.3 Awareness on Available Treatment Options among Substance Abusers

Awareness on the availability of treatment options among substance abusers is of great importance in the whole process of health seeking and utilization behavior of substance abusers. Lone and Mircha (2013) and Ogunlesi and Olanrewaju (2010) observed that the information patients have on the available treatment options influences health seeking and utilization behaviour. One among the objectives of this study was to assess the level of awareness of substance abusers on the available treatment options.

The results of the questions covering this objective are presented (Table 4.4). The results on respondent's awareness on available treatment options for substance abuse are presented in Table 4.4. The results show that the majority of respondents 223 (74.3%) had no information on the available treatment options for substance abuse and few 77 (25.7%) had information on available treatment options for substance abuse. The possible reason for the majority of respondents lacking awareness on the

available treatment options for substance abuse is low level of education. During the survey, it was revealed that the majority of respondents had primary education. This was acknowledged during key informant interviews with Kinondoni Ward Executive officer who said that: -

> "*Most youth who engage in substance abuse have either not completed standard seven or Form four, and this makes it difficult for them to understand and be aware of the availability of treatment options regarding substance use*"

The results indicated that the majority of respondents are not aware of the available treatment options. These results imply that it is very difficult for the youth to seek and utilize the available treatment options, this call for various measures to create awareness to the community members on the availability of treatment options for substance abuse. These findings are in agreement with previous studies which assert that, lack of awareness and knowledge of substance abusers on health seeking resources has been consistently recognized as a barrier to seeking help for substance abuse problems (Carolyn *et al*., 2010). Furthermore, models of health seeking behaviour (HBM) and social learning theory suggest that the lack of knowledge or awareness on the available treatment options may hinder, if not curtail, help seeking efforts.

Table 4. 3: Characteristics of the Respondents' Awareness regarding available treatment options

Variable	Description	Frequency	Percentage
Available treatment options	Yes	77	25.7
	No	223	74.3
	Total		
Sources of Information on available treatment options	Newspapers	22	7.3
	Radio/Television	104	34.7
	Internet	4	1.3
	Educational Classes	10	3.3
	Friends, family and relatives	160	53.3
	Total	300	100
Extent of getting information	Very Large extent	18	6
	Large extent	45	15
	Average	72	24
	Small extent	40	13.3
	Very small extent	125	41.6
	Total	300	100

Source: Field Data, 2016

4.3.2 Major Sources of Information on Available Treatment Options for Substance Abusers

The sources of information on the available health care and treatment options play a significant role in the awareness creation on the available substances treatment options and hence facilitate seeking and use among substance abusers. The results in Table 4.3 present the major sources of information on available treatment options for substance abusers. The results show that on average for about 160 (53.3%) of the respondents their major source of information about available treatment options were friends, family and relatives. This was followed by 104 (34.7%) of the respondents who relied on radio/television and very few 4 (1.3%), 10 (3.3%) relied on internet and educational classes respectively. The possible explanation that most of the

information on available treatment options obtained from friends, family and relatives is that most of the time substance abusers spend their time in the gangs "*Maskani*" or in their families where they go for food or to sleep.

These results imply that despite the availability of services, youths with substance abuse problem tend to rely on informal sources on the availability of services, such as reliance on friends and family as a primary source of information and help. It is important to acknowledge that although youth with substance abuse problem are more likely to seek help from informal sources, they may not receive the type of help that is needed from these sources. This calls for various government and non-government initiative such as awareness creation campaigns on the available treatment options to be communicated to the entire community. These results are in agreement with other findings which report that, if people make a specific effort to obtain health facts, they are more likely to use other health-related practices such as taking advantage of available health treatment options. It has been suggested that this information-seeking process is an integral part of the process of health seeking and as such, should receive greater attention (Rowsk, 2011). Furthermore, Literature also points out the need for engage in public awareness endeavours in rehabilitation programmes, the two pairing up. They argue, "„public awareness is critical to the success of demand reduction programmes. Its purpose is to make the public aware of the dangers of substance abuse and mobilize public participation in the war against drugs." (Nikander and Mbatia, 1996).

4.3.3 Extent of getting Information about available treatment Options for Substance Abusers

The extent of obtaining proper and reliable information on available treatment options among substance abusers is likely to contribute passively to the whole process of health seeking and utilization behavior. The results in Table 4.5 present the extent of obtaining information about available treatment options among substance abusers. The results show that about 125 (41.6%) of respondents their extent of receiving information on the available treatment options is very little, followed by 72 (24%) of respondents that averagely received information regarding available treatment options. The very little and average cohorts receiving information on available treatment options can be explained by the fact that in most cases respondents received information from friends, family members and relatives that usually hang-out together in most of the time. The implication of the results is that for the substance abusers to have proper and reliable information there is a need to strengthen and increase their channels of receiving information with respect to available treatment options for affected individuals.

4.3.4 Relationship between Awareness and Health Seeking Behavior

The results presented in Table 4.5 show the relationship between the amount of information and the health seeking and utilization behaviour. The results indicated that there is strongly relationship between the extent of information and health seeking and utilization behaviour with p- value (p = 0.029). However, the results show that there was no relationship between sources of information and health seeking behaviour among substance users with p-value (p=0.257).

Table 4. 4: Relationship between Awareness and Health Seeking and Utilization behaviours

Awareness Variables	Health seeking behaviour			X 2	df	P value
	Yes	No	Total			
Extent of information						
Very large extent	7	11	18			
Large extent	20	25	45	10.775	4	0.029
Average	20	52	72			
Little	7	33	40			
Very little	29	96	125			
Source of information						
Newspapers and magazines	6	16	22			
Radio/television	35	69	104			
Internet	0	4	4			
Educational classes	4	6	10	5.381	4	0.257
Friends, families and relatives	38	122	160			

Source: Field Survey 2016

4.3.5 Perceptions of Substance Abusers on Available Treatment Options

Service quality and effective provision probably vary considerably from one service provider to another service provider. A systematic evaluation of the substance abuse treatment system would provide insight into the factors associated with better treatment outcomes, where quality improvement initiatives should be concentrated, and how current services could be improved.

The use of evaluation findings to drive quality improvement initiatives might go some way in addressing negative perceptions about treatment. The results on perceptions of substance abusers on available treatment options are presented and discussed below.

4.3.5.1 Perceptions of Substance Abusers about the Treatment of Substance Abuse

The respondents' perceptions on the possibility of their problem being treated is one of the key factors that determine the steps one follow toward seeking and utilizing available health services. The results of respondent's perceptions on treatment of substance abuse problem are presented in Table 4.6.

Table 4. 5: Respondents Perception on Treatment of Substance Abuse Problem

QUESTIONS/RESPONSE	N^{o}	%
Perception on availability of treatment		
Yes	113	37.6
No	187	62.4
Total	300	100
Treatment options		
Mental health clinics	12	10.6
Methadone assistance therapy	64	56.6
Sobriety house	16	14.2
Counselling and psychotherapy	10	8.9
Detoxification	8	7
Support group (AA/NA sessions)	3	2.7
Total	113	100
Reasons for not being treated		
Treated individuals still on use of substances	49	16.3
Substance use is not a disease	56	18.7
No treatment available	195	65
Total	300	100
Afraid of treatment consequences		
Very much	24	8
Much	44	14.7
Somewhat	27	9
Low	20	6.7
None	185	61.7
Total	300	100

Source: Field Data, 2016

The data above (Table 4.5) shows the options which youths with substance abuse problem can use to get treatment such as in mental health clinics, through counseling, psychotherapy, sobriety houses, methadone therapy and detoxification. However,

more than half of the affected have negative perception on seeking health support for the available treatment options. This is very critical as the drug addicted will have no desire to seek medical therapy mentioned above and it will hinder the national campaigns and efforts intendied to rehabilitate addicted youths in Kinondoni Municipality and panterritorially.

4.3.5.2 Perception of Available Treatment Options for Substance Abuse

The results in Table 4.6 indicate that about 187 (62.4%) of the respondents said there are no available treatment options for substance abuse problem while 113 (37.6%) said there are available treatment options. For those who perceived that there are available treatment options they mostly perceived methadone assisted therapy 64 (56.6), sober house 16 (14.2%), followed by mental health clinics 12(10.6%), counselling and psychotherapy 10 (8.9%), detoxification 8(7%) and support groups 3(2.7%).

These results show that the majority of the respondents 187(62.4%) were not aware of the available treatment options and the few who knew the available treatment options mentioned methadone and sober houses to be the available treatment options to a large extent as opposed to other treatment options like mental health clinics, support groups and detoxification which were mentioned to less extent as its indicated in the table 4.8. This can probably be explained by low level of awareness on other available treatment options. Methadone treatment has a large coverage of advertisement and some NGOs do recruit individuals with substance abuse problems for methadone therapy.

The reasons that were mentioned by most of the substance abusers as to why they are not in treatment included no available treatment 195 (65%), substance abuse is not a problem 56 (18.7%) and most of the substance abusers who have been treated are still using the substances 49 (16.2) This finding is also supported by (Duong-Ohtsuka & Ohtsuka, 1999, 2001) who reported that there are many reasons why people with substance abuse do not seek health services including limited knowledge of available services, lack of awareness regarding the severity of problems, cultural and/or gender factors and the stigma associated with substance abuse and its related problems. Therefore, efforts are needed to orient the target population on the available treatment options. Below are some of the quotations which were given by youth with substance abuse problem during the in-depth interviews and focus group discussions.

*"Chidbenz and Ray C are two good examples that there are no treatments for substance abuse because they have money and even the former president helped Ray C but they are still in this problem of substance abuse for years now". (*Said 32 years old lady)

She added:

"Honestly I don't see any difference between receiving treatment and not receiving it.. Look at those young men; they are coming from Mwananyamala methadone clinic and we are here with them continuing to abuse drugs and they are even worse if I can compare myself with them" (said 29 years male respondent).

Furthermore, the results from this study suggest that the majority of substance abusers had negative perceptions about the available treatment options; they

perceived that the available treatment options are ineffective and hinder the use of the existing services. More specifically, they fear that the available treatment does not work and thus increase lack of enthusiasm to seek substance abuse treatment. This finding concurs with the findings from previous studies conducted in the U.S.A (Appel *et al.,* 2004; Simpson and Tucker 2002; Grifith *et al.,* 1998).

This negative perception is somehow contributed by treatment myths, including the wrong idea that there is no treatment to cure substance abuse. One recommendation for debunking these myths is a public awareness and education campaign that focuses on providing clear messages and accurate information on when and where to seek treatment as well as on the process and expected outcomes of treatment. The findings from this study suggest that the media could be a powerful tool for educating individuals, families and communities about what constitutes effective and appropriate treatment for substance abusers.

On the other hand, these negative perceptions about the, ineffectiveness of treatment have brought out genuine concerns about the quality of services offered to individuals from the available health facilities. Previous studies have pointed out several factors that affect the quality of services include high number of clients as compared to the number of staff responsible for treatment service delivery, the existence of unregistered and unregulated treatment facilities in the private sector, the limited use of evidence-based treatment models, the use of unskilled and untrained staff to deliver treatment services, and limited capacity to provide a comprehensive range of treatment services (Myers *et al.,* 2008; 2004). While the presence of these factors in the settings raises important questions about service

quality and effectiveness, such questions are impossible to address without a systematic evaluation of the substance abuse treatment system.

4.3.5.3 Relationship between Perception of Services and Health Seeking and Utilization

Table 4.6 shows the relationship between perception of available health services and health seeking and utilization were determined. It was found that dignity and respect of health providers towards individual with substance abuse disorder to have a significant relationship with health seeking and utilization behavior. *(p=0.01)*

Table 4. 6: Relationship between Perception of Services and Health Seeking and Utilization Behaviors

Perception Variables	Health seeking behaviour			X 2	Df	P value
	Yes	No	Total			
Usefulness of health services						
Very much	14	11	25			
Much	7	9	16	2.607	4	0.626
Average	8	10	18			
Little	1	2	3			
Very little	1	4	5			
Were you satisfied with the services provided						
Very much	3	10	13			
Much	10	9	19	3.508	4	0.477
Average	13	12	25			
Little	2	2	4			
Very little	3	3	6			
Very much	7	19	26			
Much	12	8	20			
Average	9	3	12	12.032	4	0.017
Little	3	3	6			
Very little	0	3	3			
Did you receive the treatment						

on time?						
Always	3	8	12			
Most of the time	16	10	26			
Sometimes	7	13	20			
Rarely	5	3	8	7.627	4	0.106
Never	0	2	2			
Attitude of health workers						
Very good	5	10	15			
Good	12	12	24			
Average	11	7	18	4.206	4	0.379
Bad	1	1	2			
Very bad	2	6	8			
Physical environment						
Very much	13	14	27			
Much	13	10	23			
Average	4	6	10			
Little	1	3	4	4.480	4	0.345
Very little	0	3	3			
Cost of treatment						
Very much	7	15	22			
Much	15	8	23			
Average	5	8	13			
Little	2	1	3	6.394	4	0.172
Very little	2	2	4			
Quality of services provided						
Very much	7	7	14			
Much	11	13	24			
Average	11	7	18	6.385	4	0.172
Little	2	4	6			
Very little	0	5	5			

Source: Field Data, 2016

Respect and treatment with dignity for individuals with substance abuse by health workers has found to be associated with access to health seeking and utilization behaviours. These findings are in agreement with many other studies (Guyatt *et al.*, 1995; Harris *et al.*, 1999; Holmes-Rovner *et al.*, 1996; LaVeist *et al.*, 2000; Morales *et al.*, 2001; Marshall *et al.*, 2001; Pellegrin *et al.*, 2001; Thom *et al.*, 1999.; Goodwin ; Happell, 2006; Kennedy, Regehr, Rosenfield, Roberts, Lingard, 2004; Kerkorian, McKay, Bannon, 2006) that reported increasing respect and dignity for

clients to increase their likelihood to choose to use the available health facilities. Respect and dignity in this context mean the relationship between the health worker and the substance abuser in which it is understood that quality care will be offered by the health worker when needed. Thus, health workers have a critical role to play in promoting health seeking and utilization behaviour.

4.4 Perceptions of Substance Abusers on their Health Status

The perception of substance abusers with regard to their health status is of great importance in determining the steps to follow in seeking available treatment options (Rapp *et al*., 2003). Some studies have suggested that the presence of future loss has a strong impact on risk perception, indicating individuals' preference to avoid losses rather than obtaining gains (White *et al* 2003; Rozin *et al.*, 2001). This perception is also further substantiated by the HBM through its component of perceived threat and perceived severity to, individuals who they perceive for substance abuse problem to be more severe and are most likely to seek help by exploring available options to manage their substance abuse problem. The SLT and the TPB may substantiate that, there is a probability that individuals with substance abuse problem may engage in criminal and deviant behaviour if they associate with those who commit simmilar deviant and criminal actions. Behaviour transfer is possible by observing and modelling, but on the other hand if the potentials hang around with those who opt to seek and utilize the available treatment options they will also oberve and imitate good models of behaviour (Bandula, 1977)

4.4.1 Respondent's Perceptions on Variable Regarding Their Current Health Status

The results on respondents' perceptions of their health status are presented in Table 4.8. The results show that about 96 (32%) of respondents most of the time, perceived substance abuse as a health problem, 95(31.7%) felt substance abuse as a health problem while only 12 (4%) never perceived substance abuse as a health issue. Moreover, the results in Table 4.7 show that about 147(49%) of the respondents felt that their health status was poor, followed by 105(35%) who felt their health status was fair (Normal) while very few 25(8.3%) perceived that their health status was good.

The possible explanation for the respondents to feel their health status was fair/normal and good is likely to be either due to unawareness of the effects of substances on their health condition or are less concerned about their health status. This explanation is supported by the study done by Possi (1996) who holds that the use of drugs such as cocaine, Bhangi, alcohol and cigarette do cause the addiction psychological problems and health problems which consequently end up in death of the addicted person. In addition, the results in Table 4.8 show that about 91 (30.3%) of the respondents felt ashamed by their substance use behavior and 68(22.7%) did not feel any shame. This was evidenced during key informant interview with Kinondoni community development officer who said:

> "*In most cases majority of the youth involved in substance abuse are aware of their health status as a result of using substances, but most of them feel ashamed to express their substance use problem mainly due to the stigma*

associated leading to a break in good relationship with other community members".

Gerdner and Holmberg's (2000) observed that individuals with substance abuse problem have a complex pathway towards seeking and utilization health services because the habit of substance abuse is unaccepted by the community and hence the victims experience different challenges. This finding is in line with the observation made by Shaikh *et al.,* (2004) in South Africa who found that the cause of drug abuse in South Africa rests on the pressure group and negligence of the community to handle the cases and stop the behaviours of drug use in the streets. The results indicate that large numbers of respondents felt that substance abuse is a health problem and their health status is poor. The possible explanation of the large number of respondents perceiving substance abuse as a health problem and their health status is poor is likely to be due to the bodily condition the individual's experience when they are in need of the next dose of a particular substance. Others did experience the general deterioration of general health conditions These results are in agreement with the findings by (American Psychiatric Association, 2013) who states that the criteria associated with substance abuse include clinically significant impairment or distress shown through various manifestations, such as the substance being taken longer than planned, unsuccessful efforts to reduce or control the use of the substance, craving for the substance, or avoiding major commitments at work, school, and home, among others. This was acknowledged by some respondents in the FGD's during field survey, who assertedt:

"*Since I started using these substances, there are a number of bodily changes I have been experiencing including being weak to such an extent that it is hard for me to perform any of my usual daily activities also often feel uneasy/not comfortable when I do not use it*" *My health has been constantly deteriorating since I started using these drugs, and I really feel sorry for myself and my family*."

From the results of individual's perception on substance abuse as a health problem, it can be revealed that despite the fact that large proportion of the respondents did perceive the use of substances as a health problem, still they find it difficult to seek and utilize the available treatment options. This is likely to be due to their low level of education, lack of awareness on the available treatment option, unpreparedness to stop, and lack of family support.

Table 4. 7: Perception of Substance Abusers on their current health status

Variable	Response	
	N	(%)
Acceptance of substance use as health problem		
Always	60	20
Most of the time	96	32
Sometimes	95	31.7
Rarely	37	12.3
Never	12	4
Total	300	100
Importance of your health		
Very much	201	67
Much	69	23
Somewhat	18	6
Low	8	2.7
Very low	4	1.3
Total	300	100
Current health status		
Very good	22	7.3

Good	25	8.3
Average	105	35
Poor	147	49
Very poor	1	0.3
Total	300	
Concern on health status		
Some how	9	3
Very much	19	6.3
Much	26	8.7
Rarely	11	3.7
Never	235	78.3
Total	300	100
Feeling shame involved in substance use		
Very much	42	14
Much	91	30.3
Average	45	15
Little	54	18
Very little	68	22.7
Total	300	100

Source: Field Data, 2016

The results above on respondent's perceptions on the importance of their health conditions are also presented in Table 4.7. The results show that about 201(67%) of the respondents consider their health condition very much important for their well being and family member as a whole and only a few 4(1.3%) perceived that their health condition is less important for their well being and family at large. The results indicate that large numbers of respondents recognize the importance of their health condition.

These results imply that there is a possibility of substance abusers to seek and utilize available treatment options if they are informed on the availability of the treatment options and their level of awareness of the effects of substance abuse is enhanced The results are some how similar with the findings form a study done by (Katung *et al.*, 2001). Which revealed that 88 percent of individuals aged 12 years of age and

above (n=125,493) indicated excellent or good health and 74 percent of the sample considered their life to be ‘a bit’ stressful at most times (Sareen *et al.*, 2005).

A small minority of the sample reported having to stay in bed or cut down on regular activities for all or most of the day. Overall, only 12 percent of the respondents perceived a need for substance abuse treatment. Despite this, condition measures revealed that approximately 20 percent of CCHS respondents needed substance abstinence services; suggesting that a significant number of people failed to recognize the need for help. CCHS researchers attribute the noted discrepancy to the possibility that participants were unaware of early signs of substance abuse problems or had a higher tolerance for distress than research suggests one should tolerate without seeking professional help (Sareen *et al*., 2010).

When compared with older age groups (i.e., 25 to 44 years, 45 to 64 years, and 65 years and over), respondents aged 15 to 24 years were found to have the highest rate of substance abuse problems (Bergeron *et al.*, 2005), indicating that they may be more likely to tolerate symptoms and are at a higher risk of failing to recognize substance abuse problems. Respondents who were aware of their needs for professional social and medical services were more likely to have co-occurring conditions, and thus, greater levels of psychological distress (Urbanoski *et al*., 2008)..

Moreover, the results on respondent’s concern on their current health status in Table 4.8 show that, large proportion 235(78.3%) of the respondents were less concerned with their current health status and a few 19(6.3%) were very much concerned with

their current health status. The possible explanation of the large number of respondents being less concerned about their current health status is likely to be contributed by the lack of awareness of the effects of substance abuse on their health status or being highly affected by substance abuse to the point of seeing it as part of their health support. This calls for various initiative geared towards improving respondent's awareness on the effects of substance abuse on their health status and availability of various treatment options. Below are some of the quotations which came from individuals with substance abuse during in-depth interviews and Focus Group Discussions.

> *"The problem with substance abuse is that in the initial stage of abusing substances we do not see it as a problem and we are enjoying a lot by abusing the substances, but later on when everything is getting harder and harder then we start regretting and looking for treatment"*

The respondents added:

> *"We do not see it as a problem and actually we enjoy abusing the drugs and for those whom you see asking for treatment it is because their heads are not that much strong"*

Again it was added by a respondent that:

> *"I do not think if it is really important for one to look for treatment as a result of abusing the substances unless he or she has other problems apart from substance abuse"*

It was further added by another respondentt:

> *"When everything is difficult, and no one accept you in the community, no one listens to you and you even do not know where to go and get help it is usually*

during that time when one tries to seek help and usually there is no one to help you except your friends who also abuses the substances and so instead of helping you he/she adds more problem to you by giving you more drugs"

The findings above clearly indicate that these youth with substance abuse problem realy need help to get them away from this harzadous behaviour which is constantly destroying their health and they still do not perceive themselves as having a serious health problem (perceived threat). Most of the time they will wait until their substance abuse problem is critical or severe (perceived severity). The possible explanation for this situation might either be that, most of them have low level of education and the education has been seen as a factor which can help an individual to recognize his/her disease condition and hence forced to look for available treatment options and so elleviate the problem (Hochbaum, Rosenstock and Kegels 1950) The nature of the perceived severity about the index of illness have also been cited as important determinants of health-seeking behavior (Kanungo *et al.,* 2015).

4.4.2 Perception of Drug Abusers Health Status and preparedness for Health Seeking and Utilization

The results in Table 4.8 show the relationship between perception of drug abusers health status and health seeking and utilization. The results show that the respondents concern on their current health status was strong and is associated with health seeking and utilization behaviours with (p=0.015). This means that enhancement of individuals concerns on their health status among substance abusers is likely to increase their possibility of seeking and utilizing available treatment options.

Table 4. 8: Relationship between Perception of Drug Abuser's Health Status and Health Seeking and Utilization

Perception Variables	Health seeking behaviour			X 2	Df	P value
	Yes	No	Total			
Accept of substance use as a health problem						
Always	25	35	60	8.926	4	0.063
Most of the time	727	69	96			
Sometimes	19	76	95			
Rarely	9	28	37			
Never	3	9	12			
Importance on your health						
Very much	58	143	201			
Much	16	53	69			
Average	5	13	18	3.753	4	0.440
Little	0	5	5			
Very little	2	2	4			
Concern about your health status						
Some what	13	12	25			
Very much	13	27	40			
Much	6	30	36	14.110	5	0.015
Rarely	7	39	46			
Never	44	108	152			
Feeling shame talking about substance abuse problem						
Very much	9	33	42			
Much	23	68	91			
Average	14	31	45			
Little	17	37	54	1.840	4	0.765
Very little	20	48	68			
Current health status						
Very good	7	15	22			
Good	10	15	25			
Average	33	93	126			
Poor	39	108	147	5.129	4	0.274
Very poor	1	0	1			

Source: Field Data, 2016

Results in Table 4.8 show the cross tabulation of several variables in relation to health seeking behaviours and results indicate that individuals with substance abuse

problem who were concerned with their poor health status were more likely to seek available treatment options as compared with their counterparts who had no concern with their poor health status. The possible explanation for that scenario is that, for youths with substance abuse problem to utilize the available treatment options they must first see their condition as a problem interfearing with their daily activities such as failing to work, to eat, to play and to enjoy life (perceived severity) then they will seek available treatment options.

These results mirror with the previous study by (Abongile, 2010) which state that, while many factors deter youths from seeking professional help, increased psychological distress has been found to increase youths' willingness to seek professional help. Youths have been recognized to seek professional help more when they perceive increasing levels of symptom and problem severity. In this way, distress is thought to motivate youth to overcome barriers to professional help that they may have previously been unable to overcome (Sheffield *et al*., 2010.). For example, Zwaanswijk *et al.*, reported that approximately six percent of youths sought help when they perceived themselves as having minor emotional or behavioural problems, but approximately 18 percent of youthts sought help when they perceived their problems to be serious (perceived severity)

It has also been clearly pointed out that the time most youth start seeking and utizing available treatment options is usually between 5 to 10 years and most of these start using available treatment options when their health status is severely poor (perceived severity) (Hochbaum, Rosenstock and Kegels 1950)

4.5 Pattern of Health Service Utilization

The pattern or environment which surrounds an individual plays a big role in facilitating the his/her use of available treatment options. Table 4.9 gives the details of the environment/pattern of individuals with substance abuse problem and who opt to utilize of the available treatment options in Kinondoni Municipality.

Table 4. 9: Pattern of Health Service Utilization of Health Service

Variable	N	%
Did you seek treatment		
Yes	83	27.7%
No	217	72.3%
Where did you seek your treatment?		
Soba house	26	8.7%
Methadone clinic	49	16.3%
Self treatment	1	0.3%
Mental health clinic	6	2%
Traditional healers	1	0.3%
Cost of treatment in a month		
Less than 10,000 tshs	28	9.3%
15,000 to 50,000Tshs	9	3%
60,000 to 20,000Tshs	24	8%
250,000 500,000 Tshs	12	4%
600,000 to 1,000,000 Tshs	10	3.3%
Health facility near to your house		
Dispensary	72	24%
Health center	116	38.7%
Hospital	82	27%
Sobs house	20	6.7%
Mental health clinic	6	2%
Counseling centers	4	1.3%
Way to reach health facility		
Foot	142	47.3%
Bicycle	18	6%
Tricycle	19	6.3%
Public transport	121	40%
What time does it take to reach to h/f	Frequency	Percentage
Less than 15 minutes	128	42.7%
15 to 30 minutes	110	36.7%
30 min to 1 hour	28	9.3%
1hour to 2 hours	24	8%
More than 2 hours	9	3%
Where would you prefer to get your treatment?		

Medical store	10	3.3%
Government Hospital	77	25.7%
Private Hospital	207	69%
Traditional healers	6	2%
After what time of dependence did you seek treatment?		
After three months	1	0.3%
After one year	10	3.3%
After five years	30	10%
Within ten years	26	8.7%
What stage of treatment did you reach		
Up to recovery	11	3.7%
Relieve symptoms	24	8%
Did not complete the treatment	32	10.7%

Source: Field Data, 2016

Table 4.9 indicates that the majority of substance abuser 217 (72.3%) never sought treatment for substance abuse problems. The few who sought for treatment opted for methadone clinic and sober houses. The majority of substance abusers spent around 10,000 Tshs to 200,000. Tshs per months for their treatment. The majority of those who used the services were likely to live closer to the health facilities where they attended. Moreover, most of them were likely to reach the health facility by using commuter busses, bicycle or by walking. Those who sought treatment were likely to spend less than an hour to get to the health facilities. The majority of those who sought treatment started to do so after a period of 5 to ten years after they started using drugs and most of them, they did not complete their treatment.

The possible explanation for these results could be explained by the awareness that individual's victims of substance abuse had, on the available treatment options like methadone and sober houses which have been mostly advertised and most people in the community are aware of their existence. Moreover, this literature is coming up so

strongly by its effectiveness in addressing the scourge. According to DCC (2008). "Another one of the successes in Tanzania has been the government-run opiod substitution therapy OST programme in Dar es Salaam, funded by PEPFAR. This service began operating in February, 2011 at the Muhimbili National Hospital and is currently being expanded to several additional sites, making it one of the largest methadone programmes in Sub-Saharan Africa."

The implication that is obtained from these results is that stakeholders' working in the field of substance abuse prevention need to focus their efforts on creating more awareness on the available treatment options. This calls for various government and non-government initiatives such as awareness campigns on the available treatment options to be communicated to the entire community. The results are also supported by the social learning theory (SLT) which emphasizes that individuals are likely to utilize the services when they are doomed they observe others using the options and they will learn from them by interacting with them through observation. The Health Belief Model (HBM) it further substanciated by introducing two constructs such as perceived benefits and perceived severity, this means the youths with substance abuse problem need to perceive that the treatment that is offered is effective to elleviate their health problem irrespective of the level of severity.

These results are in agreement with the finding which reports that, specific efforts should be made to obtain health facts. The victims are more likely to use other health-related practices such as taking advantage of available health treatment options. It has been suggested that this information-seeking process be an integral

process of health seeking and as such, should receive greater government attention (Rowsk, 2011).

CHAPTER FIVE

CONCLUSIONS AND RECOMMENDATIONS

5.1 Chapter Overview

This final chapter summarises the results, provides the conclusion for the study, and makes policy recommendations and recommendations for future research in relation to the objectives of this study. The thesis has mainly assessed the determinants of health seeking behaviours among youths involved in substance abuse in Kinondoni Municipality. Specifically, it assessed the socio-demographic characteristics of the respondents. It assessed the awareness of the respondents regarding the available treatment options and their HSB. It also examined the perception of substance abusers on their health status and their HSB" and the utilization pattern of available treatment options including their relationships with their health seeking behaviours.

5.2 Summary

5.2.1 Social Demographic Characteristics of Individuals with Substance Abuse.

The study in chapter four showed that social dermographic characteristics of individuals with substance abuse problem usually influence their health seeking behaviours. Female gender was more likely to seek services as compared with their male counterparts; those who were educated were more likely to seek treatment options when compared with those who were less educated; those who were employed were more likely to seek treatment options compared to those who were not employed and staying in maskani or hangouts. The study also revealed that, older youths with substance abuse problem were more likely to seek trament options compared to youth who were 20 years and younger, those who had good income

were more likely to visit health facilities and obtain the available treatment options as compared to those who had no or less income and those who were married or cohabiting were more likely to seek the available treatment options as compared to those who were single. Overall, all the social demographic characteristics played a role in influencing the health seeking behaviours of individuals with substance abuse problems.

5.2.2 Awareness on the available treatment options

The results in chapter four showed that, the majority of youth about 62% were not aware of the available treatment options for their substance abuse problem. The majority of them had negative perception regarding available treatment options and some of them were not even aware that thir substance abuse problem can be treated or helped with the available treatment options in Kinondoni Municipality. The reasons why the majority do not utilize the available treatment options for substance abuse problem were; lack of awareness of availability of the treatment, the treatment does not help, they could feel week, and substance abuse is not a problem. Moreover, the major source of information on the availability of treatment was mainly from friends, families and relative who are not also well informed about the available treatment options and the possible advantage that can be obtained from those treatment options. The majority of youths with substance abuse problem had little or no concern of their substance abuse problem, which could also explain why they did not utilize the available treatment options.

5.2.3 Perceptions of youth on their health status

The results from chapter four further showed that the majority of substance abusers namely about 49% perceived their health status to be poor; about 35% perceived their health status normal or fair and only 8.3 perceived their health to be good. Though most of them perceived their health status to be poor, they had less concern about their substance abuse problem and this was a strong predictor of utilizing the available treatment options. Those who were concerned with their health status were more likely to seek for their available treatment options as compared to those who were less concerned with their health status. The reason many did not utilize the available treatment options though they perceived their health to be poor, varied from not being aware of the available treatment options, substance abuse is not a problem that needs attention, and treatment does not help.

5.2.4 Pattern of Utizing Substance Abstince Services

The results of the study indicate that the majority of substance abusers never sought treatment for substance abuse problems. The few who sought treatment opted for methadone clinic and sober houses. The majority of substance abusers spent around 10,000 Tshs to 200,000. Tshs per months for their treatment. The majority of those who used the services were likely to live closer to health facilities where they easly attended. Moreover, most of the victims were likely to reach the health facility by using commuter buses, bicycle or walking. Those who sought treatment were likely to spend less than an hour to get to the health facilities. The majority of those who sought treatment started doing so after a period of 5 to ten years after they started using drugs and most of them, did not complete their treatment.

This study found that social demographic characteristics such as gender, education and income determine the health seeking behaviours of youth involved in substance abuse. The study has also found that awareness acquired through observation, imitation and motivation is one of the determinants of health seeking behaviours. Further, the perceptions of substance abusers on their health status and on the available treatments influence health seeking behaviours. The utilization patterns for the treatment such as the type of treatment sought, preference of treatment, time taken to reach the facility and the time taken to start the treatment have been found to be associated with health seeking behaviours.

5.3 Originality and Contributions to Knowledge

Contribution to knowledge means adding to the discussion or providing new solutions to known problems (Petre and Rugg 2010). This study employed Health Belief Model, Social Learning Theory, and the Theory of Planned Behaviour in assessing the determinants of health seeking behaviours among youth invoved in substance abuse in Kinondoni municipality. The study has made three significant contributions to knowledge .The contributions to knowledge include; empirical contributions, methodological contribution and theoretical contribution.

5.3.1 Empirical Contribution

Empirically this study makes a significant contribution to knowledge. According to literature reviews of various studies such as (DCC, 2015; Yusuph 2016; Masibo, 2013; Mbatial *et al*., 2009; Mbwambo et al 2012 and Msami *et al.,* 2004), there is

insufficient empirical evidence which tries to bridges the gap on the determinants of health seeking behaviors among youths who are involved in substance abuse in Tanzania, particularly in Kinondoni.. Therefore, this study has been unique and probably the first to be done in Tanzania. Therefore, its contribution to the knowledge is based on the variables like socio-demographics characteristics, awareness of the available treatment options, perception of health status among youths with substance abuse problem and the pattern of utilization of substance abstinence services and linking them with utilization of available health services. The originality of the current study is apparent in various aspects. The study is original in terms of the setting, as well as the topic being researched within the Tanzanian context. Most of the research about health seeking behaviours in Tanzania has focused on other conditions like Diabetes (Nguma, 2010), Malaria (Sekule, 2007) , TB (Tarimo, 2012) but there is limited empirical evidence on the determinants of health seeking behaviors among youth involved in substance abuse.

5.3.2 Theoretical contribution

The theoretical contribution in this study is grounded in the Health Belief Model (HBM). This study theoretically developed and empirically evaluated an integrated research framework incorporating factors from social learning theory and theory of planned behaviour, in assessing the determinants of health seeking behaviours among youth invoved in substance abuse in Tanzania. Studies which were conducted in the past used this model separately or in collaboration with other theories. So in Tanzania this is probably the first study to have the combination of HBM, SLT and the TPB.

- The study has proven that the health belief model (HBM), the social learning theory (SLT) and the theory of planned behavior (TPB) can be applied to study health seeking behaviors among persons with substance abuse problem by providing information on the following variables; socio-demographic characteristics, awareness of the available treatment options, perceptions of youth health status and the pattern of utilization of the available treatment options and linking these to health seeking behaviors among youth.
- These theotries were developed and used in different countries with different socia economic environments as compared to Tanzania. So the application of these theories in new settings to assess the determinants of heath seeking behaviours involved in substance abuse is part of the theoretical contribution interms of theoretical development
- The health belief model, social learning theory and theory of planned behavior extend their geographical use from metropolitan countries where they were discovered and highly applied to studies in various behaviors. Its use in the Tanzanian context contributes to theory development as it has extended its use to analyzing how health seeking behaviours with substance abuse can be influenced by socio-demographic characteristics, awareness of the available treatment options, perceptions, health status and the pattern of utilization of the available treatment options.

5.3.3 Methodological contribution

This study has advanced the methodological context of prior studies. Thus it provides a guideline for researchers interested in health seeking behaviours or related services in health setting. In particular, the philosophical, data collection instruments, data validity and reliability, selection of variables and sampling procedure should also enlighten researchers on the methodological aspects of obtaining data from a setting in a local context. This work has contributed to the field of methodological literature by using a holistic model approach that promoted understanding of situational influences on health-seeking behaviors in Tanzania as it is assumed that health-seeking behaviors vary from country to country in Africa. Such differences can be due to factors like social demographic characteristics of individuals, awareness, perceptions, psychological factors, cultural factors and the patterns of utilizing the available services. It once again calls for researcher to integrate more than one model or theories in elaborating health seeking behaviors.

This study, carried out in Tanzania focused on youth with substance abuse. This has contributed in providing a better understanding of the factors associated with health seeking behaviours among youth invoved in substance abuse. Compared to other studies done on individuals with substance abuse, in other countries, this study has provided a better link of factors which determine the health seeking behaviours in the unique population of substance abusers. This study has therefore advanced the methodological implications in terms of uniqueness of the population involved in Tanzania.

Most scholars have argued that the power of generalizing research findings to the population is lacking in descriptive data analysis, thus limiting generalization at the sample level. On the other hand, other prior studies used very small sample sizes that tend to generate statistical errors so their findings cannot be trusted while other studies have used larger sample sizes that tend to be affected by small distraction therefore, their finding are suggested to have had the effect of validity and reliability. Throughout this study, the author added to the body of information by presenting results that are consistent with the recommended sample size. In addition, this study has contributed to the advancement of qualitative and quantitative approach in data collection and analysis techniques.

5.3 Conclusion

The major aim of the study was to assess the determinants of health seeking behaviours among youths invoved in substance abuse. The objective has been achieved. The knowledge gap whereby studies of health seeking behaviours in Tanzania were considered scant has been bridged by this study. The study was able to add to the existing theories and model through the social learning theory (SLT), health belief model (HBM), and the theory of planned behaviour (TPB) including the equation of health seeking behaviour, and the social demographic characteristics of the young people especially in Tanzania. The research was also successful in forming current practice and policy by providing evidence based information that emphasizes on youth's voluntary participation and autonomous deliberation of matters concerning adherence or non adherence to health services available in the study area. The overall synthesis of this study shows that, the knowledge of the

determinants of health seeking behaviours can improve the panning, designing and implementation of social and health interventions aimed at improving the health status of the young people prone to the substance abuse.

5.4 Recommendations from the Study

The Ministry of Health Community Development Gender, Elderly and Children, and other health stakeholders dealing with prevention of substance abuse, need to consider inclusive and participatory approach in identifying and overcoming different levels of challenges and resistance that impact different individuals with substance abuse problem in accessing the available treatment options.

The Ministry of Health Community Development Gender Elderly and Children, in collaboration with all stakeholders in the fight against substance abuse should consider creating a more condusive environment that favours youth self esteem and self efficacy in managing health services related substance abuse.

The Ministry of Health Community Development Gender, Elderly and Children alongside Non-Governmental Organizations, professional's invoved in treating substance abuse should engage in effective awareness campaigns with youths on the available means of helping people with substance abuse problems. This can be achieved through mass media campaigns and community outreach efforts to prevent and treat youth and other members of the society involved in substance abuse.

The stakeholders in health and social welfare should encourage and or run studies to encourage the male gender to learn and emulate the female gender preparedness to

persue health seeking initiatives for all inclusive enhancement of health in the community.

The wider community, including parents and local government authority should play their roles of educating, mobilizing and empowering young people by openly discussing social, cultural, economic and political issues with young people.

The government of Tanzaniua, through the Ministry of Health Community Development, Gender, Elderly and Children with the collaboration of other stake holders in the fight against substance abuse, should strive to bring the available services closer to people with substance abuse problems, increasing speed of service provision and providing diversified treatment options to meet individual and group preferences.

5.5 Recommendations for Further Study

The researcher recommends the following areas for further study:

There is a need for further studies to explore the relationship between parenting and substance abuse among the young. The role of family support in promoting treatment for substance abuse problem warrants investigation. The accessibility and acceptability and effectiveness of the available rehabilitation services for substance abuse in Dar es Salaam and elsewhere should be established. The need for the study on variations in drug use and health seeking gender behaviours need to established in the immediate future.

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APPENDICES

APPENDIX A: DSM1-TR CRITERIA FOR SUBSTANCE DEPENDENCE

A maladaptive pattern of substance use, leading to clinically significant impairment or distress, as manifested by three (or more) of the following, occurring at any time

Tolerance, as defined by either of the following:

A need for markedly increased amounts of the substance to achieve intoxication or desired effect.

Markedly diminished effect with continued use of the same amount of substance.

Withdrawal, as manifested by either of the following:

The characteristic withdrawal syndrome for the substance.

The same or related substance is taken to relieve or avoid withdrawal symptoms.

The substance is often taken in larger amounts or over a longer period than was intended.

Persistent desire or unsuccessful attempts to cut down or control substance use.

A great deal of time is spent in activities necessary to obtain the substance, use the substance, or recover from its effects.

Important social, occupational, or recreational activities are given up or reduced because of substance use.

The substance use is continued despite knowledge of having persistent or recurrent physical or psychological problems caused or exacerbated by the substance.

APPENDIX B: Demographic Information

1. Age----------

2. Sex

Female ( ) Male ( )

3. Marital status ( )

Single ( ) Married ( )

Divorced ( ) Separated

cohabiting

4. Education

None Primary

Secondary College

5. Income

Under 100,000 Tshs per month ( ) 150,000-300,000 Tshs per month( )

350,0000-500,000 Tshs ( ) 600.000-1,000,000 Tshs and upper( )

1,200,000 Tshs and above

7. Occupation ( )

Employed ( ) Self employment

Householder Student

Retired Others

8. Family size

2 person( ) 2-4 person ( )

4-6 person ( ) Upper 6 person ( )

Are you the head of a household?.....

If you are not the head of your household, what is the occupation of that

person?

....

Who provides sources of income to your household?

Please tick as appropriate.

9. Accommodation

Landlord ( )Lodger ( )

Maskani/gheto Others ( )

10. What do you normally spend the most money on?

Please rank in order of most money spent .

Area Rank Expenditure ( ) Food ( )

Addictive drugs ( ) Clothing ( )

Housing/rent ( )Healthcare ( )

Education/training ( )Transport ( )

Labourers ( ) Leisure ( )Others

11. How would you rate your current health?

Poor 1( ) Fair 2

Good 3( )Excellent 4

12.Do you know what is making you ill?

Substance abuse Don't know

Others

13. How did you know what is making you ill?

Self-diagnosis 1 Friend, neighbour or household member 2

Person in the duka la dawa or a shop 3 Clinic/hospital/medical person 4

Traditional healer 5 Other:specify 6

14.Did you seek any treatment?

Yes 1 ( )No 2( )

If yes, where did you seek treatment?

Sobba house Methadone clinic Self treated

Mental health clinics support group Others specify

If no what were the reasons for not seeking treatment? Mention them…….

15.What was the cost of the treatment altogether?

16.What kind of health facility is the nearest to your house?

17.Which is the way you would normally get to this health facility?

Foot 1 Bicycle/Boda boda 2

Motorbike 3 Vehicle 4

Camel/donkey 5 Other: specify 6

18.Using the way you would normally, how long does it take to get to this health facility?

Less than 15 minutes 1 Between 15 and 30 minutes 2

Between 30 minutes and 1 hour 3 Between 1 and 2 hours 4

More than 2 hours

19.Has there been a time when you needed to get to this health facility but was not able?

Yes 1 No 2

20. If you had a choice, where would you seek treatment for yourself?

Shop 1 Duka la dawa 2 Government hospital 3

Private/mission hospital 4 Government health centre 5

Private/mission health centre 6 Government clinic/dispensary 7

Private clinic/dispensary 8 Traditional healer 9

Other, specify: 10

21. For how long have you been on drugs?

22. Are you aware of the availability of treatment ptions for substance abuse problem?

Yes □

No □

23. Have you ever attempted to treat your drug problem?

Yes □

No □ If no, Go to Question

24. after how long after dependence did you get care from a provider?

The same month □ After three months □

After six months □ After one year

Within 5 years Within 10 years

Above 10 years Others specify

25. Until what step of treatment have you completed your course of treatment according to provider opinion?

To recover □ To relieve the symptoms□

Do not complete my course of treatment □

25. How much was useful the usage of health services for the treatment of your substance abuse problem in your opinion?

Very much □ much□ somewhat □

Low □ Very low □

26. How satisfied are you with the behavior and accountability of health service providers?

Very much □ much□ somewhat□

Low □ Very low □

27. How much is maintained your dignity and respect, as receiving care from health care providers?

Very much □ much□ somewhat□

Low □ Very low □

28. Have you received your needed care at the right time, when you visited to health care centers?

Always □ Most of the time □ Sometimes □

Rarely □ Never □

29. How important are the behaviours of health care providers in your assessment of the services that you received?

Very much □ much□ somewhat□

Low □ Very low □

30. How important is the spent time for receiving health care services in your assessment?

Very much □ much□ somewhat□

Low □ Very low □

32. How important is the cost of health care in your assessment of services that you received?

Very much □ much□ somewhat□

Low □ Very low □

33. How important is the quality of received services in your assessment from health care providers?

Very much □ much□ somewhat□

Low □ Very low □

Psychological factors

34. Did you accept the fact that you're sick, when you saw substance abuse symptoms?

Always □ Most of the time □ Sometimes □

Rarely □ Never □

35. In your opinion, how much is important your health for the community, your family and friends?

Very much □ much□ somewhat□

Low □ Very low □

36. How much do you value your health and try to keep it?

Very much □ much□ somewhat□

Low □ Very low □

37. Are you afraid of the treatment consequences or death?

Quite□ ( ) Much□ ( ) Somewhat □ ( )

Low□ ( )none□ ( )

38. Did you have any stress about your illness and its treatment in the last three months?

Quite□ ( )Much□ ( )Somewhat □ ( )

Low□ ( )none□ ( )

39. How much do you feel shame from expression of your disease, talking about it and getting treatment for it?

Very much □ ( )much□ ( )somewhat□ ( )

Low □ ( )Very low ( )□

Individual factors ( )

40. What is your assessment of your disease severity and its symptoms?

Slight□ Average□ Severe□

41. How much information did you have about your disease and needed care before receiving care?

Very much □ ( )much□ ( )somewhat□ ( )

Low □ ( )Very low □ ( )

42. Are you suffering from a another disease?

Yes □ ( )No □ ( )I don't know□ ( )

43. How would you assess the state of your health?

Excellent□ ( )Very good□ ( ) good□ ( )

average□ ( )weak□ ( )

Socio-cultural and familial factors ( )

44. Do you think hiding the disease and tolerance is a desirable feature?

Yes □ ( ) No □ ( )

I don't know ( )

45. How much you depend on the others like family members in health care receiving? (Financial dependence, dependence in seeking care and decision making)

Very much □ ( )much□ ( )

somewhat□ ( )Low □ ( )Very low □ ( )

46. How much your illness and its symptoms prevent you from doing your daily activities? (Walking, dressing, sleeping, eating)

Very much □ ( )much□ ( )somewhat□ ( )

Low □ ( )Very low □ ( )

47. Can you receive your medications easily and without a prescription?

Always □ ( )Most of the time □ ( )Sometimes □ ( )

Rarely □ ( )Never □ ( )

48. How much you worried about your information will be kept confidential in health care centers?

Very much □ ( )much□ ( )somewhat□ ( )

Low □ ( )Very low □ ( )

49. How much close distance influenced in your choice if in last three month went to a health care center?

Very much ( )much□ ( )

somewhat□ ( )Low □ ( )

Very low □ ( )

50. How much cost of care influenced in your choice if in last three month went to a health care center?

Very much □ ( )much□ ( )

somewhat□ ( )Low ( )

Very low ( )

51. Are you able to afford your needed health care?

Quite□ ( )Much□ ( )

Somewhat □ ( )Low□ ( )

none□ ( )

52. Are you thinking about affording before you get the health care?

Quite□ ( )Much□ ( )

Somewhat ( )Low□ ( )

none□ ( )

53. How much you influenced by advertising about medications, treatments methods and health care centers in your decision making?

Very much ( )much□ ( )

somewhat□ ( )Low □ ( )

Very low □ ( )

54. How much you access to needed information for care receiving (through television, newspapers, magazines, Internet, etc.)?

Very much □ ( )much□ ( )

somewhat□ ( )Low □ ( )

Very low □ ( )

55. Where do you often get your information?

By Newspapers & magazine□ By Radio &TV □By Intranet□

By Educational classes □ By Friends, colleague and family members □

APPENDIX C : DODOSO KISWAHILI

1. Umri…….. C01
2. Jinsia

Mwanamke ( ) 2. mwanamume ()

3. Hali ya ndoa

Sijaolewa/sijaoa (1) 2nimeoa/nimeolewa (2)

Tumetalakiana (3) tumeachana (4)

Hatujaoana ila tunaishi pamoja ( )

4. cha elimu

Sijasoma ( ) elimu ya msingi ( )

Elimu ya sekondari ( ) elimu ya chuo ( )

Elimu nyingine bainisha

5. Hali ya Kipato

Chini ya Sh.100,000 kwa mwezi ( ) Sh.150,000-300,000 kwa mwezi ( )

Sh.350,000-500,000 kwa mwezi ( ) Sh.600,000-1,000,000 na zaidi kwa mwezi

Sh.1,200,000 na zaidi ( )

6. Kazi unayofanya

Mwajiriwa ( ) nimejiajiri mwenyewe ( )

Ninamiliki nyumba ya kupangisha ( ) mwanafunzi ( )

Mstaafu ( ) kazi nyingine bainisha( )

7. Ukubwa wa familia

Watu 2 ( ) watu 2-4 ( )

Watu 4-6 ( ) zaidi ya watu 6 ( )

8. Wewe ndiye mkuu wa familia yenu?

Ndiyo ( ) Hapana ( )

9. Kama wewe siyo mkuu,nini kazi ya mkuu wa familia yenu?

Mwajiriwa ( ) Amejiajiri mwenyewe ( )

Anamiliki nyumba ya kupangisha ( ) mwanafunzi ( )

Mstaafu ( ) kazi nyingine bainisha( )

10. Nini chanzo cha kipato katika familia yenu?kitaje

Unaishi wapi

Nyumbani ( ) Nimepanga ( )

Maskani/geto ( ) mengineyo ( )

11. Ni matumizi gani hukuchukulia hela yako kwa kiasi kikubwa sana?

matumizi ya kushikilia maeneo ( ) Chakula ( )

madawa ya kulevya ( ) kuvaa ( )

kodi ya nyumba ( ) matibabu ( )

Elimu ( ) .usafiri (

wafanyakazi ( ) starehe ( )

mengineyo ( )

12. .unaitathimini vipi afya yako kwa sasa?

mbaya ( ) kawaida ( )

Nzuri ( )nzuri sana ( )

13. Unahusianisha vipi matumizi ya dawa za kulevya na afya yako?

Yanaharibu afya ( ) yanaboresha afya

Hayana madhara yoyote

Ulishawahi kutafuta huduma za msaada kwa tatizo lako la dawa za kulevya?

Kama ndiyo ni wapi ulitafuta huduma hiyo? Taja .....

Na kama hukutafuta ni kwa hapana ni kwa nini ? zitaje sababu……

Ni ngazi gani ya utoaji huduma za afya iliyo karibu nawewe?

Zahanati ( ) Kituo cha Afya ( )

Hospitali ( ).Nyumba za Soba ( )

Vituo vya Afya ya akili ( )Vituo vya unasihi ( )

.unatumia njia gani kuifikia hiyo huduma ya afya?

kwa mguu ( ) .kwa baiskeli ( )

pikipiki ( ) gari ( )

Njia zinginezo bainisha……

.kwa kutumia njia unayotumia,inachukua muda gani kufika eneo linalotoa huduma za afya?

chini ya dakika 15. ( ) kati ya dakika 15 na dakika 30 ( )

.kati ya dakika 30 na saa . 1 ( )kati ya saa1 na masaa2. ( )

.zaidi ya masaa2.

.Je,kuna wakati ulihitaji kulifikia eneo hili la utoaji huduma za afya lakini hukuweza?

.ndio ( )1hapana ( )2

ungekuwa na uchaguzi,ungetafutia wapi tiba yako?

.dukani 1 ( ).duka la dawa ( )2

.hospitali za serikali ( ) hospitali za watu binafsi/misheni 4

vituo vya afya vya serikali 5( ).vituo vya afya vya watu binafsi/misheni

.kliniki/zahanati za watu binafsi 8 mganga wa kienyeji 9

.mengineyo…….bainisha 10…….

.umekuwa kwenye matumizi ya dawa kwa muda gani?

.mwezi 1 ( ).chini ya miezi 6 ( )

.ndani ya mwaka 1 ( ) .ndani ya miaka 5 ( )

ndani ya miaka 10 ( ) zaidi ya miaka 10 ( )

.Je,umewahi kutibu tatizo lako la matumizi ya dawa za kulevya?

1.ndio ( )hapana ( )i

ulikubaliana na ukweli kwamba unaumwa ulipoziona dalili za ugonjwa?

1.daima ( )

2.muda Mwingi ( )

3.wakati mwingne ( )

4.mara chachechache ( )

5.kamwe ( )

35.kwa maoni yako,afya yako ni muhimu kiasi gani kwa jamii,familia yako na marafiki?

1.muhimu sana ( )

2.muhimu ( )

3.kiasi ( )

4.kidogo ( )

5.kidogo sana ( )

36.Ni kwa kiasi gani unaithamini afya yako na kujaribu kuitunza?

1.kikubwa sana ( )

2.kikubwa ( )

3.kiasi ( )

4.kidogo ( )

5.kidogo sana ( )

37.Je,unaogopa matokeo ya matibabu au kifo?

Kawaida ( ) sana ( ) kiasi ( ) kidogo ( ) hapana ( )

38.Je,ulikuwa na wasiwasi kuhusu ugonjwa wako na matibabu yake katika miezi mitatu iliyopita?

Kawaida ( ) sana ( ) kiasi ( ) kidogo ( ) kidogo sana ( )

39.Ni kwa kiasi gani unajihisi aibu kueleza ugonjwa wako, kuuongelea na kuupatia matibabu?

Kikubwa sana ( ) kikubwa ( ) kiasi ( ) kidogo ( ) kidogo sana ( )

Sababu binafsi ( )

40.Nini tathimini ya kiwango cha ugonjwa wako na dalili zake?

Nzuri ( ) wasitani ( ) mbaya ( )

41.Ulikuwa na taarifa kiasi gani kuhusu ugonjwa wako na huduma zinazotakiwa kabla ya kupokea huduma?

Nyingi sana ( ) nyingi ( ) kiasi ( ) kidogo ( ) kidogo sana ( )

43.unawezaje kutathmini hali ya afya yako?

Nzuri sana ya hali ya juu ( ) Nzuri sana ( ) nzuri ( ) kawaida ( ) dhaifu ( )

44.unafikiri kuficha ugonjwa na uvumilivu ni sifa inayotakiwa?

Ndio ( ) hapana ( ) sijui ( )

45.ni kwa kiasi gani unawategemea wengine kama vile wanafamilia katika kupokea matibabu?(utegemezi wa kifedha,utegemezi katika kutafuta matibabu na kufanya maamuzi)

Kiasi kikubwa sana ( ) kiasi kikubwa ( ) kiasi ( ) kidogo ( ) kidogo sana.

46.Ni kwa kiasi gani ugonjwa wako na dalili zake vinakuzuia kufanya majukumu yako ya kila siku? (kutembea,kuvaa,kusinzia,kula)

Kiasi kikubwa sana ( ) kiasi kikubwa ( ) kiasi ( ) kidogo ( ) kidogo sana ( )

. Ni kiasi gani ukaribu na huduma ulichangia uchaguzi wako ikiwa katika miezi mitatu iliyopita ulienda katika kituo cha kutolea huduma za afya?

Kiasi kikubwa sana ( ) kiasi kikubwa ( ) kiasi ( ) kidogo ( ) kidogo sana ( )

50.ni kwa kiasi gani gharama za matibabu ziliichangia uchaguzi wako ikiwa miezi mitatu ilopita ulienda katika kituo cha kutolea huduma za afya?

Kiasi kikubwa sana ( ) kiasi kikubwa ( ) kiasi ( ) kidogo ( ) kidogo sana ( )

51.Unauwezo wa kukidhi mahitaji yako ya huduma za afya?

Kawaida ( ) sana ( ) kiasi ( ) kidogo ( ) hapana ( )

52.unafikiri juu ya kukidhi gharama kabla ya kupata matibabu?

Kawaida ( ) sana ( ) kiasi ( ) kidogo ( ) hapana ( )

53.Ni kwa kiasi gani ulivutiwa na matangazo kuhusu dawa,njia za matibabu na vituo vya kutolea huduma za afya katika kufanya maamuzi?

Kiasi kikubwa sana ( ) kiasi kikubwa ( ) kiasi ( ) kidogo ( ) kidogo sana ( )

54.Ni kwa kiasi gani unapata taarifa zinazohitajika katika kupokea matibabu(kupitia luninga,magazeti,majarida,intaneti n.k.)

Kiasi kikubwa sana ( ) kiasi kikubwa ( ) kiasi ( ) kidogo ( ) kidogo sana ( )

55.unapata wapi taarifa mara kwa mara

Magazeti na majarida ( ) redio na runinga ( ) Intaneti ( ) madarasa ya elimu ()

Marafiki,wafanyakazi wenzetu na wanafamilia ( )

APPENDIX D: WRITTEN INFORMED CONSENT-ENGLISH VERSION

Consent to participate in a study titled "Determinants of Health Seeking and utilization behaviors among Youth involved substance abuse in Kinondoni Municipality."

My name is Ezekiel Henry Mbao from Open University of Tanzania. I am doing my PhD on Health Seeking and Utilization Behavior among youth involved in substance abuse.

I am conducting a research as titled above. The aim is to know the factors that prevent youth with substance abuse not to seek and utilize the available health services for them and there after intervention can be done. If you agree to join the study, you will be required to answer questions on a questionnaire that will be distributed to you that will take approximately 30 minutes to fill, comprising of questions related to the research. Participation in this study will be completely voluntary. Information obtained from you will be kept confidential and anonymous. No participant's name will be written on any questionnaire. The information collected will be entered into computers with only the participant's identification number. The results of the study will be reported as group results. We do not expect that any harm will happen to you because of joining in this study. You may refuse to participate or withdraw from the study at any time. Refusal to participate or withdrawal from the study will not involve penalty or loss of any benefit to which you are otherwise entitled. There will be no specific benefits to you; the results of the study will contribute to the present body of knowledge on health seeking and utilization behavior among youth involved in substance abuse among youth and the associated factors.

If you ever have questions about this study, you should contact the principal investigator Ezekiel Henry Mbao, Open University of Tanzania, P.O. Box , Dar es Salaam. In addition, if you ever have questions about your rights as a participant, you may call Professor Hossea. Rwegoshora Chairman of the University Research and Publications Committee, P. O. Box ,

Dar es Salaam. Tel: . If you agree please sign below; and if you do not agree then you do not have to sign it.

I,……have read the contents in this form and understood. I agree to participate in this study.

Signature of research participant……

Signature of researcher…….

Date of signed consent……

APPENDIX E: WRITTEN INFORMED CONSENT-KISWAHILI VERSION

Ridhaa ya kushiriki kwenye utafiti kuhusu “Viashiria vinavyosababisha watumiaji wa madawa ya kulevya kutotumia huduma za afya zinazolenga kuwasaidia kupunguza au kuacha matumizi ya dawa za kulevya katika Manispaa ya Kinondoni”

Jina langu ni Ezekiel Henry Mbao kutoka Chuo Kikuu Huria Tanzania (OUT). Nafanya Shahada ya Uzamivu katika utafutaji wa huduma za afya kwa vijana walioathirika na dawa za kulevya. Nafanya utafiti juu ya mada iliyoelezwa hapo juu kwa lengo la kujua tatizo na sababu zinazochangia vijana walioathirika na dawa za kulevya kushindwa kutafuta huduma za afya ambazo zipo katika jamii ili kutafuta njia za utatuzi. Nitafurahi iwapo utashiriki katika utafiti huu,ushiriki wako ni wa hiyari kabisa na madodoso yatatunzwa kwa usiri na hayatakuwa na majina ya wahusika bali namba tu zitatumika. Pia, majibu ya utafiti yatatolewa kwa ujumla wake. Iwapo unakubali kushiriki, utahitaji kujibu dodoso litakalochukua takriban dakika 30 hivi. Kutokana na aina ya utafiti huu hatutegemei wewe kupata madhara yoyote kwa kuwa mshiriki. Pia unaweza kukataa au kujitoa katika ushiriki huu wakati wowote bila kukuletea madhara yoyote. Hakutakuwa na mafao yoyote kwako binafsi kama mshiriki bali ushiriki wako utasaidia kuongeza ujuzi kuhusiana na tatizo hili la utafutaji wa huduma za afya kwa vijana walioathirka na dawa za kulevya na hivyo kusaidia kupanga njia za utatuaji wake.

Iwapo utakuwa na swali lolote kuhusiana an utafiti huu unaweza kuwasilian na mimi Ezekiel Henry Mbao, S.L.P , Dar es Salaam; ambaye ndiye mtafiti mkuu wa utafiti huu. Na iwapo utakuwa na swali lolote juu ya haki zako kama mshiriki unaweza kuwasiliana na mwenyekiti wa Kamati ya Tafiti na Machapisho, Profesa Hossea . Rwegoshora, S.L.P , OUT, Dar es Salaam. Tel: .

Kama unakubali kushiriki katika utafiti huu tafadhali weka sahihi yako hapa chini na iwapo hauko tayari kushiriki basi huhitaji kuweka sahihi.

Mimi……..nimesoma maelezo haya na nimeyaelewa vyema; nakubali kushiriki katika utafiti huu.

Sahihi ya mshiriki wa utafiti……..

Sahihi ya mtafiti.……

Tarehe ya kusaini……

APPENDIX F: INTERVIEW GUIDE

What are theavailable treatment options for a person with substance use disorders?

What types of treatment are offered to people with substance use disorder in the available mental health services?

Where do you go for treatment in case of subsistence abuse?

What is your opinion towards the available mental health services?

What information do you have about treatment of your disease"

Have you ever attempted to visit any health facility for your problem?

If no, what are the reasons for not seeking?

At what stage of your disease have you gone to a provider?

To what extent was the usage of health service helpful to your condition in your opinion?

Satisfaction of behaviour and accountability of a health care provider?

Do you accept that you are sick when the symptoms appear?

What do you think are the treatment outcomes?

Appendix G Focus Group Discussion Guide

OPEN UNIVERSITY OF TANZANIA

DEPARTMENT OF SOCIOLOGY AND SOCIAL WORK

FOCUS GROUP DISCUSSIONS GUIDE

1 .To what extent do you think youth are aware of the available treatment options?

2. What are the available treatment options that are used to help individuals with substance abuse problems in Kinondoni Municipality?

3. What are the challenges that youth with substance abuse problems do phase in accessing the available treatment options

4. How do youths with substance abuse problems perceive their health status?

How do youth with substance abuse problems do perceive the available treatment options for their problem?

5. What is the pattern of utilizing the available treatment options for youth with substance abuse problem?

Appendix H: Mwongozo wa Majadiliano kwa Vikundi Maalum

CHUO KIKUU HURIA CHA TANZANIA

IDARA YA SOCIOLOJIA NA USTAWI WA JAMII

MWONGOZO WA MAJADILIANO KWA VIKUNDI MAALUM

1.Ni kwa kiasi gani vijana walioathirika na dawa za kulevya wanauelewa juu ya msaads wa kitaalamu wanaoweza kuupata kutokana na tatizo lao la dawa za kulevya?

2. Ni huduma zipi unazozifahamu ziinavyotoa huduma za kuwasaidia watu walioathirika na dawa za kulevya?

3. Ni changamoto gani wanazozipata watu walioathirika na dawa za kulevya katika kupata huduma za kuwasaia?

4. vijana walioathirika na dawa za kulevya wanazichukuliaje au wanazionaje afya zao?

5. Ni viashiria vipi vinavyo pelekea matumizi ya huduma za kuwasaidia vijana walioathirika na dawa za kulevya?

Appendix IX: Declaration of Confidentiality

To: Municipal Director, Kinondoni Municipal Council, Dar es Salaam.

I Ezekiel Henry Mbao., (Reg no) of the Department of Sociology and Social Work, Faculty of Arts and Social Science (FASS), Open University of Tanzania in Dar es salaam declare that, I will maintain secrecy and confidentiality of the obtained information, and so I will not use any data and information obtained from your organization in the course of my research for any purpose other than for my academic purposes.

Signature…… (Student)

Date ……..