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# Heroin and HIV risk in Dar es Salaam, Tanzania: Youth hangouts, *mageto* and injecting practices

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**Abstract**
HIV risk through needle sharing is now an emerging phenomenon in Africa. This article describes the practices that heroin users are producing as they establish the rules and organization surrounding their drug use. Their practices and interactions reveal the ways that they become initiated into its use, how they progress to injecting, and the important role of local neighbourhood hangouts in facilitating this process. Their practices, interactions and narratives also provide insights into what may be the most appropriate HIV-prevention interventions. Semi-structured interviews were conducted during the months of February and July 2003 with 51 male and female injectors residing in 8 neighbourhoods in the Dar es Salaam, Tanzania. Interviews were content coded and codes were collapsed into emergent themes around hangout places, initiation of heroin use, and progression to injecting. Interviews reveal that Dar es Salaam injectors begin smoking heroin in hangout areas with their friends, either because of peer pressure, desire, or trickery. One hangout place in particular, referred to as the '*geto*' (ghetto) is the main place where the organization and rules governing heroin use are produced. Three main types of heroin 'ghettoes' are operating in Dar es Salaam. As users build a tolerance for the drug they move along a continuum of practices until they begin to inject. Injecting heroin is a comparatively recent practice in Africa and coincides with: (1) Tanzania transitioning to becoming a heroin consuming community; (2) the growing importance of youth culture; (3) the technical innovation of injecting practices and the introduction and ease of use of white heroin; and (4) heroin smokers, sniffers, and inhalers perceived need to escalate their use through a more effective and satisfying form of heroin ingestion.

Injection of illicit drugs, specifically sharing contaminated injection equipment, has been known to be a causal factor associated with the transmission of HIV since the epidemic was first recognized by Western science (Blattner et al., 1997). While the behaviours involved in preparing and injecting drugs are the direct causal factors that facilitate HIV transmission, the HIV epidemic in a number of cities around the world has been and is strongly associated with heroin injection (Des Jarlais, 1992; Vanichseni et al., 1992; Vanichseni et al., 1993; Friedman et al., 1995; Wodak et al., 1995; Davies et al., 1996). While other drugs, such as cocaine and methamphetamines (Chaisson et al., 1989; Colfax et al., 2001), are commonly injected in some localities and among some populations, heroin is perhaps the illicit drug most widely injected around the world. Furthermore, despite sometimes dramatic changes in heroin injectors' use of injection paraphernalia, the behaviours associated with heroin

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abuse continue to influence the course of the worldwide epidemic (Carneiro et al., 1999; Des Jarlais et al., 1999; Avants et al., 2000). Data from a number of countries, however, has shown that early intervention to reduce injection equipment-sharing risks can have a major impact in preventing HIV epidemics among drug users (Des Jarlais et al., 1995).

There are a number of reasons that heroin may have a special relationships to HIV infection. An important reason that heroin may be so closely tied with the HIV epidemic is that the social organization of heroin abuse has created a sub-culture. The illegality of possessing the drug, the constant need for needles to inject, the necessity of a safe place for injecting, and even the pharmacological effects of the drug may have the social effect of concentrating heroin users in common spaces (Murphy & Waldorf, 1991; Patrick et al., 1997). Places where heroin users congregate to inject vary from place to place, but all provide the opportunities for injectors to seek out needle sharing (Rothenberg et al., 1996; Rothenberg, 2001). Further, such subcultures may also provide conditions for the transmission of HIV through the sexual contacts of drug users and the sexual networks associated with drug use and exchange of sex for drugs (Ross & Williams, 2001). There is evidence that it may be the sexual contacts of injecting drug users as much as their drug-use associated risk behaviours that transmits HIV, and thus interventions that target both their drug-related risks as well as their sexually related risks are necessary (Ross et al., 1992).

There has been little information on drug injection in Tanzania or Africa in general. Injection of illicit substances has just been reported in the literature along the Kenyan coast (Beckerleg, 2004; Beckerleg & Hundt, 2004). Injecting practices are a relatively recent phenomenon in East Africa and in Africa as a whole. Consequently, the role of illicit drug injection in the HIV epidemic in Africa has received minimal attention. HIV prevalence in Tanzania has been estimated at up to 9.2%, although this figure has been recently revised to 6.7%, reflecting more representative sampling frames (National AIDS Control Programme 2002). In contrast to the estimated seroprevalence of the general population, a study conducted in Tanzania during 2003–2004 found that HIV seropositivity of blood residues in needles presented by heroin injectors ranged from 0–90% in different Dar es Salaam neighbourhoods (McCurdy et al., under review).

This study examines the ways that heroin injectors are producing the rules and organization of the spaces where they inject in Dar es Salaam, Tanzania. The development of appropriate interventions for HIV prevention among heroin injectors must be based on an understanding of the subculture of heroin injectors within the specific context from which it emerges. This article presents information about the ways that heroin injectors use the *mageto* of Dar es Salaam to share practices, needles, drugs, and sex in their pursuit of heroin.

## The socioeconomic and political setting

The emerging heroin culture grew simultaneously in a rapidly changing political and socioeconomic environment. As in most African colonies, the lack of infrastructure Tanganyika inherited from Britain made the period of transition into independence difficult and fraught with complications. During the mid-1980s a socioeconomic crisis arose following the Ugandan War and difficulties arising from attempts to implement some of the *ujamaa* socialist policies. As deficits increased, exports decreased, and dependence on foreign assistance grew in 1986, the Tanzanian government adopted structural adjustment policies in an attempt to resolve the financial crisis it faced (Lugalla, 1995; Tripp, 1990). The economic liberalization policies mandated the devaluation of currency, privatization,

and the introduction of fees for educational and health services. People's financial ability to access schools, clinics and hospitals decreased at the precise moment the HIV/AIDS crisis began a concomitant crisis in the community. During 2003, the Tanzanian government raised the official minimum wage to approximately 50 dollars a month, but few youth have access to employment in the formal sector. The growing lack of employment, rising costs of living, experience of parental loss due to AIDS, and increase in poverty are leading more youth to seek opportunities in the informal sector.

Increasingly, parental loss is affecting youth from once middle-class neighbourhoods who, with the death of a parent, end up moving to a poorer neighbourhood and losing the educational opportunities they once enjoyed. Consequently, they spend more time than they had previously in local neighbourhood hangouts. Tanzanian youth interact across socioeconomic, ethnic, and religious backgrounds in formal and informal spaces. As youth meet with family, friends, neighbours and acquaintances they increasingly share more than just a joke or a story. Unfortunately, one phenomenon that youth from all socioeconomic backgrounds are embracing is heroin and the local spaces where youth spend their time are facilitating the emergence of a heroin subculture.

## Methods

Semi-structured face-to-face interviews with 27 female and 54 male drug users were conducted between February and July 2003. In February, 5 key informants identified 50 interviewees from 7 distinct neighbourhoods in Dar es Salaam. These initial interviewees identified the types of drugs used in Dar es Salaam and the practices associated with them. Nineteen of the 50 drug users interviewed in February were injecting heroin. In July, 32 more interviews were conducted with 31 heroin injectors not previously identified. One of the February interviewees, a pregnant woman who had been smoking heroin in February, had begun to inject and was interviewed again in July. A total of 33 men and 18 women injected heroin. Seventy-two interviews were conducted in neighbourhoods adjacent to the city centre. Forty-eight of the 50 February interviews were conducted in a container with a converted office space; the other 2 interviews were conducted in a Land Rover parked in a single family's gated complex. Twenty-two of the 32 July interviews (one with the woman who had been smoking while pregnant who was injecting and breast feeding) were conducted with heroin injectors in a back room in two different family compounds in one of the neighbourhoods near city centre. The last 10 interviews took place in a rented room in the back of a guest hotel in one of the more distant neighbourhoods. Topics covered in the interviews included initiation into drug use, current and past drug use, drug use practices, social relationships among drug users, and drug use norms in Dar es Salaam. Interviews were tape recorded and transcribed verbatim into computer files in Swahili. Interviews were content coded and codes were collapsed into emergent themes around hangout places, initiation of heroin use, and progression to injecting.

The research project was reviewed and approved by the Tanzanian Commission for Science and Technology (COSTEC), the Tanzanian National Institute for Medical Research (NIMR) Institutional Review Board, the College Research and Publications Committee (CRPC) of the Muhimbili University College of Health Sciences, and the University of Texas Health Sciences Center at Houston Institutional Review Board. All participants verbally consented to participate in the study. By obtaining verbal consent we protected the study participants from identification and action by the legal system since they can not be linked to any incriminating data about their illegal drug use.

## Findings

By 2003 Tanzania was no longer just a drug transit site, unfortunately heroin had become part of the local economy. Social workers in Dar es Salaam estimate that there are approximately 200,000 to 250,000 drug users in this city of approximately 3 million (IRIN, 2004). Up until the late nineties, points of contact for the purchase of heroin once centred in the business district where sales and consumption took place in one site. A few men controlled the sales. Over a five-year period that situation changed drastically as the sale of heroin moved from a few big men to small-scale entrepreneurs. Today drug users from all over the city move around to different areas to purchase heroin from many different male and female entrepreneurs from several neighbourhoods from city centre to the suburbs. For the most part, these entrepreneurs are not drug users and they do not allow the consumption of drugs near their premises. Drug users responded by developing spaces and practices to suit their needs.

### Maskani *and* mageto

By 2003, youth in Dar es Salaam had many different types of places that they spent time at and even more names to describe them. The terms *mageto* (pl. of *geto*, the English ghetto) and *maskani* were the hangouts most often referred to by the drug users in this study. *Maskani* were open air spaces where youth could meet and mingle; *mageto* were private rooms rented in a house.

A *maskani* could be a parking lot or street corner or it could be a secluded area behind an abandoned home. Sometimes it was an open space where anyone might pass by, other times it was an area meant to be hidden from the general public and police. When asked about the allure of the *maskani* and *mageto* one drug user replied:

> I think this is because of employment, life, due to the fact the most of us we stay in the *geto* and on the street corners you have nothing to do the whole day. Therefore you are easily drawn in the dealings like that [drug culture] due to the unemployment. Eeeeh [You see]? That is why it is easy to get involved in drugs. Lack of employment explains it for most of us.

Another heroin user described a typical *maskani* scenario in this way: 'It is in the place where a lot of youth are staying, sitting and smoking. Often times the heroin smokers do stay separate, [they] separate themselves. So you may find they are ten, fifteen, thirty, and forty.'

Among Tanzanian youth generally, the term *geto* popularly refers to a rented room that any young man might rent. The renter is considered the owner of the *geto*. For those involved in the drug culture, the *geto* is also a rented room with an owner, but for drug users its primary importance is that it should function as a safe place to use drugs.

There are three types of heroin *mageto* functioning in Dar es Salaam today: taste, cash, and free. In the taste *geto* drug users offer the owner of the geto some of their heroin in exchange for entry to the room. In the cash *geto* users pay between 200 and 500 TZ shillings ($\sim$US\$0.20–0.50) for admission to the room. Depending on the neighbourhood and how much they have paid for entry, the users can expect to spend a longer time in the room and may even be served tea and a snack. In the free *geto* men and women can enter and use heroin without a financial or drug transaction.

Often times the *geto* owner also is a *dokta* (doctor) who can inject those who do not know how to inject, feel queasy about injecting, or can no longer find veins in which to inject. These *docta* are not medically trained individuals; but injectors who are experienced in giving injections. Many of those who can no longer inject themselves are being assisted to inject in the carotid artery. Some manage to inject in the carotid artery without assistance. In the taste and cash *mageto* the *dokta* will often include the injection as part of the entrance fee. In the free *geto* and even in private homes, *dokta* charge a fee of 100 shillings ( ~US$0.10) for their injection services. In each of these *mageto* the individual entering the room is expected to supply their own works.

*Initiation of heroin use*

Football pitches, the open air *maskani*, drug *mageto*, and private homes were the sites where most youth in Dar es Salaam were initiated into heroin use. Many times those who smoke were initiated into the behaviour on the street corner or on a football field as they watch the neighbourhood game. Sharing unadulterated cigarettes is common since many can not afford to buy a pack of cigarettes and most people will purchase only one or two cigarettes at a time. So no one would be suspicious of a cigarette being passed around a group of youth or adults. Some youth are intrigued about heroin use and decide to try the heroin-laced tobacco or marijuana cigarettes. In some cases they requested their initial puff of the *joint* or *cocktail*:

> I knew exactly what were they doing . . . They asked me, 'Mr., do you want to test?' I said, 'I would like to try.' And I tried. When I smoked, I found that it suited me. Then I decided to be a *mteja* [heroin user].

> We enter into it [heroin use] because of peer pressure. Meeting with our friends seeing everything they use. Then, we friends, every day we walk together . . . I watch what he does and then me, I just have to try it . . . Its because of our friends.

Peer pressure strongly motivated youth's participation in the drug culture.

Some young men and women claimed they were tricked into heroin use by friends who shared the heroin-laced cigarettes or cannabis with them for a period often of not more than three days. After the three-day period of feeling overtired and beginning to feel 'like they have malaria', many related that their friends tell them, 'No, no you don't have malaria! You have been smoking heroin and now its in your blood. You're addicted, and you can begin to participate in this drug culture with me.' For example, one man reported that:

> I did not know . . . that he had already mixed something into the marijuana . . . I smoked with him as usual. What surprised me was for marijuana you smoke till you are satisfied then you share with others. But this he smoked two puffs and passed it. He used a lot of saliva and said smoke two puffs. Now remember, I knew nothing, so I smoked, but as I finished smoking . . . I felt very bad. I asked him, 'What is happening? Why is it different from the marijuana I smoke every day?' He told me, 'Aaa; this marijuana is very strong. That's why I told you to come this way. This is from Mbeya, from Mbeya to here that is why it is very good.' He told me there was no problem . . . I told him I felt bad as I was saying goodbye . . . I knew nothing until it reached the third day. I was exhausted. That day we smoked the ordinary marijuana. I told him, 'ee why don't I feel *fresh* (good) with

> this one? Let's go buy [what we've been using] ... The next [4th] day he told me, 'Ee Mr., that was heroin. So you are also already in to it, so what is important is that you give me five hundred [shillings (US$0.50) so we can smoke.' And, truthfully, I gave the money I had.

One woman described her initiation into heroin use by a girlfriend:

> When I moved in with her is when she taught me how to use drugs ... [the first time] I took something like 3 puffs, after I smoked it I told her I felt dizzy and she told me to sleep. I asked her for the second time why the cigarette was like that, but she hid that she had [laced it with heroin]. She just told me to sleep; perhaps I was getting a fever. By that time I did not understand, so I slept. The next day went fine; during the night she put some drugs in a cigarette and gave it to me. After I smoked it, I forced her to tell me what she put in it because every time I smoked a cigarette it didn't feel quite the same. She told me that she wanted to teach me to use drugs. With those drugs already in my body, I had to keep on using them. The third time is when she told me. On the fourth day I also had to contribute some money with hers to go buy and smoke.

Users repeatedly claimed that by the third day of smoking heroin they were addicted and had no choice but to begin to participate in the drug culture and begin to pursue money in order to purchase it.

The repeated referral of being addicted after three days use is more likely to have something to do with a Swahili expression, than with actual time. The Swahili expression is, after the third day of being a guest, its time to pick up a hoe and help. After an initial guest phase enjoying the drug for free, they were told or realized that they needed to go to work to help bring in money for the heroin they consumed.

No one described an initial anger at their friends for pulling them into the heroin milieu. Perhaps they were reluctant to admit their own interest and desire to become involved. Some injectors did note that they started smoking because they wanted to be accepted as part of the group. Almost all were initiated by someone who was older or more influential. One male injector originally started heroin to impress and get to know a female heroin smoker. At first youth noted that they enjoyed the experience of the highs. It was only later that they realized what this was doing to their lives and the extent to which their health and social support was deteriorating. Then they might complain to their drug using companions, but they felt there was nothing that could be done about it. Recruitment into and desire to join the heroin subculture allowed users to have a wider network of 'buyers' with whom they could share the cost of heroin and works.

### *The progression of heroin use*

Interviewees report that injecting practices were introduced during 1998 into Kariakoo, the main market area and drug and sex trade area. During 2000 when white heroin became more readily available, its ease of use facilitated the movement from smoking to injection.

General progression into injecting heroin in Dar es Salaam follows a typical pattern from smoking to sniffing, inhaling (*chase*), injecting, and injecting with sedatives. Once someone has smoked a *joint* or *cocktail* for anywhere between six months and two years they often are encouraged and desire to move on to a more intoxicating form of the drug. According to the heroin injectors, heroin smokers often become inhalers of *chase* for between six months to

two years 'until their lungs are so compromised that they have to quit'. Sniffing or snorting is often very short lived, if pursued at all, because of the undesirability of the bloody nose that accompanies it and loss of sense of smell. Some skip both snorting and *chase* and go straight from smoking into injecting. One woman explained:

> He [her boyfriend, a pusher] started me with a *joint* [cigarette laced with heroin]. [Eventually] I felt I was too used to the *joint*, and I did not benefit enough from it, so I went to a *cocktail* (marijuana laced with heroin). Then I came to feel the *cocktail* did not suit me. Then I came to the syringe.

Only two men interviewed claimed they began heroin use by a less social path. These Muslim men from a poorer Swahili neighbourhood claimed they simply watched injecting behaviour in a *geto* and then went home with *brown sugar* (brown heroin), a lemon, and a syringe and shot up alone.

### *Brown vs. white heroin*

By 2000 there were two forms of heroin in circulation in Dar es Salaam – brown and white. For two decades only brown heroin had been generally available and most users had only smoked. Brown is the only form of heroin that can be used for doing *chase* (inhaling). Both brown and white are used for smoking and injecting. Brown heroin, however, requires cooking before injecting and white does not. White is described as more pure with a more intense and longer lasting high. It is sold in smaller units than brown for a smaller price per unit. In 2003 brown heroin generally sold for 1000–1500/ shillings ($1.00–$1.50)/unit and white sold for 500–1000/shillings ($0.50–1.00)/unit.

When asked about the difference between brown and white heroin, one user reported that the 'poor use brown, those with a little more [money] use white'. Users agreed that 'a big percent of people use white nowadays'. To prepare brown heroin, users explained that they used the following process:

> . . . we took a *Konyagi* (local gin) bottle lid, eeeeh [you see], tied it with a wire, a long wire to handle it, and that becomes like a pan. Then you take the *brown sugar* and pour in the pan you measure clean water and pour it you take lime and mix with it and then boil. You burn a piece of paper underneath the lid . . . When boiled and ready you put it down and take a clean cotton and put it so as you can draw and leave the dirt behind. Eeeeeh [you see]?. You draw in the syringe and you leave it to cool because it is warm. When it is cool then you inject.

The use of brown heroin for injection required time, implements, skill, and a safe place to prepare it. The arrival of white on the market and the elimination of the cooking technique required for injecting brown made white much more accessible. It also offered a more intense high for those seeking that thrill. The general availability of children's syringes, consisting of a 2 ml syringe with a 23 gauge needle, sold in a pack with the syringe and needle, the facility of simply mixing white with water and injecting made the prospect of injection easier, quicker, and more accessible to heroin smokers and those snorting, inhaling, who might be on the verge of shifting to a more efficient and intense heroin experience. It also provided those already injecting brown heroin with a simpler, faster, and cheaper way to inject.

*Injecting with pills*

As the amount of heroin injectors needed to get high increased, they tried to increase the number of times they injected. Between five to 10 pills of valium or phenergan (promethazine hydrochloride) would be added in addition, prior to injecting, to intensify the high. One man reported:

> I take *phenergan* then inject, also I take valium then I inject . . . *phenergan* is more powerful . . . when you take *phenergan* at this time [mid morning] you might even not be able to take drugs, probably till two o'clock or you may stay for five hours. When you have not taken *phenergan* you may inject now and find that after five minutes you need to inject again.

Men and women recognized that this was the most advanced stage of heroin use and that the next step for many associates who took pills and injected was either reducing their use, overdosing, or death from an illness related to their heroin injecting and pill-taking practices.

*Issues related to injecting and HIV*

Most drug users claimed they purchased the needle and syringe for 100/- shillings ( ~US$0.10) after they got their drugs and were on the way to the shooting gallery. Some claimed they bought a new syringe every day, others admitted that they used the set three times a day – hiding it somewhere at the shooting gallery and returning later to use it. Users usually rinse out the syringe and needle in tap or bottled water a couple of times before they use it.

Of the 45 injectors who spoke about sharing needles, sixteen denied that they or other injectors share syringes 'these days'. Eight others denied sharing syringes themselves, but admitted others share. Seven acknowledged passing used syringes to others who were injecting after them, and 14 admitted that people share syringes. Four from this last group stated that they had shared with others in groups of three or four. A fifth person noted that even 10 could share one syringe. Interviewees offered these descriptions of needle sharing behaviours:

> Often women remember [to bring a] syringe. Me, I do not borrow anyone's. It is because of diseases. A lot of them. You see? Therefore I buy [syringes], but after I inject, when someone comes to borrow [it], I give [it to] him. I do not want it back from him again. Yes. When he tells me, 'Here it is.' I tell him, 'No, just take it.'

> In there [the *geto*] we are watching each other. We observe the health of someone. If we see the health of this one . . . [is okay], then we can borrow her syringe. But if I see raised shoulders [sign of wasting], [I know] her health has deteriorated. I can not borrow her syringe.

> People mostly affected [by AIDS] are these who inject. And generally they do not care . . . you may find the same syringe I use, you may use it, and others may use the same syringe mmm. This one injects, and the other one takes it, put in drugs, and injects. So you find it is very easy to transmit AIDS, if I have AIDS then I will transmit to other people . . . Often times when one has already shot up, he takes and draws water in the syringe and flushes it out. He may do so thrice, after flushing out water he removes that

> needle and wraps it in a piece of paper and reserves that syringe for future use. He may use that syringe even five, ten time even more . . . and there are other people who share that single syringe . . . I think about half the people will . . . [share works].

Male and female injectors were aware of the risks of sharing needles and preferred not to share, but noted when they were desperate they would share.

*Risk of sex in the geto*

Interviewees noted that sex between members of a *geto* was common, and that most women would have had sex, willingly or not, with men in their usual *geto* over the course of a year. When women did not have access to cash and needed a fix they could go to the geto and try, usually successfully, to trade sex for heroin. Women also reported that they could wake up in the *geto* after passing out from an injection and discover that a man had ejaculated in their vagina. Men and women reported that this was not forced sex if the woman had not tried to push the man away or fight back, even if the woman had been too intoxicated to refuse or was unconscious. One man described women's sexual liaisons in the following way:

> First, she depends on selling her body. Second she will be with all those who use heroin [in the *maskani* or *geto*]. All those [men] there, maybe she has walked with them . . . That is the mind of the woman who uses drugs. Today she will be with me, tomorrow you come. If you find you have money, she will have sex with you. If you are in the hurry to have sex with her, you will need to buy drugs and do them with her, you see? Now right there is where you can see . . . if she has AIDS, this one gives that one . . . There isn't anyone that will come and say, 'Go to the shop and buy a condom'.

All but one of the female injectors acknowledged they were sex workers. The one who claimed she was not a sex worker lived with her husband and children. Her husband also used heroin. Sex workers reported that they insisted and tried to use condoms with their clients, but it did not always work out. They noted, however, that they did not use condoms with their partners and they were not vigilant about condom use with friends and associates in the *geto*.

*Stigma*

The social stigma associated with heroin use, and injecting in particular, is extremely high in Dar es Salaam. Most of the users hide their drug use from non-drug using friends and their family for as long as possible. Once people begin to suspect they are using, they constantly confront the drug user and attempt to persuade them to discontinue their drug-related behaviour. As they become more involved in illicit drug use activities their relationships with non-drug users become more strained and they begin to spend more and more time in the drug-using milieu where they feel comfortable and can avoid persecution. Often by the time they begin injecting, or shortly after they begin injecting, they cross over a line of what is considered social acceptable behaviour. Many men are stealing money and objects and women are engaging in sex work. Eventually, they lose all semblance of what is considered proper behaviour. They lose interest in their appearance, fail to bathe regularly, scratch themselves constantly, and develop sores and illnesses that they do not treat.

> . . . when you abuse drugs, you become different from the rest of your fellows. First you may lack cash and may be pushed to have it. You may go to steal and the like so long as you have to get [cash for drugs]. You may sell all the household belongings and finish everything and leave your house empty. Therefore, one who uses drugs, his life is completely different from the ordinary person you see. You become even different from your own family.
>
> To tell the truth I have become *alosto* (lost). I have to be strong hearted. For example, I have separated from my family, they are staying at Magomeni, and I am alone at Kinondoni. I just stay in the *geto*. I can get someone's veranda and sleep until morning . . .
>
> They [people who do not use drugs] despise us so much; they see us as a certain insect. Yes we, who are heroin users, we perceive our fellows who are not using as better than us, because for us to take bath is a problem, for us to wash is a problem. You can not even go to the hospital when you are sick until you get some heroin.

As injectors they operate outside the milieu of mainstream society, often unnoticed and ignored.

## Discussion

It appears that conditions facilitating the emergence of an epidemic of heroin injection among the young in the poor and middle classes of urban Tanzania may exist. For two decades, up until the late nineties, heroin users had mostly only smoked brown heroin. When injecting was introduced during 1998 and white heroin became more readily available in 2000, its ease of use facilitated the movement from smoking to injection. Attracted by older more influential users, youth looking for a way to become popular, develop connections, and an opportunity to try something new initially find heroin use attractive. In 2003 injectors using white heroin reported moving from smoking to injecting over the course of two years either when their friends and acquaintances began injecting or when smoking no longer satisfied them.

Many youth blame their addiction on peer pressure, lack of employment opportunities, and an abundance of unstructured free time. Even structured leisure time, like viewing pickup football games in the neighbourhood, has become an opportunity for initiation into heroin use. This is where some youth are first exposed to heroin, knowingly or not, in a cigarette they share with friends on the football pitch.

Four factors have facilitated the movement from non-injecting to injecting practices. First, Tanzania's transition into a drug consuming community. Second, the growing importance of youth culture, hangouts, and the peer pressure, desire, and trickery associated with initiation into heroin use that facilitates recruitment into the heroin milieu and the development of relationships based on the pursuit of heroin. Third, the technical innovation of injecting practices and the introduction and ease of use of white heroin. One no longer needed to cook heroin before injection. Finally, the transition to injecting that is based either on the perception of a need for more intoxicating fix that is no longer attained by the current type of usage or peer pressure.

The newly emerging injection culture is arising in the context of an established HIV/AIDS epidemic. Youth are aware of the dangers of needle-sharing practices and they take steps to protect themselves most of the time. However, when they are desperate to avoid the pain of withdrawal, they share works. Here we describe the practices that heroin users are

producing as they establish the rules and organization surrounding their drug use. Their practices and interactions reveal the ways that they become initiated into its use, how they progress to injecting, and the importing role of local neighbourhood hangouts in facilitating this process.

In Dar es Salaam, neighbourhood hangout places (e.g., the football grounds, someone's single rented room, a parking lot, or a secluded space) are the spaces where youth meet regularly in small and large groups. In these *mageto* (rented rooms) and *maskani* (hangout places), rich and poor, educated and illiterate youth spend a lot of time observing and learning from one another.

As impoverishment and lack of employment grow, so to does the time that youth spend in their hangout spaces. Boredom, peer pressure, curiosity, the lure of excitement, depression, stress, and anxiety all contribute to the movement of youth out of their accustomed roles in the family and community into a new popular culture the youth are constructing that is part Swahili, hip, sophisticated and urban, part gangster hip hop, and part global leisure pursuits. This leisure includes not only sports and music, but drugs. These youth's lives that are embedded in poverty and lack of opportunity are being drawn into the global drug trade as drugs move through this transit site and filter into the local community.

This study reveals that there are several points in which an HIV prevention intervention might be introduced. Needle exchange and condom promotion programs must be explored with the local community so men and women of different generations, experiences, interests, and concerns can begin to negotiate and develop HIV prevention programs that will be effective in the local context.

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