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Drug abuse in Africa

T. ASUNI

*Department of Psychiatry, College of Medicine, University of Lagos,
Lagos, Nigeria*

O. A. PELA

*Clinical Pharmacy Unit, Faculty of Pharmacy, University of Benin, Benin,
Nigeria*

ABSTRACT

Apart from cannabis abuse in northern and southern Africa and khat chewing in north-eastern Africa, the history of drug abuse in Africa is relatively short. The abuse of drugs in Africa is nevertheless escalating rapidly from cannabis abuse to the more dangerous drugs and from limited groups of drug users to a wider range of people abusing drugs. The most common and available drug of abuse is still cannabis, which is known to be a contributing factor to the occurrence of a schizophrenic-like psychosis. The trafficking in and abuse of cocaine and heroin are the most recent developments in some African countries that had had no previous experience with these drugs.

Efforts should be made to design and implement drug abuse assessment programmes to determine the real magnitude and characteristics of the problem and to monitor its trends. A lack of funds and a shortage of adequately trained personnel have made it difficult to implement drug abuse control programmes. In addition to formal drug control involving the implementation of legislation, there is an informal system of drug abuse control operating through the family, church, school, neighbourhood and work environment, as well as healthy recreational activities. It is suggested that efforts in African countries should be directed towards strengthening not only the formal drug control system but also informal control in order to compensate for the insufficient funds and the shortage of personnel trained in implementing formal drug control measures. It is very likely that the drug problems in African countries will worsen in future unless more effective measures are implemented to arrest the current situation.

Introduction

Drug abuse is defined as "... excessive or inappropriate use of a [psycho-active] substance by a person; such use being considered or judged to be illegal (immoral) by the culture and resulting in harm to the

person or society" [1]. In defining the phenomenon, therefore, the key determinant is the perception of society of what constitutes drug abuse. It may be stated in general terms that the socio-cultural values and standards relating to drug abuse in Africa have been weakened by the influence of international developments relating to drug abuse, which have given rise to the change in what society considers abuse.

Historical background

With the exception of north Africa, where cannabis resin (hashish) has traditionally been used by members of the Sufi sect, east Africa, where the use of khat has been institutionalized, and perhaps southern Africa, where cannabis (dagger) has been widely used [2], there is no evidence to support the view that the abuse of drugs has been part of the African heritage [3, 4]. Other psycho-active substances currently being abused do not have historical antecedents in any part of Africa. Africans, though deeply religious, have not used drugs as a medium in religious rituals, and none of the indigenous herbal psycho-active substances have been used in ceremonies [2].

The situation in Africa and the life-styles of the Africans have drastically changed over the past years under the influence of industrial and urban developments. These developments have, in turn, changed the way in which the Africans achieve ataraxia; at present, the easiest way to achieve it is to resort to psycho-active substances.

Khat (*Catha edulis*), a plant grown mainly in southern Arabia and eastern and southern Africa [5], first received international attention in 1935 at the League of Nations [6]. The psycho-active effects of khat chewing, which are derived from cathine and cathinone [7], are similar to the effects produced by using amphetamines. Within the African region, khat has been grown and used in Ethiopia, Kenya, Madagascar, Somalia and the United Republic of Tanzania. The fact that the pleasurable, stimulating and euphoric effects of khat chewing can only be derived from the fresh leaves and shoots of the plant may have contributed to the low popularity of khat as a substance of abuse beyond the local areas of cultivation.

The plant *Cannabis sativa*, from which cannabis preparations such as marijuana and hashish are derived, grows wild in Africa. Certain evidence suggests that the cultivation of cannabis and its use as a drug of abuse were introduced into Africa from India [8-10] by the Sufi sect and by Asian traders and travellers [9, 11]. One study indicated that the cannabis plant and its use could have been spread across the Sahara to west Africa around the sixteenth century [8]. There is also evidence suggesting that soldiers returning from the Second World War were responsible for the increased

incidence of cannabis abuse in west Africa, particularly in Nigeria [2, 4]. This is supported by the fact that in west Africa there is no known indigenous name for cannabis, nor has it been used there for mystical purposes. This is also supported by research findings indicating that cannabis is an important factor in the occurrence of mental illness in Africa [12, 13]; this factor is much less known in cultures where cannabis has for a long time been consumed [14].

Another possible route was across the Indian Ocean. This may have been the route by which travellers from India brought cannabis from India to east, central and south Africa as early as the second century, but there is no evidence to suggest that the use of cannabis spread at that time from there to the west coast of Africa.

Current drug abuse situation in Africa

Because of the lack of information on the subject, an assessment of the extent, patterns and trends of drug abuse in all the countries of Africa is not an easy task. There are no systems for collecting and retrieving data on drug abuse in African countries, and drug abuse assessment projects are urgently needed for all African countries.

This article has, to a large extent, been prepared on the basis of data provided by various workshops and seminars held on the subject in the course of the past 12 years.* The following paragraphs summarize the drug abuse situation according to the most commonly abused substances.

Cannabis

Cannabis grows wild in most parts of Africa but it is also illicitly cultivated. It is the most widely abused illicit drug in the region. It appears to be less abused in countries of east Africa, such as Ethiopia and Somalia, where the abuse of khat is prevalent. Although cannabis is not indigenous to west Africa, it is illicitly cultivated and widely abused in that part of the continent. In Nigeria, cannabis is predominantly abused by teenagers, who begin using it at the age of 14. The situation in other west African countries is similar.

* In particular, the 1974 Workshop of the Association of Psychiatrists in Africa (held at Nairobi, Kenya), the African Seminar on Problems of Drug Dependence (held at Lagos, Nigeria, in 1980) and the World Health Organization Workshop on Prevention and Management of Drug Dependence through Primary Health Care (held at Lagos, Nigeria, in 1985).

Khat

The chewing of khat has been practised for years and is, to a large extent, socially accepted in Ethiopia, Kenya, Madagascar and Somalia; some of these countries are introducing control measures to discourage the cultivation and use of khat. Apart from the habitual use of khat, Workneh [15] reports that it is used by students to improve their academic performance, by truck drivers to keep themselves awake and by labourers to supply the extra vigour and energy they need for their work. It is interesting to note that the same reasons have been reported by cannabis users in west Africa.

Amphetamines

Amphetamines are imported into Africa, although there is no significant medical justification for using these substances. They are often illegally smuggled into African countries, where they eventually find their way into open markets and patent medicine stores.

A few countries, such as Somalia, the Sudan and Togo, have not reported any amphetamine-related problems, but there is general consensus that the abuse of amphetamines in Africa is a problem mainly among adolescents and unskilled labourers, such as drivers and farmers.

Opium

Opium is reported to have been abused, sometimes in combination with cannabis or alcohol, in Mauritius, mainly among the Chinese ethnic group.

Cocaine, heroin and lysergic acid diethylamide

These drugs are not manufactured in Africa but have been increasingly present in Nigeria and other west African countries, as shown by recent seizures and arrests. The evidence suggests that African, and especially west African countries, are used by drug traffickers as transit points for heroin trafficking from South-East Asia to Europe and North America. It has recently been reported that some Nigerians have been used as carriers of drugs and some have invested in the illicit drug trafficking [16]. Cocaine and heroin have recently been seized for the first time in the Sudan.

An increasing abuse of cocaine and heroin has been reported in Nigeria [13]. The abuse of these drugs has also been reported in other African countries such as Kenya, Liberia and Mauritius.

Sedative-hypnotics

For the purpose of this article, sedative-hypnotics include barbiturates, benzodiazepines and other substances, the abuse of which presents similar problems. These substances are imported for legitimate medical purposes, but reports from various African countries indicate that they have also been abused, especially by women. A study in Nigeria has shown that, in order of magnitude, the abuse of these substances is second in rank following alcohol abuse [13]. Mandrax (methaqualone and diphenhydramine) was commonly abused in Nigeria in the early 1970s, but since it was banned, its abuse has abated [13]. However, some other African countries, such as Swaziland, have reported an increase in the trafficking and abuse of Mandrax.

Glue and petrol sniffing

An increase in the abuse of benzene by inhalation has been reported among Sudanese children [17]. Recent reports from Kenya, Somalia, Swaziland and Zambia indicate the abuse of glue and petrol by sniffing, though the extent of such abuse varies from country to country. Pela and Ebie [13] highlighted the potential for abuse of volatile solvents in some occupational groups in Nigeria. Most recent reports from Ethiopia indicate that the abuse of glue and petrol is prevalent among juveniles.

Pethidine, morphine and demerol

These drugs have mainly been abused in African countries by individuals working in the field of health, but such abuse has not been widespread.

Effects of drug abuse in Africa

The amotivational syndrome has been described as an effect of cannabis abuse. It leads to a poor school performance and the adolescent may eventually drop out altogether.

The percentage of cannabis-associated psychosis has been reported to be between 12 and 40 per cent of all psychosis in African psychiatric hospitals. These findings leave no doubt that the abuse of cannabis in African conditions can contribute to the development of psychosis in susceptible individuals. Boroffka has observed that two types of psychosis may develop in association with cannabis abuse: (a) a reaction to the first exposure to cannabis abuse in a previously well-integrated personality; and (b) escalation of a psychotic process in a personality that has already

been breaking down (the resort to cannabis is in this case a symptom of the incipient psychosis) [18].

The cannabis-associated psychosis is a schizophrenic-like disorder and may be accompanied by a bout of excitement. Certain evidence suggests that cannabis use is one of the important contributory factors in automobile accidents. It has been reported that criminals involved in highway or armed robberies use cannabis before committing such criminal acts. The habitual cannabis user is usually a drifter, unable to maintain a job or establish a continuous relationship with others, especially with members of the opposite sex.

Amphetamine psychosis, which is usually acute, is especially noticeable among students during pre-examination period.

As khat chewers spend more time chewing khat than working, khat abuse affects the productivity of the countries involved. Khat users from the lower income group may spend as much as half of their daily earnings on khat.

The abuse of cocaine and heroin is a new and increasing phenomenon in most African countries and there is currently no evidence available to assess its psycho-social effects.

The relationship between crime and drug abuse has not been sufficiently studied in African countries, and this subject merits the attention of future research. There have been reports suggesting that adolescents have stolen money from family members to procure the drugs of their choice. Reports of stealing outside the family and mugging have not been very common. There have been reports that the use of cannabis is associated with serious criminal behaviour, such as armed robbery, reckless driving, assault and homicide, but such reports have not been substantiated.

Treatment and rehabilitation

The holistic approach to treatment is favoured, encompassing the whole of the individual. Treatment is carried out by a treatment team, which includes a nurse, a clinical psychologist, a social worker, an occupational therapist and a psychiatrist who usually leads and co-ordinates the team. In most African countries, there is a dearth of treatment personnel. These countries cannot afford the over-specialization and the rigid division of roles in treatment.

Detoxification is considered an integral part of the whole treatment and is not usually applied as an isolated entity. Rehabilitation goes along with psychiatric treatment, which involves relatives and friends of the addicted person. There is no special treatment set-up for drug-dependent

persons in African countries. Treatment usually commences in a general psychiatric hospital, but there is a shortage of such facilities. The patient is hospitalized for detoxification and his close relatives and friends are asked to help in the treatment process. On the basis of observation and information obtained from the patient and his relatives and friends, the treatment programme defines the patient's problems, including those of a personal, familial, economic, social, occupational or marital nature, as well as ways to deal with such problems.

During detoxification the patient may receive social and pharmacological support to avert or reduce withdrawal symptoms, but it is not the practice to administer a substitute drug for maintenance purposes in African countries.

It has not been possible to follow up drug abuse cases in any systematic manner after treatment, because patients are difficult to trace when they stop attending treatment facilities. It is believed that some traditional healing practices can enhance and reinforce the effectiveness of treatment. Acupuncture has been used for the treatment of addicts in Mauritius, where it has been found to reduce the severity of withdrawal symptoms [19].

The duration of in-patient treatment varies from patient to patient and from hospital to hospital, but, in general, it exceeds the usual period required for detoxification. The major criterion for discharging the patient from a treatment facility is that the patient, having been weaned from his drug, appears to exhibit no yearning for it and has worked out a practical and realistic plan to keep off drugs. It is of particular importance that strong social and family support is provided for the discharged patient, who as a general rule continues treatment in an out-patient department. The family members, in co-operation with the therapists, monitor the patient's movement and behaviour.

Control mechanisms

Psycho-active substances are controlled in Africa either through formal or informal control measures.

Formal control

The formal control measures embody national legislation that implements the two main international drug control conventions [20, 21]. Nearly all African countries are already signatories to these two conventions. Legislation in most African countries provides heavy penalties for offences involving very dangerous illicit drugs, such as cocaine and heroin.

For example, in Nigeria, death by firing squad is the punishment for illegal possession, use, trafficking or cultivation of such drugs. In formulating policies, no distinction is made between the drug pusher and the user. Offences relating to cannabis are treated more leniently in most African countries.

There are some difficulties in enforcing formal control measures, mainly because of the shortage of funds and trained personnel required to implement such control.

Informal control

In addition to the control system entailing the implementation of drug control legislation, there is a system of informal control, which includes the family, church, school, neighbourhood and work environment, as well as healthy forms of recreation. Since the implementation of the official control system is limited by inadequate funding and a shortage of trained personnel, greater emphasis needs to be placed on the informal control system.

The most important component of this system resides in the family. One of the reasons often given for drug abuse by young people is peer pressure, but it should be remembered that such pressure succeeds only if it is stronger than family and parental influence on the young. Family and parental influence depends on the level of affection, communication, interaction and cohesion within the family. Very often, young people are left to their own devices with the assumption that they will learn from their own mistakes. Unfortunately, the damage done by some mistakes is irreparable. For instance, in African countries there is a lack of educational facilities, and an adolescent who has dropped out of school may find it impossible to enrol again in an educational institution once he has outgrown the pattern of behaviour that led him to his failure.

In smaller towns and villages, bringing up children is not the exclusive responsibility of the parents and the family. It is a task that is also shared by neighbours, except in the big cities, where the local community spirit is much weaker. Furthermore, respect for tradition, which includes respect for elders and for the family name and status, obliges each family member to consider at all times the impact of his behaviour on the honour and prestige of his family.

There are certain patterns of behaviour, such as drug abuse, that are not socially acceptable and carry a certain degree of opprobrium, an attitude that must be very clearly maintained. Such behaviour should not be condoned or tolerated. It is, for example, a grave mistake to glamorize or praise artists or other successful personalities who are known to abuse drugs, while at the same time playing down the fact that they are dependent on drugs.

The major religions do not approve of the non-medical use of drugs and drug dependence. Participation in religious activities and observance of religious tenets can certainly help in controlling drug abuse.

Healthy recreational activities help young people to spend their free time in a constructive manner and to draw their attention away from drug abuse. Youth organizations, such as boys' clubs and girls' clubs, the Boy Scouts and Girl Scouts and Guides, are examples of informal programmes that can carry out such activities and thus help to prevent drug abuse.

Future trends

It is expected that improved communication, particularly the completion of the proposed trans-African highway linking east and west Africa, may lead to an increase in drug trafficking and other drug-related problems in Africa. Improved communication may result in a broader distribution of the khat and cannabis that grow in Africa and of illicitly imported drugs, such as cocaine and heroin.

While the widespread abuse of drugs such as cannabis had initially been observed among the marginal and lower economic classes of society in west Africa, such abuse has been spreading to the more affluent members of society, and this trend will probably continue.

Adolescents and young adults appear to be the main populations at risk of drug abuse. It is very likely that, in future, youth may turn to the use of more potent drugs, with all the predictable health and socio-economic consequences.

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