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Globalization and Drug and Alcohol Use in Rural Communities in Nigeria: A Case Study

CHARLES FIKI

This paper presents an exploratory study of alcohol and drug use in two rural communities in Plateau State, Nigeria. The aim is to raise awareness of the rural alcohol and drug problem. The paper examines the patterns of alcohol consumption and drug use, and their perceived functions for substance use among rural farmers in Nigeria. The study shows the common use of marijuana and alcohol in addition to prescription drugs. There is also evidence of multiple or combinational drug use. Pleasure and relaxation emerged as the major reasons for drug and alcohol use. Factors influencing alcohol and drug use are the relative neglect of rural communities, and the activities of hawkers, quacks, and other untrained individuals pervading the rural health sectors. The paper calls for further research to adequately capture the reality of alcohol and drug use in rural communities in Nigeria.

Keywords: Nigeria, globalization, drug use, alcohol use, rural communities

Introduction

Drug and alcohol problems in Nigeria have assumed epidemiological dimensions. A visit to most hospitals reveals the preponderance of drug-related psychotic disorders. In a study of five selected psychiatric hospitals, Obot and Olaniyi (1991) show that drug related cases have increased since 1985. In a related study, Ikwuagwu et al. (1993) found that about
60 percent of substance abusers are young persons. Other studies also raise an alert on the dimensions and epidemiology of drugs and alcohol consumption and abuse in Nigeria (Nevadomsky, 1982; Ebie and Pela, 1981; Ifamayi and Ahmed, 1987; Odejide, 1997; Adelekan, 2002; Obot, 2003). Judged by reports in the popular media, accumulating research evidence in scientific journals, and the increasing tempo of anti-drug activities by Federal and state Ministries of Health, Private Non-governmental organizations and concerned individuals, Nigeria today has a growing drug problem (Obot, 1993: iv).

This awareness has identified the 'drug and alcohol problem' as exclusively an urban problem. Consequently, research initiatives, educational interventions, and interdiction measures are determined by urban values and trends, which have not sufficiently improved the situation in the rural communities. The rural drug and alcohol scene is affected by this paucity of information, because rural drug problems are more likely to be seen as primarily isolated problems of little national interest. There is the need for studies to explore, assess, and monitor the rural alcohol and drug use in Nigeria, because the solutions to the problem lie in the community itself.

This paper presents a recent exploratory study of alcohol and drug use in two rural communities in Nigeria. It aims at generating knowledge and enhancing the understanding of precipitating factors of alcohol and drug use in rural areas.

Drug and Alcohol Use in Nigeria: A Review

Venturing into a relatively new terrain must necessarily begin with an exhaustive review of the trends in literature as a bridge between the past and the future. Alcohol and drug issues emerged in the literature in the 1960s (Asuni, 1978). However, rigorous academic interest did not surface until in the 1970s. The first trend of literature prevalent in the 1970s and 1980s attempts to capture the nature of drug use among youths and students (e.g., Asuni, 1978; Akindele, 1974; Olatawura and Odejide, 1975; Anumonye, 1980; Novadomsky, 1981). Some research in this trend focuses on specific regions (Odejide 1987; Novadomsky, 1981), and other research focuses on the incidence of mental health in Nigeria (Akindele, 1974; Asuni,
In a major review of this research, Pela and Ebie (1982) note that there was no age limit to drug use because there is a decline in the age of exposure to drugs and alcohol. The initial contacts have increased to include clandestine agents, home medicine chests, open markets, chemists' shops and cannabis farms. As a result, there was no relationship between religion, culture, social class, and drug and alcohol use (Pela and Ebie, 1982; Odejide, 1982). Nevertheless, alcohol consumption was confined to private spaces (home and immediate neighborhood) in the past, and generally indulged in during traditional religious rituals and social occasions such as naming, wedding and burial ceremonies (Olatawura and Odejide, 1975). Many other communities in the southern part of the country also offer alcohol as a gesture of hospitality. It was argued that consumption of locally brewed alcohol may not be considered an abuse because of the symbolism that goes with it.

The second trend prevalent in the 1990s attempted to replicate the previous studies within time and space, and to examine the contours of drug use, trends and impacts. A major factor accounting for this resurgence in scholarly interest is the direct interventionist policy of the Nigerian state in the 1980s. The drug law and decree of 1984 introduced a punitive death penalty clause, which attracted the attention of domestic and international human right activists. In addition, the United Nations Drug Control Program that emerged in the early 1990s provided a launching pad for increased academic and political interests.

Scholars began to evaluate and reexamine the trends and impacts of drug and alcohol use in the 1990s. These scholars examine how drug and alcohol use reflects gender, regional, demographic and occupational categories, and in some cases, the impact of these drugs. Obot (1993) notes that while alcohol consumption is not age-, gender- or class-specific, it is consumed for recreational and instrumental purposes. In rural-urban contexts, he observes that most rural communities engage in agriculture, producing grains, root crops and fruits, which form local in-puts in both local and industrial breweries. This makes it easier for a burgeoning production of, and accessibility to, alcohol. As a result, Burukutu and *Pito* are locally produced and consumed in the middle belt/northern
part of the country, while *palm wine* and *ogogoro* (gin/whiskey) are produced in the south (Obot, 1998). Other studies such as Ikwuagwu et al. (1993) observe the worrisome preponderance of young persons in hospitals for alcohol and drug problems. The fact that most of them come from rural communities is very disturbing.

Concomitant with these trends is a public health approach of harm reduction that emerged in Nigeria in the late 1990s. The emergence of this approach is influenced by the prevalence of HIV and other diseases associated with substance abuse. A major outcome of the research provoked by this approach is that there is a steady closure and possibly a final disappearance of the gender differences in drug use in Nigeria (Adelekan, et al, 1996). In addition, this research notes the emergence of drug use by injection, such as heroin and cocaine. Adelekan and Stimson (1996) remark that, while a local market of heroin developed from the beginning of the 1980s, reports of injection use among drug treatment populations and other groups emerged in the 1990s. This trend is seen to be part of the diffusion of new drug-use patterns in countries with no preexisting history of such use, due to the existence of drug trafficking routes (Adelekan, 1998; Adelekan and Stimson, 1996; Fitch and Stimson, 2003).

Drawing on clinical and epidemiological data, this diffusion approach helps to further understand the variability of drug use in Nigeria and its precipitating effect on risky health behaviors. Reflecting the variability of substance use in Nigeria, alcohol and cannabis are the main substances of abuse by clients admitted in Enugu (south East), Calabar (south-south), Minna (central), and Kaduna (north central). Clients who were dependent on heroin and cocaine were found in Enugu (south east), Minna and Kaduna (north central), Kano (north), and Maiduguri (north east). Abuse of amphetamine, hypnosedatives (diazepam or valium), rubber/glue and petrol was reported more from the northern facilities. While the use of injectible substances are increasing in Lagos (south west), dapsone, tramil, pentazone, pawpaw leaves and phenerga are also used in Maiduguri area. The studies also note the use of combinations of these substances such as cannabis, alcohol, heroin and cocaine (Stimson, et al, 2003; UNDCP, 1997;
Adelekan and Stimson, 1996). The fruitfulness of these studies in creating awareness of the menace of drug and alcohol use in Nigeria is incontrovertible; however, these studies contribute to the understanding of how substance use is related to health problems such as HIV and Hepatitis, as well as the methodology of rapid assessment in developing countries and variability of drug use. In line with this study, the process of diffusion in drug use is also captured by the globalization trend. The reality of rural drug and alcohol use remains a challenge for research.

The third trend in the literature is the tendency to see the drug problem within the political and economic framework (e.g. Alubo, 1987, 1994; Alubo and Ogbe, 1987; Alemika, 1990, 1993, 1998; Ahire, 1990). While some scholars examine the drug problems as essentially a fake-drug syndrome (Alubo and Ogbe, 1987; Alubo, 1994; Erhun, 2001), others emphasize the historical and prevailing socioeconomic order and the failure of state policies on drug and alcohol production and use (Alemika, 1990, 1993, 1998; Ahire, 1990). In the rural context, the challenge of the first group is to examine the interface between living conditions on the one hand, and drug and alcohol use on the other, and how they impinge on individuals to produce a milieu for drug and alcohol use. The challenge of the second group is to examine the fundamental failures in the structure and governance of society that promote drug and alcohol use, rendering their control problematic (Alemika, 1998). Considering the context of this research, the suggestiveness of these scholars is more important than the legitimacy of their derivatives because their framework provides a broader picture of governance of the alcohol and drug problem, as it reflects the type and nature of the community for this study.

However, this repertoire does not cover two rural factors: namely the reality of consumption of the rural people, and the conditions that instill drug and alcohol use. These factors must be considered because the rural community is both a site of production and consumption of drugs and alcohol. Such a balance invigorates the understanding of the prevailing contours of socioeconomic order in the rural areas and the associated drug use. In this way, one gains an understanding of the rural milieu as an entity influenced by a variety of 'outside'
actors and factors in addition to the rural dwellers themselves of which the state is an important part.

Analytically, the challenge in this paper is to account for the factors that reinforce and constitute the population as consumers in the alcohol and drug scene in the first case (O'Malley and Mugford, 1992; O'Malley, 1998). What is also called to account is how specific demands develop for particular drugs and alcohol in particular settings, and the images of pleasure or excitement in the commodities that promote them. The next section examines the research setting as a background to the methodology and discussion of findings.

Methodology

Research setting

In Nigeria, rural communities share several characteristics, which include small size, low population density, relative absence of social amenities (such as communication and health facilities), agrarian economy and low technological application. According to the population census of 1991, 'rural' is used to describe a community with a population of less than five thousand (5,000). Similarly, the Directorate of Food, Roads and Rural Infrastructure (DFRRI), a federal agency responsible for national and international rural development programs established in 1988, defined a rural area, for operational and policy purposes, as a community with inadequate basic social amenities/infrastructure and engagement in agricultural production. Social amenities encompass elements of modernity such as good roads, pipe-borne water and electricity. This de-emphasizes the population index for a rural community and raises the rural-urban development differentials as they affect the living conditions. In other words, rural communities are generally behind in national development efforts and parameters.

Two rural communities were selected for this study due to accessibility and their location within the locus of interest of the sponsoring institution. The two rural communities are Foron (CS1) and Miango (CS2), which are found within the 140 km radius of Jos metropolis, the administrative capital of Plateau state, Nigeria, defined as Upper Plateau. According
to the population census of 1991, they have a population of 4,000 and 4,200 respectively. Upper Plateau is one of the naturally endowed areas of tropical Africa, where the exploitation of its resources (tin-based economy) has, historically, created environmental problems that have adversely affected agriculture, making fertility and land cultivation relatively difficult. However, agriculture in these communities is labor intensive and remains the most viable economic activity supplemented with mining. Given the low technological application, manual implements are used for production. Due to the abundance of grains produced here, burukutu and pito are thriving local alcohol beverages. Other alcoholic products such as beer, spirits and gin are also found in local liquor stores. Besides these facilities, two patent-medicine stores were found in CS1 and CS2, which implies that social amenities are inadequate.

Method

A mixed methodological design was used for this study, drawing on both quantitative and qualitative approaches. This method was adopted in order to capture an overall picture of drug and alcohol use of the people in this exploratory study, because rural communities are relatively too complex to be captured by the use of one variable, or measure, or one method of data collection. This is due to the absence of reliable clinical data on mortality and morbidity in most rural areas in Nigeria. Consequently, focused group discussion (FGD), document search, and inventory of amenities were used in addition to questionnaire administration and a structured personal interview schedule. These methods are relevant to the nature of the community as seen in other studies (see Bryman, 1994; Cresswell, 1994; Laluff, 1999; 316; Schwandt, 1997: 78).

The targets of the study were farmers, who were active during the research period. Participants in the FGD were farmers not covered by the questionnaire administration. Key informants and insider assistance play an important role in mediating the relationship between the ‘researcher’ and the ‘researched’ by providing access and answers to emerging questions (Charmaz and Mitchell, 1997). The analysis of the transcripts followed thematic references and connections in the interview. This task was made easier by the proficiency of
the researchers in the local languages. Structured questions in the FGD include history of drug use in the community, community approval of drug and alcohol use and solutions to the problem of drug and alcohol use.

Sample Description

A random sample of 200 was chosen from the two communities for the questionnaire survey, out of which 196 responded (effective sample), representing a ninety-eight percent (98%) response rate. Each of these communities was allocated a proportional sample of 100 with a mean age of 29.71 years and average annual income of ten thousand naira. Two criteria defined the selection of the participants in this sample: 1) farmers were actively engaged in farming during this study; 2) farmers were willing (volunteered) to be interviewed. In each of the communities we surveyed ten farms, two of which engaged paid laborers, over a period of two months. Group size (cluster) of farmers varies from 1 to 10 on each farm, while the maximum number of paid laborers found on one farm was five. This sampling method ensured that farmers involved in both practices (group farming, and paid labor) were represented.

The sample is composed of 153 male farmers (78.1%) and 43 female farmers (22.9%). This disproportional gender representation is due to cohort effects on the sample, which reflect the number of women on the farm or directly involved in farm activities during the period of the study. In part, this disproportion should not be surprising because farming in most communities is a male dominated activity. The FGD also consisted of male farmers over 40 and female farmers aged from 20-35.

Findings

Except for the marked absence of hard drugs, there is evidence that respondents have used other types of drugs and alcohol. Prescription drugs are commonly used among the respondents for nonmedical purposes. Seventy-eight percent of the users reported recent usage, while only twelve percent reported usage over their lifetime. Of the recent users, eighty-four recent users (55.1%) have used a combination of soneryl
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or valium (hypnosedatives) and kpaya (amphetamine), while thirty four recent users (22%) have actually used diverse forms of analgesics. The remaining thirty five recent users (22.9%) did not indicate the specific drugs often used. Similarly, forty-six (30%) recent users of prescription drugs have also used alcohol and some herbs (daukartayaro) at the same time or sequentially. Among the lifetime users, only 8 respondents (35%) indicated having used analgesics while the rest did not indicate the specific drugs, which they used.

Marijuana belongs to the realm of the personal in the communities under study due to its prohibition by the law and the disapproval of its use by the people. Private marijuana use is tolerated, but toleration does not equal approval. Drug use and expected behaviors are culturally conditioned and controlled by well-established tradition in local communities (Comitas, 1975). By keeping their marijuana use hidden, parents avoided exposing their children prematurely to an influence they considered potentially harmful (Hathaway, 1997:115). Fifty seven respondents (29.1%) admitted to being recent users of marijuana while fifty nine (30.1%) respondents fall into the lifetime use category. Fifty six (28.6%) have never used marijuana while twenty four (12.2%) respondents abstained from answering the question. About seventy two percent (41) of recent marijuana users have used some forms of prescription drugs and alcohol at the same time or sequentially.

The community appears to be flexible and tolerant about alcohol. There are 'beer parlours' (bars) and 'burukutu/pito joints' where the purchase and drinking of alcoholic beverages are routine activities, as is 'take home' use. In these joints and bars, use of alcohol with some drugs was reported. According to a respondent in the FGD, people use many prescription drugs together at times for various reasons. When asked to indicate the types of drugs used, he said "just go to the store and ask for mix".

This phenomenon introduces the 'mix concept' in rural drug and alcohol use. The 'mix' sample obtained from the store has a variety of drugs containing vitamins, analgesics and stimulants, among others. What is interesting about this form of polydrug use, which is unique, is that it is a prescription given by people the local community have judged
to be knowledgeable about drugs. This raises an important issue for discussion in subsequent sections.

Table 1: Nature and Frequency of Drug and Alcohol Use  

<table>
<thead>
<tr>
<th>Type of Substance</th>
<th>Lifetime User %</th>
<th>Recent User %</th>
<th>Never Used %</th>
<th>No Response</th>
</tr>
</thead>
<tbody>
<tr>
<td>Marijuana</td>
<td>30.1 (n=59)</td>
<td>29.1 (n=57)</td>
<td>28.6 (n=56)</td>
<td>12.2 (24)</td>
</tr>
<tr>
<td>Alcohol e.g., (Beer, spirits)</td>
<td>51.5 (101)</td>
<td>45.4 (89)</td>
<td>3(6)</td>
<td>-</td>
</tr>
<tr>
<td>Local Alcohol (e.g. Burukutu and Pito)</td>
<td>41.8 (82)</td>
<td>53.5 (105)</td>
<td>4.7(9)</td>
<td>-</td>
</tr>
<tr>
<td>Psychotropic Substance (e.g., Cocaine, Heroine)</td>
<td>-</td>
<td>-</td>
<td>67.8 (133)</td>
<td>32.1 (63)</td>
</tr>
<tr>
<td>Prescription Drugs (e.g., Soneryl, ICD, kpaya (amphetamine), analgesics etc)</td>
<td>12 (23)</td>
<td>78 (153)</td>
<td>-</td>
<td>10 (20)</td>
</tr>
<tr>
<td>Herbs (e.g., Daukartayaro, Dan Cameroon etc)</td>
<td>34 (67)</td>
<td>41 (80)</td>
<td>16 (31)</td>
<td>9 (18)</td>
</tr>
</tbody>
</table>

Further interviews indicate that operators of the stores do not think there is anything wrong with the idea of mixing drugs for ingestion. A typical combination of 'mix' includes vitamins (folic acid is a constant), analgesics (pain relievers) such as panadol, and a sleeping pill (for evening use). The combinations vary according to the intended user and time of day (i.e., young or old, morning or evening). A young person
would require an active combination (including some form of stimulant) while older persons would require a combination to induce rest and relaxation.

The specific roles that drugs and alcohol are perceived to perform in the life of the users serve as the mobilizing theme for drug and alcohol use. There was no predominant reason among the respondents for drug and alcohol use. The survey reveals the reasons for taking drugs and alcohol vary by individual. Fifty six respondents (28.6%) have used some form of drugs and alcohol for purposes of relaxation, which is slightly higher than 'health/illness' (23.5%), 'to remain strong' (20.4%) and work purposes (15.3%). Six respondents (3.1%) take drugs and alcohol 'just because people take it,' while eight respondents (4.1%) take drugs and alcohol to 'escape from problems'. Discussing the leisurely use of drugs and alcohol, a participant in FGD observed that "some people take alcohol in the evening after a normal day’s job, while some take medicine to have a rest. It is rare to see people sit at the 'joint' all day taking alcohol without finding something to do."

While the responses are uniformly distributed, it is clear that alcohol and drugs are used predominantly for pleasure and relaxation. This is supported by Ericson’s (1989:179) finding that the most commonly mentioned response was 'relaxation, followed by euphoria, recreation, creativity, provide insights, pleasure and escapism'. Twenty four percent (13) of respondents in the pleasure/relaxation category have recently used marijuana while twenty percent (11) of them currently use some form of alcohol. In the same vein, current users of prescription drugs constitute thirty percent (14) of 'health/illness' category, twenty percent (8) of 'strength' and twenty-one percent (6) 'work more' category.

Responding to the issue of perceived functions of drug use, a young female participant in the FGD observes that:

People, particularly young men, use some medicines that are meant to make people sleep with the belief that they intoxicate and make them feel good. Some of these drugs are soneryl, kwaya, and Chinese capsules. In the case of alcohol, I think people who drink beer take it just for enjoyment, while those who drink burukutu take it because it also helps the body.
When asked about how burukutu/pito helps the body, the respondent drew a link between the raw material (grains) and its nutritional value as a form of food that may be helpful to the body. The facilitator of the FGD then drew her attention to the fact that beer is also made from barley; in return, the participant observes that beer has chemicals unlike the naturalness of burukutu/pito. While people might have used alcohol and drugs for health purposes, people also use these substances for recreation.

The sources of drugs among respondents corroborated the findings of past studies (e.g., Erhun et al, 2001; Alubo, 1994; Pela and Ebie, 1982) that the rural drug scene is an open market exploited by everyone. Eighty-two respondents (42%) obtain their drugs through the patent medicine stores while forty-five respondents (22.8%) identify hawkers as their source of obtaining drugs. Five percent (10) of the respondents identified government clinics and hospitals as their source; ten percent (20) obtain their drugs through private clinics or hospitals; and 11.2 (22) percent of the respondents identify ‘friends as a source.’ The fact that government hospitals are usually in short supply of drugs makes drug sales outlets a burgeoning enterprise in the rural areas.

Discussion

The pattern of alcohol and drug use in rural areas is not much different from that reported in urban centers (see inter alia, Obot, 1993; Adelekan, 1998; UNDCP, 1997) except for the marked absence of hard drugs and injection use. Even in urban centers, while hard drugs have been noted for some years because Nigeria is a transit point, injection use is a recent development (Adelekan and Stimson, 1996; UNODC, 1997). Thus, the data above support the view that alcohol and drugs are used for different purposes.

Rural alcohol and drug use is influenced by three factors, the first of which is the relative neglect of rural communities in the provision of facilities needed to enhance the quality of life of the people. This neglect renders the rural population vulnerable to the vagaries of substance use and sales outlets. At the time of this research, there was only one patent medicine store
in each of the communities studied. A government hospital is available within a 100-kilometer radius, and there is a dispensary in each of these communities. Drug availability in these dispensaries and government hospitals is pathetically low.

Secondly, untrained individuals are prevalent in the rural health sector in the distribution, sales, and prescription of drugs. As a result, all sorts of drugs and alcohol brands are sold by petty-traders, who sell items from cigarettes to oranges, on roadsides and corners. They hawk drugs that range from over-the-counter items to antidepressants, stimulants, and antibiotics as part of their normal business activities. The activities of these clandestine agents, home medicine clients, open markets, chemist shops, and Cannabis farms dominate the drug scene. Specifically, the poor state of the public health care delivery system has led people to seek help from other sources to the extent that people who least possess the credentials to dispense drugs now perform the role of medical experts in rural communities. The prevalence of diverse forms of 'For-profit' drug stores and their activities in the rural sector has brought to the fore the issue of commodity culture.

Drugs and alcohol are commodities that must be consumed, and the rural communities are markets to make them available. Understood in this context, diverse means are invented to make people use drugs and alcohol brands that are made available, for which the 'mix culture' is one. This situation provides the background to the prevalence of counterfeit drugs in rural communities in Nigeria, which has been used as the basis for rural drug and alcohol problems. There are no generally reliable data on mortality and morbidity arising from the consumption of alcohol and drugs in Nigeria. However in 1987, 14 children died after being administered fake chloroquine phosphate injections while in 1990, 109 children died after being injected with fake paracetamol (Alubo, 1994; Erhun, et al, 2001). Based on media accounts, several deaths have also been reported in many hospitals for misuse of drugs and wrong prescriptions from sales outlets. These scenarios clearly signify the reign of the markets over public health and social welfare.

Third, there is an absence of an effective enforcement and monitoring system for alcohol and drug sales and use as practiced in urban centers. Currently, National Agency for Foods,
Drugs Administration and Control (NAFDAC) and National Drug Law Enforcement Agency (NDLEA) are increasing their activities in rural areas. They are still relatively obscure, and their impact has not been felt (Alemika, 2001; Obot, 2004). Moreover, while NAFDAC focuses on fake drugs, NDLEA targets hard drugs. There is therefore an absence of surveillance on general substance use in rural areas. This failure is partly due to the emphasis on liberalization and deregulation of the markets in Nigeria in order to create enabling environments for private investment. Because rural communities are the least policed in every aspect, hawkers and untrained individuals concentrate on the rural markets.

In this way, the risk environment constrains the freedom and ability of alcohol and drug users to make rational choices. This risk environment is characterized by the activities of salespersons, hawkers and patent medicine dealers, the marked absence of facilities and the absence of an effective monitoring system. Only what is made available is consumed. Both professionals and quacks often legitimize this form of consumption since there is hardly any consultation with doctors, nurses, pharmacists or quacks without a prescription. It is in this way that the preponderance of respondents in those four functions can be situated. People use drugs for different purposes, but these functions are influenced by the images that hawkers and sales agents conjure for the consumers, and the nature of the risk environment. In the case of prescription drugs, the mix culture amounts to ‘drugging the people’ as the rural people are confined to their fate according to the dictates of hawkers and sales agents. This is made possible by creating a perceived need for commodities, including alcohol and drugs, as evident in the ‘mix’ concept. Ogoh Alubo aptly captures the situation thus:

there is a pill for every ill. Much like food or water, pills have come to dominate human lives as basic survival needs. Through the unsolicited advice of drug manufacturers and sales people, we are told there is a pill, not just for all ills but also for all occasions: to enable us work, sleep, aid digestion and to soothe aches and pains (Alubo, 1985:98).
In so doing, meanings attached to particular alcohol and drugs are valorized as aspirations and achievement, particularly in marginal communities.

The case of "Aromatic Schnapps" illustrates this point concisely. 'Aromatic Schnapps' is a brand of gin produced by Seaman Brothers, a German company that operates in most African countries. Aromatic Schnapps is instilled in the appetite of the local communities so much that it has become part of the tradition of urban and rural communities. How this is achieved is compelling to know! The advertisement on billboards, radio and TV ads reads: "Aromatic Schnapps, the drink of the Elders. It is part of our tradition." Like the Viagra advertisement where the elderly of all persuasion celebrate their return to a rejuvenated sex life, the clips that accompany this Aromatic Schnapps statement present the elders as jubilant when a successful young man and a potential suitor presents Aromatic Schnapps to the elders as a first step to meeting the bride's family. This iconic representation of Aromatic Schnapps as the magic for bridging the cultural gap between the two families is clearly appealing and fashionable to a particular population. Schnapps is, today, an important component of tradition in most African countries despite its German origin. It is a major requirement for marriage engagements, complementing all items traditionally required by the bride's family from a potential suitor. Schnapps is a major 'drink' used to celebrate achievement (i.e., purchase of a car, naming ceremonies, etc), a 'drink' dedicated to the gods for blessing.

As this research makes clear, rural communities are no longer immune to urban and global influences. These influences include "drugging the people" for profit, and cultivating a robust consumer base for drug and alcohol use. While multiple drug use and use of prescription drugs are not entirely new, the rural dimension of this problem raises some public health and social welfare concerns, and brings the efficacy of the regulatory system into question.

Conclusion

While this exploratory study may not be sufficient to make general conclusions on the prevalence of substance use, it
does point to the emerging reality of the rural communities. Because of the increasing penetration of rural communities by the forces of globalization, particularly the commodity culture in tandem with other change agents, rural communities are no longer insulated from social problems. Commodity culture forms the people as consumers by mobilizing functional cultural properties of the community, and by playing on the socioeconomic condition of the people for profit motives. It uses diverse imagery to ensure the patronage of consumers. Such is the prevailing situation of consumption of alcohol and drugs in rural communities in Nigeria. As evident in this study, global, market and urban influences render the rural communities vulnerable to the activities of entrepreneurs (hawkers, patent medicine dealers, professionals and quacks) of various drugs, ranging from illegal to the fake drugs, where they have found market niches.

Rural communities are particularly exposed to the social and health consequences associated with the practice of drugging the people, of which the "mix culture" in drug and alcohol use is emblematic. As the call for responsive regulation progresses, such global and urban processes and influences require effective monitoring and regulatory programming to reconcile their implications with community context and effects. This paper calls for further research to adequately comprehend substance use in the rural communities in Nigeria, and in Africa overall. This is important if one is to understand how the pervading commodity culture is undermining agency by constraining the ability and freedom of users to make rational choices within the context of the communities of fate. It is also needed to understand the convergence of rural trends and the pattern of the urban drug scene, which has obvious implications for social welfare of the people. The need to focus on substance use in such marginal populations beyond occasional descriptive glimpses is important.

References


Ikwuagwu, P.U.; Nafziger, J.C.; and Isichei, H.U (1993). “Pattern of Substance Abuse in The Psychiatric Unit of Jos University teaching Hospital: A prospective Study”.

In Obot, I.S (ed) *Epidemiology and Control of Substance Abuse in Nigeria*. Jos, Nigeria: Center for Research and Information of Substance Abuse.


Odejide, O. (1997). “Adolescent and Young Adult Substance Abuse in Nigeria”. *Status of Adolescents and Young Adults in Nigeria*. Ibadan: Center for Health Services, Training, Research and Development.


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Endnotes

1 These are local alcohol fermented from grains such as corn, barley, maize, and/or cassava.

2 Palm wine is a popular Nigerian wine tapped from palm kernel trees while Ogogoro is the locally made gin existing in different tastes.

3 This study was conducted when the exchange rate of Nigerian Naira to U.S. Dollar was 82. One dollar currently exchanges for 132 naira.

4 While beer parlors are licensed outlets of leisure for beer, burukutu/pito joints are also outlets of leisure that require no licensing for sales and production.

5 Also known as polydrug use, is defined as “the use of more than one drug or type of drugs by an individual consumed at the same time or sequentially (World Health Organization).
The common term used at the patent medicine store is a code mix of English and Hausa, the local language: *Ka bani mix*. When translated directly, it means 'give me mix'.