

## **Alcoholism in Africa during the Late Twentieth Century: A Socio-Cultural Perspective**

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### **Abstract**

*As modern breweries began to expand in Africa during the late twentieth century, alcoholism became an increasing cause for concern. Drinking patterns shifted away from traditional norms as relaxed government policies seemed to sanction indiscriminant selling and access to alcohol. Alcohol dependence and problem drinking became increasing concerns as related social problems became more pronounced. Winick's theory of drug/alcohol dependence is used as a framework for illuminating the problematic use of alcohol in Africa during the late twentieth century. Key factors include access to dependence producing substances; disengagement from negative proscriptions about their use; and role strain and/or role deprivation. Measures for addressing these issues are discussed along with future strategies for tackling the continuing problem of alcoholism in Africa.*

**Key Words:** Alcoholism, Africa, Nigeria, Late Twentieth Century, Socio-cultural Factors

### **1. Introduction**

People around the world have probably used alcohol before history was ever recorded. According to one observer, "alcoholic beverages are probably as old as agriculture" (Horton 1974:539). In so far as both ancient and modern societies have used alcoholic beverages, it can be assumed that problems associated with alcohol abuse are not culture or age specific.

By and large, people drink alcohol for pleasure or in order to avoid or reduce pain, discomfort, anxiety and fatigue. It should be noted that the consumption of alcohol per se does not necessarily constitute a problem. Social or moderate drinkers do not find the use of alcohol all that problematic. However, this article focuses on the problem of alcoholism or pathological drinking in Africa.

In this article the authors examine alcoholism in the context of Africa, focusing on socio-cultural factors contributing to alcoholism during the late twentieth century. The overriding objective is to deepen awareness and understanding among researchers, academicians, policy makers and practitioners about the problem of alcohol abuse amongst the youth in Africa, to highlight the impact of alcoholism; and to investigate and assess strategies aimed at mitigating the problem at that time. In reviewing strategies for reducing the incidence of alcohol abuse in Africa, preventative measures are examined in this article. The article looks next at world and African trends in alcohol consumption,

### **2. Alcohol Consumption: Global and African Trends in the Late Twentieth Century**

World trends in alcohol consumption rose steeply during the several decades preceding the 1980s. Data collected from 97 countries revealed that between 1960 and 1972 alcohol production rose by more than 60 %.

Regions with the highest level of economic development tend to have the highest per capita consumption of alcohol. In western countries the upsurge in alcohol production is attributed to the rising prevalence of social drinking and the highly industrialized production of alcohol. The World Health Organization (WHO) estimated that during the late twentieth century there were 140 million people in the world who were alcohol dependent (Mayor 2001). Alcohol consumption had become a generally accepted social habit in many countries of the world and especially in the poor states where, in some countries, the revenue earned from the trade in alcohol constituted a large percentage of the national income. The increase appeared even more dramatic in Africa, with its proliferation of modern breweries.

In Africa and Asia the marked increase had been attributed to relaxed religious sanctions against consumption and the increase in supply as modern industries produced alongside local distilleries and breweries (WHO 1980:23).

Okon (1984) suggested that there was a relationship between per capita consumption and the incidence of alcohol abuse in Africa. She argued that if such a relationship is accepted, then alcohol abuse must have been on the increase in Africa. According to Okon, alcohol is thought to be the most commonly abused substance in Nigeria. Possession was and is legal and access readily available. During the 1960s through early 1980s the number of breweries in the country had increased dramatically from about 10 to 60. The pattern of consumption was no longer restricted to the middle aged, but had widened to include the young adults and adolescents, with a narrowing male/female ratio that cut across religious groups (Okon 1984:2).

The problem of alcoholism in Africa, as with the case of other drugs, may not have been as severe in Africa as it was in more industrialized nations. This may have been especially true when one considers that the popular beer drinks had a lower alcoholic content than the mixed drinks consumed in more developed countries.

There were no reliable statistics for ascertaining what percentage of the population abused alcohol in Africa. The magnitude of the problem however, may be appreciated after a glance through medical/psychiatric records, welfare complaints, traffic accident reports, school reports, work reports, police and court reports. Where these fall short, the bulk of the iceberg may surface when observing individuals in rural and urban drinking places, ceremonial gatherings, or in the homes of those whose entertainment centered around alcohol consumption.

### ***3. Alcohol Abuse and Alcoholism: A Theoretical Perspective***

A host of biological, psychological, social and other theories have been proposed for explaining the incidence and prevalence of alcohol abuse. These theories consider single or combinations of factors such as biochemical, psychological, social, cultural, economic and legal factors. For the purpose of this paper we will mainly examine alcoholism among African youths and factors leading to alcoholism using a sociological theory proposed by Winick (1974).

Socio-cultural factors which may be the root cause of alcoholism in Africa are identified, using Winick's theory of drug (alcohol) dependence as a framework. The theory supposes that the incidence of dependence increases with access to dependence producing substances; disengagement from negative proscriptions about their use; and role strain and/or role deprivation. Various socio-cultural factors are considered under each of these three suppositions. The major points indicate that social sanctions against alcohol consumption in Africa appear to be weakening, especially for females and adolescents. Certain religious taboos about drinking were no longer taken seriously. With governments' increasing investment in breweries throughout Africa, there was an implied stamp of approval by the 'gatekeepers' of society.

The use of alcoholic beverages is an ancient custom among many African communities, as it is in other parts of the world. The preparation of fermented beverages was one of the early technologies that was developed over millennia. Unlike the use of other drugs, the consumption of alcoholic beverages has never been an illegal act (Mushanga 1988:136).

Alcohol abuse began posing an increasing threat to the well-being of the society. According to WHO (1995), the pattern of consumption had shifted from the middle aged to include larger numbers of young adults and adolescents, with a narrowing male/female ratio that cut across religious groups. Alcohol abuse was a growing social problem amongst African nations and particularly among younger age groups.

It became the drug of choice among youths. Young people drank too much and at too early ages, thereby creating problems for themselves, for people around them, and for society as a whole ([www.enotalone.com](http://www.enotalone.com)).

In Africa, many people tended to view the consumption of alcoholic beverages as socially useful and even necessary. This perception was likely to persist for a long time in the future. Even though the drinking of alcoholic beverages has lost some of its traditional values, new values seem to be emerging (Mushanga 1988: 136-137). As distribution of modern and crude alcoholic beverages begin to surface in every nook and corner, the easy access seemed to increase demand. Since cultures stressed hospitality, occasions abounded for obtaining free drinks. When things are free, people are often more eager to overindulge thereby leading to addiction to alcohol.

As the taking of homemade brews had long been seen as a means of coping with the physical and psychological stress experienced with hard manual labor, there was little wonder why modern alcoholic beverages became the most popular substances for abuse amongst the youths. Members of society caught in the whirlwind of industrialization and urbanization may very well resort to former defense mechanisms in an attempt to cope with mounting pressures.

#### **4. Definition of Terms**

The so-called alcohol problem was shrouded in controversy. Part of this controversy was connected with the drug abuse phenomenon, that is, the utilization of drugs in ways which are medically, socially and legally non-sanctioned. The controversy, moreover, had a lot to do with societal definition of and response to drugs, alcohol inclusive.

In the area of drug (alcohol) studies, definitions of terms such as “addiction,” “dependency,” and “drug abuse” or “misuse” tends to be characterized by a lot of confusion and controversy. In fact, there is so much definitional overlapping that in many instances these concepts are used interchangeably. In defining the key concepts used in this article, we largely adhere to the definitions recommended at that time by the World Health Organization which has over the years tried to clarify and streamline the definitions in question.

Although the terms “addiction” and “dependence” are often used interchangeably, they do not mean the same thing. Owing to the imprecision and negative connotation associated with the term “addiction,” the WHO recommended that the term be scrapped and substituted by “dependence,” which the world body defined as: “a state of psychic or physical dependence, or both on a drug, arising in a person following administration of that drug on a periodic or continuing basis.”

In general, the term “alcohol abuse” covers illicit procurement and/or use of drugs to such an extent that personal health and/or community welfare are threatened. The WHO defined drug abuse as “persistent or sporadic excessive drug use inconsistent with or unrelated to acceptable medical practice.”

Because alcoholism manifests a diversity of behavioral tendencies, there is need to identify distinct categories of relevant drinking patterns. In this connection, Clinard and Meir (2004:310-312) have identified four categories of drinkers, namely: the social or controlled drinkers, the heavy drinkers, the alcoholics and the chronic alcoholics.

A social drinker’s reasons for drinking revolve around the search for sociability, conviviality, and conventionality. The amount of alcohol consumed is so small that it does not induce a state of intoxication. Apart from indulging in more frequent use of alcohol than the social drinkers, the heavy drinkers take three or more bottles of liquor, which leads to occasional intoxication. The third category consists of those who consume alcoholic beverages in excess of ordinary dietary and social requirements. Excessive reliance on drinking adversely affects the drinker’s health, interpersonal relations as well as task performance. Finally, chronic alcoholics are distinguished by what Clinard and Meir refer to as compulsive drinking, and this involves solitary drinking, morning drinking, leading to serious general physical deterioration.

Persons in the last two categories are those likely to display violence while intoxicated; experience difficulty in attending and performing at work, school etc.; encounter legal problems due to arrest for intoxicated behavior, traffic accidents while intoxicated, and have arguments or difficulties with family members or friends because of excessive alcohol use.

To some extent, the above mentioned typology is similar to that used by Sudimma (1983) in his study of drinking patterns among the Angas of Nigeria. His categories are as follows:

1. Abstainers-those who drink once a year or not at all.
2. Normal drinkers-those who drink moderately, on a daily basis with normal meals or as part of ritual sacrifices, without dependency.

3. Heavy drinkers- those who drink at most occasions to the point of intoxication, whether at celebrations, market days, weekends, month-ends, or during free offers.
4. Alcoholics-those who drink all day and are usually tipsy. They cannot resist the urge for drinks (as they feel compelled to drink).

When comparing the two sets of typologies, one sees clearly that Sudimma's refers to a culture where greater levels of drinking are regarded as normal. Although alcohol serves multiple purposes for the Angas, it has become like food in that it is regularly taken with meals. Although Clinard, Meier and Sudimma all view the pathological use of alcohol as a compulsive disorder, it is not a true compulsion in the sense that the individual derives pleasure from it and may wish to resist only because of secondary deleterious consequences (APA 1980:235).

### ***5. Socio-cultural Factors Leading to Alcoholism in Africa***

Wide variations exist in the cultural patterns of alcohol use, its integration into everyday life, and the meanings associated with it. Culture shapes all aspects of alcohol use, including its physical and social consequences. Heath (1982) notes that socio-cultural factors are as critical to the understanding of the influence of alcohol on behaviour as are physiological or psychological considerations. Culture, in short, exerts a powerful influence over the use of alcohol throughout the world. Historically, Africans have always been accustomed to the consumption of fermented beverages which, as a group, have less alcoholic content than distilled beverages. These beverages are obtained from ripe bananas, millet or honey and sorghum. In Botswana, brewing and beer consumption have generally been an integral part of village life while sorghum, a staple food throughout southern Africa, was a primary ingredient in the production of traditional alcoholic beverages (Molamu & Manyeneng 1989).

Usually, the consumption of alcoholic beverages was restricted to elders of the community and drinking was social rather than an individual activity. Women were generally excluded from drinking parties but not entirely. Economic globalization brought about dramatic and widespread social transformations, especially in the developing world. Many parts of Africa south of the Sahara were facing starvation partly because the energy that would go to the production of food was spent in the distillation of alcoholic drinks; and partly because, the little grain that should be preserved for harder times, was used up in the preparation of beverages for distillation (Mushanga 1988:137).

It may be difficult to find out what is happening in society, whether at its grassroots or in its corridors of power even in the best documented societies. In developing societies, these difficulties are compounded by a lack of adequate statistical services and of academic as well as market and public opinion research. In most African countries, socioeconomic divisions play out in complex ways in drinking patterns and problems (Room et al., 2002). In most of these societies economic realities constrain alcohol consumption by much of the populace, limiting both the frequency of drinking and the choice of beverage.

Concern over young drinkers had become especially acute with reference to college or university students in African countries during the latter half of the twentieth century. Among the many factors for this is the fact that they are a young population (roughly 18-23), many of whom are away from home for the first time and newly freed from other scheduling constraints, amid a group of age mates who often valued socializing. Obviously, the use of alcohol and other drugs among the youth was not purely a medical problem. The chemical characteristics of drugs largely determine their effects upon the organism, but cultural norms dictate the circumstances under which various drugs are used (Clausen 1966:198). As previously noted, no society is drug or alcohol free. Nevertheless, the level of alcohol consumption and abuse varies from culture to culture. Variability in alcohol use and abuse depends fundamentally upon societal definitions and reactions. In the context of Africa much of the traditional drinking in developing societies was sporadic and communal, drinking in these countries could no longer be understood simply in terms of these traditional factors. These led to people finding loopholes within the cultural norms and over consuming alcohol which in future may lead to alcoholism.

Drinking patterns are learned. Accordingly, 'group associates and cultural factors are important in determining who will become excessive drinkers and who will not.' Many contemporary drinking patterns have come as an inheritance from previous generations (Clinard & Meier 2004:314). In investigating the determinants of alcoholism in different cultural settings sociologists usually focus on the role of social groups. They consider the significance of group values, beliefs, and attitudes in shaping drinking patterns in various societies.

Rates of alcoholism and problem drinking may partially reflect the integration of drinking behaviour patterns into the culture or subculture (Clinard & Meir op.cit; p. 331).

In the African context, for instance, people are treated in large part because of their age. The age at which people may begin to drink is not clearly specified, but alcohol use certainly varies over the course of a normal lifetime, and in all but a few societies, people often hold strong opinions about the propriety of one's drinking at various ages. Among the few surveys of drinking patterns that asked about children's use of alcohol, it was found in Cameroon to be "...an important element in the traditional life..." one which "...corresponds with general drinking patterns (Heath 2000:76-79)".

Drinking among the youths was by and large, a group activity, and reflected the cultural influences of family members, friends, peers and reference groups. Turning to Winick's theory of drug (alcohol) dependence, the theory (which is based on WHO's definition of dependence) seems to be broad enough to explain a large portion of the incidence of alcoholism in Africa. The theory makes the following three suppositions about the incidence of drug (alcohol) dependency:

1. Drug dependency increases with access to dependence producing substances.
2. Drug dependence increases where there is disengagement from negative proscription about the use of drugs (alcohol).
3. Drug dependency increases with role strain/role deprivation.

The first statement of the theory proposes that high dependence or abuse is positively associated with access. Many social analysts who have examined the drug problem in Africa cite access as one of the leading determinants. In the absence of stringent legal restrictions and enforcement we find that age is no barrier to one having ready access to alcohol. Often minors are involved in the retail sell of alcohol. Many may feel they have no other alternative as they feel compelled to assist in protecting the family's business.

The readily available alcohol can easily become the main thirst quencher and a food substitute when other options are not at hand. Many people feel the sale of alcoholic beverages is a lucrative and relatively easy business, especially with the government's liberal policy on distribution. Petty distributors sprung up here and there, many without valid licenses. Since the culture demands hospitality, the dealers often had a continuous stream of customers. The use of alcohol was and is inextricably intertwined with social ritual. However, not every person who drank adhered to socially sanctioned and culturally determined drinking norms.

Government's heavy investment in the breweries seemed to imply a stamp of approval. The government's interest was probably creating a more favorable image of alcohol in the minds of the public, especially the youths. Alcohol ceases being a moral issue and becomes a business investment. Although financial status is not a leverage on who uses or eventually abuses alcohol, it does seem to determine where and what types of alcohol one is likely to use or abuse. Money determines the class of drinking place to which one may have 'financial' access. The class may range from the local type pubs to the modern air conditioned hotel parlours. Equally so, in countries like Botswana, Uganda and Kenya, we find people from the lower income groups consuming more of the locally made brews and wines (stopoti, khadi, enguli, chang'aa and skhokhoetc.), whereas the higher income groups had greater ease in purchasing the more expensive brews and other drinks manufactured in the large industries (Heineken, Castle light, Peroni, St. Louis, etc.).

It is mainly during large ceremonial gatherings that we find people of various financial statuses coming together to consume the same types of drinks. At marital ceremonies all kindred and friends of various social standings gather to celebrate the marriage of a near and distant relation. The consumption of alcohol is expected and may often be a main attraction, especially for those whose limited resources prevent them from having access to a variety of drinks. During extended ceremonies, usual abstainers for religious and other reasons, may find lack of adequate drinking water or food to be a convenient excuse to indulge in drinking alcohol. Sometimes medical excuses may be offered or various sacred scriptures referred to in an attempt to exonerate drinkers. Those who fail to rationalize or intellectualize their drinking behaviour publicly may resort to secret drinking.

When drinks are free there is the tendency to take full advantage while the supply lasts. Adult males are often the main consumers since the society regards drinking alcoholic beverages as more of a masculine, adult activity. Nowadays, more and more women and youths are joining in the competition. Especially during ceremonies of mourning and merrymaking, less stigma seems to be attached to females' drinking behaviour.

Social norms relax again and again at the various gatherings: the naming ceremonies, marriage ceremonies, holiday celebrations, funerals and ritual sacrifices.

In areas where market days are less frequent, such days usually usher in a wave of overindulgence as people appear to fill themselves and enjoy in anticipation of the next market day. It seems that a number of cultural practices socialize individuals into a life dominated by alcohol consumption. Since roughly 70 percent of the African populations are rural dwellers, many are relatively idle between planting and harvesting.

Previously, women and children were punished if they drank excessively, as children were regarded as too tender and women as having too many domestic responsibilities. Some of the stigma attached to female drunkards was connected to indigenous religious beliefs. In Nigeria children and women of Dawaki district regularly indulge in drinking 'mos.' Young children are sometimes given 'mos' by their mothers, to aid them in sleeping while the daily chores are being done. Although children and women regularly indulge in drinking, their level is on a lesser scale than the men. Sudimma (1983) found that although women are the main brewers of 'mos,' only 12% of the women sampled reported themselves as being heavy drinkers or alcoholics, whereas, 32 % of the men sampled indicated they were heavy drinkers or alcoholics. The question of accuracy may arise from self-reports, but the likelihood is that access has a differential effect on drinking behaviour of men, as compared to women.

As beer industries continue to proliferate in many African countries, people have greater access to alcoholic beverage to use and also abuse. Depending on one's geographical or social location, locally made brews may also be very popular drinks. More industrialized nations tend to have more of a mixture of drinks that are used or abused, even though beer is also popular at parties and outings. In most African nations, a variety of drinks may only be consumed by the elite since the costs of imported drinks are prohibitive for the average person. The second part of Winick's (1974) theory asserts that 'disengagement from negative proscriptions about the use of alcohol leads to a higher incidence of abuse.' This is a highly plausible explanation when one realizes that there are very weak sanctions against the use and abuse of alcohol. The public and victims often do not recognize when drinking has gone beyond the recreational stage, until it poses a serious threat to their jobs, families and community. Most societies seem to ridicule and tease 'the drunkard,' but criticisms may appear to be more destructive than constructive.

At times the drunkard appears to be the person society mothers as a child with a chronic illness, as weak efforts are made to abate the problem. When an individual perceives that society is indifferent towards his behaviour, his internal control may weaken. He may eventually view alcohol as an adaptive means of defending himself in times of stress. Those engaged in the production of ingredients for their own home brews are often beyond the control and supervision of any legal authorities. A husband can, at times, idle away his time in a drunken state while his wife tends the farm, without his fearing for his livelihood or any serious harassment. Where the culture condones the taking of alcohol after heavy manual labor, one may be inclined to feel reluctant to intervene in controlling someone's drinking behaviour who has worked so hard for the 'fruits' of his labor.

In a study by Amali (1982) of alcoholics at Jos University Teaching Hospital in Nigeria, more than 50% of the alcoholics interviewed felt their drinking behaviour was not harmful. Roughly  $\frac{3}{4}$  happened to have been referred by relatives. The majority of the patients were adult males, aged 26 and over (63% and 90% respectively), married (54%) and most frequently engaged in farming (93%). Although the sample size is too small to generalize to the population of alcoholics at large, the findings are in line with public opinion. An additional conclusion that Amali drew from the study is that, although youths and the higher educated individuals also have drinking problems, their problems may either not be as severe or they may see a greater stigma attached to sick labels and psychiatric treatment.

When an individual's drinking behaviour deteriorates to an acute psychotic reaction, relatives may be motivated to seek treatment, not necessarily for the drinking, but to control the evil forces which are assumed to have taken control of the person. Where mental disorders are assumed to be the result of witchcraft, there is the tendency for relatives and friends to have a more favorable and sympathetic attitude towards the victim (Sambo 1982). Alcohol disorders as opposed to cannabis disorders are often attributed to the work of enemies. Individuals, whose mental disorders are attributed to faults of their own, tend to be viewed very negatively and are often rejected. Those whose behaviour is very disturbing may eventually become outcasts, roaming the streets as beggars.

Normally when help is sought, the traditional healer is often the person of first resort, especially in areas lacking modern psychiatric facilities. Some people feel either compelled, more comfortable, or more confident relying on traditional healers. Since traditional healers, by the way, are not required to document or report cases handled, large numbers of alcoholics may go unnoticed.

Alcoholics residing in close proximity to modern psychiatric and medical facilities also run the risk of going unnoticed and untreated, where medical staff fails to make a definitive diagnosis or where they feel impotent to treat the problem for lack of time and adequate resources. Many medical practitioners feel hesitant to refer unsettled cases to the traditional healers for a variety of reasons. One major factor may be the generally unfavorable attitude of psychiatry (whether modern or traditional) held by the medical profession (WHO 1980:148). Another factor may be the lack of reliable evidence that the traditional healer is able to treat drug dependent patients. A third, among other factors, may be simple professional pride. Referring unsettled cases to another set of practitioners (particularly those regarded as less qualified) is tantamount to accepting defeat and as such, is humiliating.

On the other hand, alcohol and tobacco, which are presumably equally detrimental to health, are widely sanctioned and used extensively by the youths. The implication of this is that public attitude toward drug taking and the drug taker is unbalanced, if not ambivalent. And purely pharmacological explanations would be inadequate in illuminating government's paradoxical position.

The last supposition in Winick's theory of alcohol abuse identifies role strain and role deprivation as causal factors. Role strain refers to the felt difficulty in fulfilling the obligations of a role. Role deprivation refers to the reaction to the termination of a significant role relationship and loss of the occasion for the behaviors associated with a role situation (Winick 1974:4).

Role strain and role deprivation cannot possibly account for all cases of alcoholism amongst the youths in Africa, but a number of cases do seem to fit. Relevant examples of cases under each would be as follows:

#### **Role Strain**

1. Relying on alcohol to help fulfill farming tasks
2. Relying on alcohol to relax as an entertainer, host, and hostess
3. Relying on alcohol to cope with the physical and psychological stress experienced as a nurse, student, breadwinner, teacher, security guard etc.
4. Relying on alcohol to help one 'be a man'

#### **Role Deprivation**

1. Relying on alcohol to cope with one's inability to parent a child
2. Relying on alcohol to cope with the loss of a job or school opportunity.
3. Relying on alcohol to cope with a severed relationship (resulting from divorce, death, mobility, institutionalization, rejection).

In a number of studies (e.g. field tales of hazardous home brewed alcoholic beverages; the case of SelibePhikwe, Botswana) of drinking behaviour, culture (not race or biology) was cited as the chief motivator for drinking. Pitso (2007) asserts that, one of his major findings is that of the heterogeneous home brewed alcohol consumed in SelibePhikwe was a reflection of the multifarious Setswana ethnic groups found in SelibePhikwe. In addition, Larkin, (1965) notes that culture is a determining factor of patterns of alcohol consumption among blacks. Alcoholics are viewed by psychologists and psychiatrists as feeling inadequate, being latently homosexual, desiring self-destruction and self-punishment, attempting to escape from their inner guilt and conflicts, or being insecure and dependent upon others for support (Mushanga 1988:141). Role strain lends application in these cases. Where a person feels he/she cannot maintain a cordial and mutually interesting relationship with someone who is inclined towards drinking, such a person may resort to consuming alcohol as well. In this case, an individual experiences difficulty in satisfying the expectations of a significant person and thus feels obligated to share in the major pastimes of the other individual.

The concept 'role deprivation' is especially applicable in explaining the incidence of alcoholism among those caught in the whirlwind of urbanization and industrialization, especially the youths. Such individuals may feel alienated by their environment as a result of various changes.

With respect to the preceding discussion, we find that each of the issues in Winick's theory of drug (alcohol) dependence contributes, more or less, in explaining the increasing incidence of alcoholism in Africa during the latter twentieth century.

## 6. Conclusions

Given that alcoholism in Africa seemed to increase during the late twentieth century, the big question is what was done to address this issue? There was no singularly effective approach to the treatment of alcoholism. The alcohol using population is so heterogeneous that a combined approach is often deemed the most effective answer. Thus, 'the solution to problem drinking and alcoholism rested with the assistance provided by traditional public health, mental health, general hospital, public welfare, vocational rehabilitation or medical services' (Schafer 1975:401).

Alcoholism was regarded as an illness, a disease that can be a public health problem. The explanation of alcoholism is as disputable as its "cause." The prevention and treatment of alcoholism is as elusive as that of malignant tumors. For centuries people have known that the history of liquor is a history written in blood and tears; for liquor has shed more blood, broken more homes, armed more murderers, slain more children, men and women, than any other scourge ever recorded in the annals of human existence. Each year, alcohol claims more lives, costs more money than what allied forces spent on the Second World War. In the field of public health, the prevention of a disease consists of dealing with the causative agent, the patient and the environment, and this includes cutting off the lines of communication between the agent, the patient and the environment. But the prevention of alcoholism is difficult to achieve because alcoholism is a disease with a social aspect to it; because the use of alcohol has many social functions to fulfill whereas other diseases like small pox, HIV/AIDS etc. do not; and moreover, because there is no single causative agent for scientists to concentrate on (Mushanga 1988: 141-144).

Formal and informal, voluntary and involuntary methods were applied in dealing with alcoholism in many countries. These methods include moralistic and educational approaches, medical measures, psychological and psychiatric approaches, as well as community based strategies. The basic method of controlling alcoholism is the internalization of social norms, involving the proper socialization of children. In this connection, educational and religious institutions are designed *inter alia* to spread enlightenment about the dangers of deviating from conventional standards of behaviour. "Behind a veil of obviousness lurks the absolutely fundamental fact that every society is predicated upon the unquestioned assumption that its members, in their overwhelming majority, are not only competent to conduct their everyday affairs in accordance with whatsoever their society counts as correct forms of conduct, but where a chance is possible... will freely elect to do so. Put differently, every society assumes that its members are responsible for their doings, which is to say that they are moral agents. There seems to be a mutual recognition by both the "normal" and deviant members of society of the powerful societal mechanisms working not only to label deviance as strange and different from normality, but also to hide and shield the deviant performances (Beauchamp 1980:51-71)." Increasingly however, the victim chooses to challenge the label of deviant and demands a change in society's response and reaction to their condition. In some cases this has amounted to a demand in that society accepts at least in part, responsibility for their plight.

The medical approach entails the use of drugs such as antabuse or methadone to counteract the effects of alcohol intake. However, institution-centered treatment of physical dependence alone is deemed to be inadequate. 'The presumption (underlying the medical approach) is that rather than being an integral part of society's structures, drug (alcohol) abuse is an aberrant phenomenon afflicting otherwise healthy individuals' (Schechter 1975:4). Nevertheless, in order to motivate the alcoholic to give up drinking, extra medical approaches are necessary.

Based on psychological (Freudian etc.) and psychiatric theories, the third approach emphasizes individual and group psychotherapy. Such approaches had to be adapted to fit into the cultural context of Africa. However, doubts were expressed about the effectiveness of psychotherapeutic techniques in reducing alcoholism in the long run. 'Such approaches have not been credited with marked success on a permanent basis and reported successes may represent spontaneous recoveries that would have occurred without any therapeutic intervention' (Freeman 1973:526-527). The use of psychotherapy in African countries has been limited for a number of reasons, including shortage of trained professionals and paraprofessionals, and professional and societal indifference.

Community-linked strategies emphasize intensive reeducation and rehabilitation of pathological drinkers within the context of voluntary social welfare agencies.

Acting as therapists, community leaders required necessary training to provide groups of alcoholics with educational and other resources to enable them to become more responsible and useful members of society. Both past and future approaches relate to Winick's theory.



Measures can be taken in an attempt to control the three variables associated with an increase in alcoholism amongst African youths. To control 'access' the following steps may be taken:

1. Legal restrictions and enforcement against the sell and purchase of alcohol by minors in both rural and urban areas (although problems of monitoring rural areas are bound to arise, the policy should be the same).
2. More stringent policy on alcohol distributorships, to help centralize the sale of alcoholic beverages, which could be earmarked for the government's use in alcohol prevention and treatment programmes. Problems of accounting and misappropriation of funds are possible, but the effort is worth guaranteeing a minimum amount of funds for continuous control strategies.

Concerning 'disengagement from negative proscriptions about the use of alcohol,' we suggest the following:

1. Educational campaigns aimed at informing rural and urban youths about the use and dangers in the abuse of alcohol. This is necessary to counteract the present glorification of alcohol via media advertisements.
2. Introduction of the subject as part of health science at the primary school level. This is an important starting point since children are being socialized to drink at early ages.

Regarding role strain and role deprivation, these measures may be taken:

1. Creation of more leisure activities, accessible to the average person, which do not centre around drinking.
2. Improved technology to reduce the physical and psychological stress associated with tedious manual labor.
3. Improved opportunities for employment, training, housing, etc.
4. Production of counsellors, motivated to work with people whose own resources are inadequate for resolving their role problems.

To affect well planned change strategies, a central coordinating council on alcoholism is necessary. Such a council should work to pool ideas and resources, develop prevention and control plans, and to provide the proper support in implementing change.

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