DRUGS /SUBSTANCES ABUSE AMONG STUDENTS OF KADUNA POLYTECHNIC

BY

FATIMA ZAKARI IMAM
MPH / MED /37527 /2002 -2003

NOVEMBER 2004

DRUGS /SUBSTANCES ABUSE AMONG STUDENTS OF KADUNA POLYTECHNIC

BY

FATIMA ZAKARI IMAM
MPH / MED /37527 /2002 -2003

**BEING A DESSERTATION PRESENTED TO THE DEPARTMENT OF COMMUNITY MEDICINE,
FACULTY OF MEDICINE, IN PARTIAL FULFILMENT OF THE REQUIREMENT FOR THE AWARD OF MASTER DEGREE IN PUBLIC HEALTH (MPH) OF THE AHMADU BELLO UNIVERSITY, ZARIA**

NOVEMBER 2004

DECLARATION

I hereby declare that the work presented in this project for the award of Master Degree in Public Health has not been presented either partly or wholly for any degree elsewhere.

The work is entirely the result of my research conducted under the supervision of Dr. E. S. Essien. The works of other researchers have been acknowledged accordingly in the section entitled REFERENCES.

_____

FATIMA ZAKARI IMAM

CERTIFICATION

This thesis entitled DRUGS /SUBSTANCES ABUSE AMONG STUDENTS OF KADUNA POLYTECHNIC, by FATIMA ZAKARI IMAM, meets the regulation and requirements governing the award of Master Degree in Public Health of Ahmadu Bello University, Zaria, and is approved for its contribution to knowledge and literary presentation.

_____ _____

Project supervisor Date
Dr. E.S. Essien,
Senior Lecturer, Department of Community Medicine
Ahmadu Bello University, Zaria.

_____ _____

Dr. A. U. Shehu, M.B.B.S., DTM & H, FWACP, Date
Head of Department,
Department of Community Medicine
Ahmadu Bello University, Zaria.

_____ _____

External Examiner Date

_____ _____

Prof. J. U. Umoh, DVM (ABU), MSPH, Ph.D (Missouri) Date
Dean, Postgraduate School,
Ahmadu Bello University, Zaria.

DEDICATION

I hereby dedicate this work to my husband, Idris M. Imam and my children, Najib, Amir, Suraj, Zainab and Zahra'u.

_____

FATIMA ZAKARI IMAM

ACKNOWLEDGEMENT

First and foremost I am thankful to Almighty Allah for leading me through the various stages of this work.

I gratefully acknowledge the support of all that contributed towards the success of this work in one way or the other. My appreciation goes to the Management of Kaduna Polytechnic for granting me the Sponsorship and opportunity of study leave.

My sincere gratitude also goes to my supervisor, Dr. E. S. Essien, who made detailed and objective critism of every submission to him. He offered a number of useful suggestions without which the project would never have been written.

I also wish to register my thanks to A. U. Shehu to for his immense contributions towards this study. My gratitude also goes to Dr. N. Sambo, Dr. S. Idris, Dr. Sufyan support and assistance during this project. My sincere gratitude also goes to Mr. Joel Maidawa for his untiring efforts during the data analysis and statistical interpretation of this research.

Also acknowledged are the support and contributions of the staff and students of Kaduna polytechnic especiall Mallam Abdulmalik of the Department of applied Siences who assisted with usefull information and data collection during the pilot and final study.

My sincere gratitude also goes to the entire members of my family especially my husband, Idris M. Imam and my children, Najib, Amir, Suraj, Zainab, Zahra'u and also my aunty, Fatima Daudu, for their patience, love endurance, support and encouragement during the study.

My sincere thanks also goes to the entire staff of the Department of Community Medicine in the Faculty of Medicine, Ahmadu Bello University , Zaria, and the 2002-2005 Masters In Public Health Students for their various contributions during the study.

TABLE OF CONTENT

CONTENT **PAGE**

Cover page

Title page……..……..……..i

Declaration…….……ii

Certification……...……....iii

Dedication……..……..……...……..…iv

Acknowledgement…….……..v

Table of content ……...…….……vi

List of tables……..….....vii

List of figures……..……..……viii

List of appendices…….……..ix

Abstract…….....……x

CHAPTER ONE

1.1 Introduction……1

1.2 Justification…….……..…….3.

1.3 Aims and objectives…..……..4

CHAPTER TWO: LITERATURE REVIEW

2.1 Introduction……..6

2.2 Definitions of some terminologies……7

2.3 Historical background……10

2.4 Problem statement……11

2.5 Classification of drugs/substances…….18

2.6 Consequences of drug/substance abuse……..26

2.7 Aetiology/risk factors of drug abuse……...28

2.8 Initiatives and efforts at combating drugs/substance abuse…….32

2.9 Conclusion ……..35

CHAPTER THREE: METHODOLOY

3.1 Background of the study area….....37

3.2 Materials and methods……..…….39

CHAPTER FOUR: RESULTS

4.1 Socio-demographic characteristics of the study population……...42

4.2 Knowledge about the drug(s), prevalence and pattern of drugs use…….45

4.3 Reasons for drug used and factors influencing drugs use……

4.4 Site effect experience by drug users……...

CHAPTER FIVE

DISCUSSIONS……...……..

CHAPTER SIX

6.1 Recommendations…….…….…….

6.2 Conclusions…….

6.3 References……...

APPENDICES

Appendix I

Appendix II (questionnaire)

Appendix III

Appendix IV

Appendix V

LIST OF TABLES **PAGE**

Table 4.1.1

Table 4.2.1

Table 4.3.1

Table 4.4.1

LIST OF FIGURES **PAGE**

Figure 4.1.1.

LIST OF APPENDICES

Appendix I..……..…….....

Appendix II …….....……

Appendix III…….....

Appendix IV…….…….…….

Appendix V……...…….....……

ABSTRACT

CONTEXT

MEODOLOGY

RESULTS

CONCLUSION

CHAPTER 1

1.1 Introduction

There is a growing public concern in our country, Nigeria, about involvement of adolescents and young adult in drug abuse, which is defined as the non - medical use of substances by human beings that may modify one or more of its functions and may impair an individual ability to function effectively and may result in social physical or emotional harm[1]. While it is universally accepted that drugs can be of tremendous benefit to man and society, it is also acknowledged that inappropriate use of drugs can be harmful to man .The personal, social and public health problems associated with psychoactive substance use, have continued to arouse world wide interest and concern. Various reports and researches conducted have illustrated this phenomenon. Drugs/substance abuse is a world wide hazard with dangerous complications that affect many countries around the globe, Nigeria inclusive. The problem varies from place to place.

The African seminar on problems of drug dependence held in Lagos, Nigeria declared that "Drug abuse and dependence producing substances are widely prevalent in African countries have continue to increase. These problems affect the individual, the family and the society in general. Substance abuse which was originally conceived as the problem of a selected few is today becoming a problem of a sizeable proportion of the world population. The problem is so grave that it has extended beyond the usual characteristic profile of abusers being male, adult, and urban-based to now include females, youngsters and those who live in rural areas. Its economic effect is so devastating that it is estimated that the annual retail cost of psychotropic substances by prescription is over two billion naira while the alcoholic industry which produces over

five billion gallons of alcoholic beverages annually generate more than four billion naira from sales to a consumer population of about 30-35 million people[2].

Illicit Drug traffic known to generate huge profit and fortune and that is one reason why it has been very difficult to combat the drug traffic in spite of several laws that have been promulgated. For instance, it has been estimated that the sum of $400 billion is the turn over of illicit drug industry, which is equivalent of approximately 8% of total international trade and therefore larger than the trade in iron steel, motor vehicle, textile, tourism[3]. Drug abuse and other associated problems constitute a major threat to the survival and effective functioning of human societies, lives are lost daily through addiction and activities of addicts. A significant number of deaths from accidents and violent crimes have been traced to the activities of persons under the influence of drugs[4,5,6]. Treatment facilities nation wide are now gradually being over burden with drug-related problems and cases[4,7]. The need to prevent drug abuse among the general population and by the growing generation of Nigeria thus becomes imperatives.

Nigeria which once served only as trans-shipment route for drugs soon became a "consumer" country when it was observed that the increasing incidence of drug abuse among students is a contributory factor in the ugly confrontation between school administrators and students[8,9,10]. The problem of drug abuse poses a far greater health hazard than most imagine. Psychoactive drugs and substances have the primary effect on the mind such as altering mood, feelings, perceptions and behaviours. These drugs are usually taken to give an insulation from the real world and its difficulties[11]. This is accompanied by the feeling that varies according to the drugs used. This is common to those whose personality development is insufficient to enable them cope with the normal life.[12]

One of the hazards of using of drugs/substance to alter mood and feeling is that some individuals eventually develop dependent on the drug. They have diminished flexibility in terms of their behaviour toward a particular drug or substance. They became dependent on the drug for their feeling well being. The intensity of this need or dependent may vary from mild desire to a craving or" compulsion to use the drug/substance and when the availability of the drug is uncertain they may exhibit a pre-occupation with its procurements. In extreme form, their behaviour exhibits the characteristics of a chronic relapsing disorder, this is a state referred to as" addiction or dependence"[13,14,15]. The substances commonly abused include tobacco, alcohol, stimulants like caffeine, nicotine, cannabinoids, amphetamine, volatile solvents like glue, petrol, diethyl ether, chloroform correction fluid, psychotropic medicines such as sedatives, anxiolytics, hypnotics etc[16,17,18]. Most of the drugs being abused are beneficial, but also have devastating after effects such as psychosis, paranoid schizophrenia, chronic addiction with all the implications of mental and physical dependency[14,15,16]. Some of the social and environmental contributory factors associated with substance/drug abuse include living away from home, relaxed parental control, alienation from family, early exposure to drugs, peer influence, easy access to the drugs and their availability etc[3,19]

1.2 Justification

Some crimes committed under the influence of drugs include murder, rape, robbery, homicide, destruction of lives and properties, violation of traffic regulations leading to accidents, affecting the user and or the people of the society in general. Studies conducted showed that youths account for about 70% of the population engaged in drug[14] again bearing in mind that the youths of this country constitutes about

43% of the entire population, then drug abuse has an alarming negative influence on the future of the country. It is therefore pertinent that research programs should be carried out to determine the population at risk, the changing pattern, trend and prevalence of drug abuse over time among the higher institution students in Nigeria, because the youth and school going population constitute a high risk group and the most susceptible to drug abuse. Also, to determine the effect of drug abuse on an individual and the society to allow for adequate social monitoring, planning and evaluating of services. Perhaps, the incorporation of drug treatment and prevention programmes into primary health care (as part of mental health component in schools health services) would be a giant step in the right direction.

This particular research work will attempt to find out the practice of psychoactive substance and drug abuse among the Kaduna Polytechnic students, and the research findings may contribute towards providing information for planning health education and other important measures to effectively help in cubing the menace of drug abuse among youth. The problem of drug abuse being of public health importance needs to be effectively and efficiently control, to greatly reduce the menace and consequences such as crimes and cultism. Kaduna Polytechnic is highly cosmopolitan with students admitted from all over Nigeria and other countries. It has been in one fore front in the training of high and middle level manpower for the various sectors of the nation's economy, therefore the project will have a great impact on many youth and the nation in general.

1.3 Aims and objectives

1.3.1 Aim: To determine the pattern of drugs/substances abuse among students of Kaduna Polytechnic.

1.3.2 Objectives:

i To assess the level of knowledge of Kaduna Polytechnic student on drugs/substances abuse.

ii. To identify the various types of drugs abused by the students.

iii. To identify predisposing factors for drug abuse among the students.

iv. In the light of the above findings to make recommendations to the management on how to minimized the problem in the school.

CHAPTER 2

LITERATURE REVIEW

1.1 Introduction

Drug abuse or substances use is now known to be a common term referred to any use of illicit substances. Legally, the term means any use of drugs that have been classified as illegal in a country. Medically, the term means the use of any drug in a way that is harmful to the body either immediately or in the long term. It also connotes taking drugs without medical advice. Socially, the term indicates that the effects of the substance being used interfere with the individuals social life[11,20,21]. It is also defined as the use of a drug which is viewed as posing a problem by the society concerned[22.] Thus, drug abuse generally refers to drug use that results in the physical, mental, emotional and social impairment of the user[3]. Abused substances include alcohol, tobacco and tobacco products, stimulants, cannabis, sedative-hypnotics and narcotics. These drugs or substances of abuse belong to an heterogeneous pharmacological group and the link between them is that the sensation of euphoria they produce and the abusers want to continue to enjoy the effect.

This become problematic as the desire for more of the substance takes the better part of an individual and makes him live in a way that the community can no longer accept. Besides, the habit which he develops causes him or the community some harm or danger[23]. The major problem that arises from the consumption of psychoactive drugs is dependence, the compulsion to use the drugs despite any deteriotion in health, work, or social activities. Dependence varies from drug to drug in its extent and effect[24]. Drug abuse is a problem that is caused by social, economic, political, legal and cultural factors existing within the society. Most of these factors determine the typical pattern of drugs that are being abused in Nigeria. Drug abuse blocks meaningful use of time,

energy and creative thinking and destroy a persons ambition to become great, making him hopeless and unproductive. These serious facts notwithstanding, various research reports have confirmed that Nigerian youth in both urban and rural areas and of different socio-economic backgrounds have indulged in the use and abuse of dangerous and illicit drugs[25]. Nigerian youth face the problems of drug use as means of escaping immediate difficulties[11]. Studies conducted showed that youths accounts for about 70% of the population engaged in drug, again bearing in mind that the youths of this country constituted about 43% of the entire population[16,26,27], then drug abuse has an alarming negative influence on the future of the country, therefore there is much cause for alarm and concern. The problem of drugs and drug abuse are multi factorial, which seem to defy known and existing solutions, not only in the third world countries, but even in the technologically advanced nations. No single approach seems to effectively work; no single theory seems to adequately unravel the mysteries, and no profession can claim monopoly of the knowledge of dealing with and/or handling the problem.

2.1 Definition of some terminologies

Drugs: These are substances which may modify one or more of body functions[1]. Drug is a chemical other than those required for the maintenance of normal health which on administration alters biological functions[28]. The World Health Organisation (WHO) scientific group defined a drug as; any substance or product that is used to modify or explore physiological system or pathological states for the benefit of the recipient. A drug is nay chemical or substances other than food which affects the structure or function of the body of any organism[29].

Substances: Includes drugs as well as other compounds which are pharmacologically active, though the two terms drugs and substances have been used interchangeably in this study.

Psychoactive drugs/substances: These are drugs/substances possessing the ability to alter mood, anxiety, behaviour, cognitive process or mental tension. They mainly have their effects on the brain and psychological functions.

Drug Abuse: Referred to consumption of drug other than for medical purpose[30]. A drug is abuse when it is obtained illegally or the legally obtained one is misused[29]. Drug abuse is the persistent, excessive and improper use of drug without regard tom medical practice which may lead to body dependence on drug[21]. It is the use of drug when it is not medically necessary, when use of socially acceptable drugs[21].

Drug Addiction: This is a condition which becomes a costumed to the pharmacological content of a drug and the psychic effect could no longer work on the biological nature of the body unless the content of such drug is increase. Usually addiction leads to dependence since the body mechanism are being destroyed to work naturally[28].

Drug dependence: A state psychic and sometimes also physical resulting from the interaction between a living organism and a drug characterized by behavioural and other responses that always include a compulsion to take drug on a continuous or periodic basis in order to experience its psychic effect, and sometimes to avoid the discomfort of its absence. Tolerance may or may not be present. A person may be dependent on more than one drug[31]. Drug dependence is the excessive craving which develops as a result of repeated administration of a drug despite the terrible psychological or physical effects produced by these susbtances[32]. There are two forms of dependence:

i) Psychological dependence is a state in which a person's thoughts, emotions and activities are dominated by the drug to which the person is dependent to the extent that he craves drug when he can not get a regular supply and in the right quantity.

ii) Physical dependence: Is a state in which the body is adapted to the presence of the drug and when the administration of the drug is suspended or reduced, various abnormal reactions, typical of each drug occur. These reaction are termed withdrawal or abstinence syndrome.

Tolerance: That is an adaptive characterized by diminished responses to the same quantity of a drug or by fact that a larger dose is required to produced the same degree of pharmacodynamic effects.

Drug control: This is a national and international agreement governing and restricting production, movement and use of a drug to medical and scientific needs in the interest of public health and for the prevention of drug abuse. This is aimed to optimize the risk-benefit ratio.

Youth: Include young adults in their twentieth (20 – 29) years old as well as adolescents in their tens (10 – 19) years[33]. Youth is anybody in the period between early childhood and old age[34]. It is a period of risk and vulnerability, it is a time of experimentation, exploration, curiosity, a search for identity and risk taking, such risk taking can include the use of alcohol, tobacco and other drugs. It is thins time that young people seek to achieve independence from their parents and to become established as adults. It is a period of changes in the body both hormonal, physical, emotional and behavioural changes that make the individuals vulnerable to so many influences.

Vulnerable: Is the degree to which an individual is unable to anticipate, cope with changes, resistance and hazards or problems.

Preventions: These includes activities designed to provide permanent protection from a problem.

2.3 Historical Background

The history of using mind-altering drugs to excess, or in a manner disapproved by society, is as old as the human race. Fermented beverages were probably used by prehistoric humans, who depicted their effects on cave walls. Opium and marijuana have been in worldwide use for centuries and the Indians of South America recognized the stimulant properties of the coca plant long before the Spanish conquest[13]. It is stated that all naturally occurring sedatives, narcotics, euphoriants hallucinogens and excitants were discovered thousands of years back[35]

Each society develops rules and guidelines for the use of drugs. Although the bible frequently mentions wine in approving terms, it warns against drunkenness. In some cultures, men may drink fermented beverages to intoxication, women and children who do so may be punished. Alcohol use is widely accepted in western society, but its use is prohibited and condemned in Islamic cultures. In the eastern world, opium was once a widely accepted recreational drug. In the United State and England, it was available on grocery store shelves until the late nineteenth century Cocaine, the ingredient that was responsible about 100 years ago for making coca-cola "the pause that refreshes" is now an illegal drug in the United States.

2.4 Problems Statement

Many social, economic and political factors have contributed to the global spread of alcohol and other psychoactive drugs. In the nineteenth century drugs tended to only be available where they were produced, or very close to the source of production. However, the growth of transportation, tourism and communications in the twentieth century has made it possible to transport goods and people quickly to any part of the world. Drugs too, are being transported to distant places. Given the economic rewards of producing and transporting drugs, it is not surprising that they are available almost all over the world. It has been estimated that the illegal market for drugs is worth between US$ 100$ - 500$ billion world wide[36]. These figures are of course more than estimates, but even at the lower level represents a substantial and lucrative market. Global trends in drug production, transportation and consumption are difficult to describe and assess because of the complexities of the issues involved and the lack of accurate information on what are clandestine activities. Drugs are being produced in increasing numbers, making them more readily available through both legal and illicit channels. A drug culture life style with its own jargon support and maintains its members in their drug-seeking behavior and helps to make the illicit market profitable.

There has been a sizeable increase in the production and use of illicit drugs throughout the world. The United Nations International Drug Control Programmes estimate that the global production of coca leaf has more than doubled and that of opium poppies more than tripled since 1985[37]. Moreover, new forms of existing drugs e.g smokeable" crack" cocaine, changes in the modes of administering these drugs e.g transitions from opium smoking to heroin injection in South East, Asia) and one introduction and proliferation of now synthetic drugs e.g DMA "ecstasy" other amphetamine-type stimulants and so called designer drugs all create new or exacerbate

existing substances related problems. Of particular importance is the fact that drug injection has become a major transmission route for HIV [38,39,40].of scientific and public health efforts to address these new issues, significant advances in drug abuse epidemiological research methods have been achieved. These advances have included improved techniques to assess the extent of drug related behaviours and problems, but also the introduction and development of methods which aim to understand behaviour as much as measure them [41,42,43].

Substance abuse is a major social and public health problem. The abuse of one drug-alcohol-currently is one of the major causes of death in the United Sates, ranking only behind coronary diseases and cancer. Substance abuse cost the American economy billions of dollars a year[44,45].

Alcohol is one of the most widely abused drugs among youth in Nigerian schools. This is because it is widely available and socially acceptable. The use of alcohol has continued to rise since Nigerian law does not prohibit its production, sales or consumption. Alcohol is one of most widely used and abused substance and is available in all but the most isolated areas of the world or in a few countries on strict religious prohibitions. Although alcohol consumption has recently declined in many developed countries[44,46], its use has been increasing in developing countries[47]. This increase is often occurring in countries with few methods of prevention, control or treatment. Alcohol problems are now occurring in places where they did no exist before. For example, alcohol was not traditionally used in many Asian and Western Pacific counties. How ever, it now constitutes a serious health problem. In Sri Lanka, for example, 10% of all hospital admissions are alcohol related[44]. Between 1970 and 1980 alcohol consumption increased by about 3.6 % in Asian countries where alcohol is not used traditionally[44]. Also rates of liver cirrhosis increased in wine producing

countries such as Hungary, Romania, contrary to the situation of declining rates in many North American and European countries[48], it was shown how beer consumption has increased in Turkey because of multinational has increased beer companies[49].

Some Islamic countries such as Saudi Arabia, Yemen, Kuwait and Iran have banned alcohol, but a research on "substance abuse among Iranian male students" shows that 13.5% of them are using alcohol. A research to investigate the rate of substance abuse among Iranian male student shows that 13.5% of them are using alcohol among the 500 students that were randomly selected from schools[50]. However, in Egypt alcohol is readily available and is used by about 34% of the student population[51]. In Nigeria, alcohol is the most widely abused drug among youth. Alcohol is widely available and socially acceptable. Its use has continued to rise since the law does not prohibit is production, sales or consumption. Alcohol is associated with socialization, therefore, it is not preserve for adult males but also abused by females, adolescent and the youth. A study conducted on parental influence on alcohol among teenagers (age between 11-15 years) in Benin City, revealed that 60% of them started drinking at home, usually during traditional activities or administered by parents as alcohol concoction (mixture of alcohol and herbs)[52].

Another study shows that alcohol related problems were evidence among adolescents in schools[52,53]. Another survey carried out on the patterns of drug use among 484 randomly selected secondary schools students in Warri and Effurun, 66% of the students both the boys and the girls have had some experience with alcohol[54]. A study on the prevalence of drug use among secondary school students in Ilorin metropolis shows that 65% of the 240 students, selected randomly form six schools, abuse alcohol[55]

The high rate of bear consumption in Nigeria was influence by the opening of beer enterprise production in many states. In 1978 alone, six new bravery plants were opened while nine more were built between 1981-1985. By 1986 however, there were already 30 breweries in Nigeria with production capacity of 16.1 million hectoliters of beer and related drinks and this explains the sudden upsurge of beer consumption from 1986 to date[38,39]. The increased production of beer and availability of local beverage like ogogoro and burukutu coupled with loose laws which permits the importation of large amounts of foreign alcoholic drinks further compounded the problem. Alcohol and cigarette smoking, constitute a more problem to the society than all other psychoactive substance coupled together and it also constitutes a major problem to healthy social and or occupational function.

Another comprehensive study carried out on drinking behaviour and social change among secondary school students in Ibadan and Abeokuta, 54% of the sample of 1123 students admitted having use alcohol. 58% of the users were males and 50% were females and the age of their first use of alcohol was estimated as eleven[56]. On a rather larger scale, an International council on alcohol among secondary school students in four states namely Lagos, Oyo, Bendel, and Anambra, the results of these study incriminated alcohol as one of the most commonly abuse drugs by secondary school students, majority of the users eventually graduate to drug dependency which may be manifested while they are in tertiary institutions, hence leading to high prevalence of substance abuse in tertiary institutions[57,58]. Alcohol use can impair health, its abuse leads to many life-threatening, chronic physical, and emotional illnesses. Alcohol abuse is in reality a potentially fatal illness. Alcohol is the commonest depressant used to ease tension, cause relaxation or help users to forget their problems..

Anxiolytics (barbiturate and benzodiazapam) have continued to be used for their therapeutic efficacy in health care, and therefore they continue to be available for illicit drug use all over the world. The use is becoming high at concerts social function or any event that provides the motivation for use. Since these drugs are easily accessible and readily available from chemists, shops and black market where the drugs may be mixed or have unreliable content, the risk associated with this pattern include accidents occurring during an intoxicated or out of control state, overdose danger because of the trend to mix drugs with alcohol or other depressants, and the potential for addition.

The abuse of tranquilo-sedatives and hypnotics have been increasingly observed in Nigeria. Studies have found that even students abuse these drugs especially the barbiturates and the benzo diazepines[16,17,53,54]. The use of these drugs was found to be more common among adult females than adult males and their main reason of use if to relieve tension and anxieties[36,37,54]. Since these drugs are easily accessible and readily available from chemist shops and from medicine chests drawers in homes, it becomes a drug of choice for students.

Tobacco continues to be the substance causing the maximum health damage globally. According to WHO estimates, there are around 1.1 thousand million smokers in the world, about one-third of the global population aged 15 years and over[59]. Substantially fewer cigarettes are smoked per day per smoker in developing countries than in developed countries. In the early 1990s, average adult per capital consumption in developed countries were 2590 versus 1410 in developing countries. However, the gap in per adult cigarette consumption is narrowing. Tobacco is estimated to have caused around three million deaths per year in the early 1990s, and the death toll is steadily increasing. Unless current trends are reversed, that figure is expected to rise to 10 million deaths per year by the 2020s or the early 2030 (by the time the young smokers

of today reach middle and older ages). With 70% of those deaths occurring in developing countries[59].

A study conducted by Additions foundation of Manitoba on substance use among Manitoba High School Students. shows that smoking often becomes a strong addition that begins early in life, and according to some literature nicotine is considered a 'gate way' drug that precedes and may increase risk for other drug use[60]. Over half of the total number of students (4,680) surveyed had smoked at some point in their lives, with females more likely to smoke than males (60% versus 54%). Smoking rates increase as one gets older. Slightly over 43% of all senior students smoked in the past year, compared with 34% of Junior Students. The average age that students start smoking is 13 years, and there is no difference between males and females in terms of when they started smoking. 52% smoke less than 20 cigarettes in a week, while 18% smoke more than 60 cigarettes in a week[57]. Heavy smoking is more among males than females with 22.8% of males usually smoke more than 60 cigarettes per week, whereas 12.3% of females smoke this amount[60].

Another study carried out among youths at High risk of dropping out of school in Texas, where 6,724 at risk youth were studied, it shows that 70% of them have used tobacco compared to 45% of the youth not at risk[61]. A study on substance abuse among Iranian students where 500 students were randomly selected from high schools in different regions in Shiraz the capital city of far province and has a population of more than one inclusion shows that cigarette ranked first among of the substances with (36.9%), out of which 26% of them are males and the remaining females both of which are regular smokers[50]. A clinical paper on cigarette usage was found to be 35% among senior students during a study on patterns of substance abuse among school age children[62]. In Nigeria tobacco is legal and socially acceptable, therefore it is readily

available for youth to commonly indulge in cigarettes smoking. A study on the contribution to the onset of cigarettes smoking among secondary school students shows that 40.5% of the boys and 8.4% of the girls were found to smoke[63].

Cannabis sativa (Indian hemp) is illegally cultivated in many parts of Nigeria and is reported to be widely used in Nigeria[64,65,68,67,68]. Some studies have shown that cannabis is abused by youths from both privileged and less privileged socio-economic backgrounds[69,70,71] . Reports showed that its use is more common among males than among females[72,73]. These studies have also identified adolescents and young adults as constituting the risks groups. Surprising, a study found that some children started using cannabis at a tender age of eleven years [53].

Unlike alcohol that is a drink, cannabis is usually consumed by smoking the dried leaves with the seeds. Other method in which cannabis was found to have been used is taking it with alcoholic beverages or use of the leave in the preparation of pepper soup, porridge or tea [57,67]. Other stimulants that were found to have been abused by Nigerians include amphetamines, caffeine, (kolanut, coffee, tea), narcotic (tobacco cigarette) and lastly cocaine. These drugs because of the soothing effects and the increased sense of well-being that they produce have been found to be commonly abused by adolescents and youths, especially students. It is common to hear students discuss about their usefulness in aiding concentration, alertness and relaxation while they are studying. The use of the minor stimulants such as kolanuts coffee/tea to which students eventually become psychologically dependent, because of their frequent use and their social acceptance is common.

Heroin and cocaine have been identified as the “New Arrivals” of drugs in Nigerian scene. Heroin accounted for 16% of the total admission of drug patients while cocaine

accounted 9.3% in psychiatric Hospital[73,74]. Another study rates cocaine and heroin/morphine use as 1.6% and 2.3% respectively among university students [75,76,].

2.5 Classification

a) The general depressant of the Central Nervous System (C.N.S) (Tranquilo-sedatives and hypnotics)

   i) Alcohol

   ii) Barbiturates/benzodiazepines

b) The Stimulants of the C.N.S. e.g Amphetamines, Cocaine, Marijuana, Caffeine (Kolanuts, Coffee and Tea, Cocoa), Nicotine (tobacco/cigarette).

c) The Hallucinogens e.g. LSD, Mescaline, Myristicine, Paramethoxy Amphetamine (PAM)

d) Narcotics e.g Heroin, Morphine, Opium and Codeine

e) The miscellaneous group e.g Inhalants Solvents, Glue, Paints and Gasoline, Nitrous oxide.

2.6 CNS Depressants (Alcohol And Anxiolyitc Agents)

The drugs in this category have a depressant effect on the central nervous system, they include alcohol and the anxiolytic agent which reduces anxiety and also have sedative effects that is promoting relaxation or hypnotic effects that is producing sleep. Anxiolytic agents include among others, the barbiturates such as Phenobarbital and the diazepam (valium). Many youth use these agents rather than problem solving methods to help them cope with the pressures of life. Central nervous system depressants are some of the most widely used and abused drugs in existence. They are

believed to relieve stress and anxiety, and some induce sleep. CNS depressants produce many side effects including problem of dependence.

Effects

Alcohol is rapidly absorbed from the stomach and small intestine after ingestion and becomes evenly distributed throughout the body. Intoxication occurs when more alcohol is consumed than can be metabolized. Problems developed with prolong use of large amounts of alcohol and the development of tolerance. Excessive consumption of alcohol often results in a reaction popularly known as the hangover, with headache, nausea, vomiting, dizziness, tremor, diaphoresis, thirst and gastritis. Other disturbances include alterations of liver functions, acid-base balance end electrolyte homeostasis and affectation of many organs of the body such as musculo skeletal and reproductive system.

2.7 CNS Stimulants

Marijuana *Cannabis sativa,* a hemp plant, is the source of marijuana. The parts of the plant vary in potency. The resinous exudates of the flowering tops of the female plant (hashih, charas) is the most potent, followed by the dried leaves and flowering shoots of the female plant (bhang) and the resinous mass from small leaves of florescence (ganja). The least potent parts are the lower branches and the leaves of the female plant and all parts of the male plant. Mercury may be a contaminant in marijuana grown in volcanic soil. The drug is usually inhaled by smoking. Effects occur in 10 – 20 minutes and last for 2 – 3 hours "Joints" of good quality contain about 500mg of marijuana (which contains approximately 5 – 15mg of tetrahydrocannabinol with a half-life of 7 days). Marijuana soaked in formaldehyde and dried ("AMP") has produced unusual

effects, including autonomic discharge and severe though transient cognitive impairment.

Effects

With moderate dosage, marijuana produces two phases: mild euphoria followed by sleepiness. In the acute state, the user has an altered time perception, less inhibited emotions, psychomotor problems, impaired immediate memory, and conjunctiva injection. High doses produce transient psychotomimetic effects. No specific treatment is necessary except in the case of the occasional "bad trip", in which case the person is treated in the same way as for psychedelic usage. Marijuana frequently aggravates existing mental illness and adversely affects motor performance.

Studies of long-term effects have conclusively shown abnormalities in the pulmonary tree. Laryngnitis and rhinitis are related to prolonged use, along with chronic obstructive pulmonary disease. Electrocardiographic abnormalities are common, but no long-term cardiac disease has been linked to marijuana use. Chronic usage has resulted in depression of plasma testosterone levels and reduced sperm counts. Abnormal menstruation and failure to ovulate have occurred in some women. Cognitive impairments are probable, though studies are not conclusive. Sudden withdrawal produces insomnia, nausea, maralgia, and irritability.

Amphetamines and Cocaine

Stimulant abuse is quite common, either alone or in combination with abuse of other drugs. The amphetamines, including Methedrine ("Speed") – one variant is a smokeable form called "ice", which gives an intense and fairly long-lasting high – methylphenidate, and phenmetrazine, are under prescription control, but street availability remains high. Moderate usage of any stimulants produces hyperactivity, a

sense of enhanced physical and mental capacity, and sympathomimetic effects. The clinical picture of acute stimulant intoxication includes sweating, tachycardia, elevated blood pressure, mydriasis, hyperactivity, and an acute brain syndrome with confusion and disorientation. Tolerance develops quickly and, as dosage is increased, hyper-vigilance, paranoid ideation, stereotyping, bruxism, tactile hallucinations of insect infestation, and full blown psychoses occur, often with persecutory ideation and aggressive responses. Stimulant withdrawal is characterized by depression with symptoms of hyperphagia and hypersomnia. People who have used stimulants chronically, occasionally become sensitized ("kindling") to future use of stimulants. In these individuals, even small amounts of mild stimulants such as caffeine can cause symptoms of paranoia and auditory hallucinations.

Cocaine is a stimulant. It is a product of coca plant. The derivatives include seeds, leaves, coca paste, cocaine hydrochloride, and the free base of cocaine. Cocaine paste is a crude extract that contain 40 – 80% cocaine sulphate and other impurities. Cocaine hydrochloride is the salt and the most commonly used form. Free base, a purer (and stronger) derivative called "crack" is preserved by simple extraction from cocaine hydrochloride.

There are various modes of use. Coca leaf chewing involves toasting the leaves and chewing with alkaline material (e.g the ash of other burned leaves) to enhance buccal absorption. One achieves a mild high, with onset in 5 – 10 minutes and lasting for about an hour. Intranasal use is simply snorting cocaine through a straw. Absorption is slowed somewhat by vasoconstriction which may eventually cause tissue necrosis and septal perforation; the onset of action is 2 – 3 minutes, with a moderate high euphoria, excitement, increased energy lasting about 30 minutes. The purity of the cocaine is a major determinant of the high. Intravenous use of cocaine hydrochloride or

“freebase” is effective in 30 seconds and produces a short-lasting, fairly, intense high of about 15 minutes duration. The combined used of cocaine and ethanol results in the metabolic production of cocaethylene by the liver. This substances produces more intense and long –lasting cocaine-like effects. Smoking freebase volatilized cocaine because of the lower boiling point acts in seconds and results in an intense high lasting several minutes. The intensity of the reaction is related to the marked lipids solubility of the freebase forms and produces by far the most severe medical and psychiatric symptoms.

Effects

Cardiovascular collapse, arrhythmias, myocardial infarction, and transient ischemic attacks have been reported. Seizures, strokes, migraine symptoms, hyperthermia, and lung damage may occur, and there are several obstetric complications, including spontaneous abortions, abruption placenta, teratogenic effects, delayed fetal growth, and prematurely. Cocaine can cause anxiety, mood swings, and delirium, and chronic use can cause the same problems as other stimulants unexplained nasal bleeding, headache, fatigue, insomnia anxiety, depression, and chronic hoarseness. Sudden withdrawal of the drug is not life-threatening but usually produces craving, sleep disturbances, hyperphagia, lassitude, and severe depression (sometimes with suicidal ideation) lasting days to weeks.

Caffeine

Caffeine along with nicotine and alcohol, is one of the most commonly used drugs worldwide. About 10 billion pounds of coffee, the richest source of caffeine are consumed yearly throughout the world. Tea, cocoa, and cola drinks also contribute to an intake of caffeine that is often astoundingly high in a large number of people. Low to

moderate dosess (30 – 200mg/d) tend to improve some aspects of performance (e.g vigilance).

The approximate content of caffeine in a (180mL) cup of beverage is as follows: brewed coffee, 80 – 140mg; instant coffee, 60 – 10mg; decaffeinated coffee, 1 – 6 mg; black leaf tea, 30 – 80mg; tea bags, 25 – 75mg; instant tea, 30 – 60mg; cocoa, 10 – 50mg; and 12 – oz cola drinks, 30 – 65mg. a 2 –oz chocolate candy bar has about 20mg. Some herbal teas (e.g. "morning thunder") contain caffeine. Caffeine-containing analgesic usually contain approximately 30 mg per unit. Symptoms of cafeinism (usually associated with ingestion of over 500mg/d) include anxiety, agitation, restlessness, insomnia, a feeling of being "wired", and somatic symptoms referable to the heart and gastrointestinal tract.

It is common for a case of caffeinism to present as an anxiety disorder. It is also common for caffeine and other stimulants to precipitate severe symptoms in compensated schizophrenic and mani-depressive patients. Chronically depressed patients often use drinks as self-medication. This diagnosis clue may help distinguish some major affective disorders. Withdrawal from caffeine (> 250mg/d) can produce headache, irritability, lethargy, and occasional nausea).

2.8 Narcotic/Opioids

The terms "opioids" and "narcotics" are used interchangeably and include a ground of drug with actions that mimic those of morphine. The ground includes natural derivatives of opium (opiates), synthetic surrogates (opioids), and a number of polypeptides, some of which have been discovered to be natural neurotransmitters. The principal narcotic of abuse is heroin (metabolized to morphine), which is not used as a legitimate medication. The other common narcotics are prescription drugs and differs in

milligram potency, duration of action, and agonist capabilities. All of the narcotic analgesics can be reversed by the narcotic antagonist naloxone.

Effect

The clinical symptoms and signs of mild narcotic intoxication include changes in mood, with feelings of europhoria; drowsiness; nausea with occasional emesis; needle tracks; and miosis. The incidence of snorting and inhaling heroin ("smoking") is increasing, particularly among cocaine users. This coincides with a decrease in the availability of methaqualone and other sedatives used to temper the cocaine "high". Overdosage cause respiratory depression, peripheral vasodilation, pinpoint, pulmonary edema, coma, and death.

Dependency is a major concern when continued use of narcotics occurs, though withdrawal causes only moderate morbidity. Increased temperature, blood pressure, pulse, and respiratory rate and depth. In withdrawal from the most severe addiction, vomiting, diarrhoea, weight loss, and spontaneous ejaculation or organism commonly occur. Complications of heroin administration include infections (e.g, pneumonia, septic emboli, hepatitis and HIV infection from using non-sterile needles), traumatic insults (e.g arterial spasm due to drug injection) gangrene, and pulmonary edema.

2.9 Hallucinogens/Psychedelics

About 6000 species of plants have psychoactive properties. All of the common psychedelics (LSD, mescaline, psilocybin, dimethyltryptamine, and other derivatives of phenylanine and tryptophan) can produce similar behavioural and physiologic effects. An initial feeling of tensions is followed by emotional release such as crying or laughing (1 -2 hours). Later, perceptual distortions occur, with visual illusions and hallucinations and occasionally there is fear of ego disintegration (2 – 3 hours). Major

changes in the time sense and mood later occur (3 – 4 hours). A feeling of detachment and a sense of destiny and control occur (4 – 6 hours). Of course, reactions vary among individuals, and may include panic, depression, confusion, or psychotic symptoms. Pre-existing emotional problems, the attitude of the user, and the setting where the drug is used affect the experience.

2.10 Miscellaneous Drugs, Solvents

The major problem in the use of these drugs related to phenylpropanolamine, which had all the side effects of any stimulant, including precipitation of anxiety states,, auditory and visual hallucinations, paranoid ideation, and occasionally delirium. Aggressiveness and some loss of impulse control were reported, as well as sleep disturbances even with small doses.

Antithistamines usually produce some central nervous system depression – thus their use as over the counter sedatives. Drowsiness may be a problem. The mixture of antithistamines with alcohol usually exacerbates the central nervous system effects.

Laxatives sometimes can lead to electrolyte disturbances that may contribute to the manifestations of a delirium. The greatest use of laxatives tends to be in elderly and in those eating disorders, both of whom are the most vulnerable to physiologic changes.

Anabolic steroids are being abused by people who wish to increase muscle mass for cosmetic reasons or for greater strength. In addition to the medical problems, the practice is associated with significant mood swings, aggressiveness, and paranoid delusions. Alcohol and stimulant use is higher in these individuals. Withdrawal symptoms of steroid dependency include fatigue, depressed mood, restlessness, and insomnia.

Sniffing of solvents and inhaling of gases (including aerosols) produce a form of effect similar to that of the volatile anesthetic. Agents include gasoline, toluene, petroleum ether, lighter fluids, cleaning fluids, paint thinners, and solvents that are present in many household products (e.g nail polish, typewriter correction fluid).

Typical intoxication states include euphoria, slurred speech, hallucinations, and confusion, and with high doses, acute manifestations are unconsciousness and cardiorespiratory depression or failure; chronic exposure produces a variety of symptoms related to the liver, kidney, bone marrow, or heart. Lead encephalopathy can be associated with sniffing leaded gasoline. In addition, studies of workers chronically exposed to jet fuel showed significant increases in neurasthenic symptoms, including fatigue, anxiety, mood changes, memory difficulties, and complaints. These same problems have been noted in long-term solvent abuse.

2.11 Consequences

From the foregoing, it is apparent that the abuse of drugs constitutes a menace to the society, and has devastating effects on the youth. It affects their future since they engage in the habit at a transitional period between childhood and adulthood. Drug abuse produces negative effect on the user, his family and larger society. The abuser faces risks that are both psychological and physiological. These risks range from panic, irritability, depression, anxiety, psychosis, insommia, brain damage, loss of motivation, lack of interest in constructive activities and even death. The adverse consequences of drug abuse can be divided into the following categories.

Physical: Some of the effects of drugs include damage to important organs like brain, liver, pancreases, medical conditions like hypertension, chronic cough and above all some researches have shown that HIV infection associated with drugs addiction is

becoming a significant socio pathological problem in Nigeria and other countries[77]. A study on substance abuse and human immuno deficiency virus disease among 641,086 cases of AIDS in the United States had been reported to the Centres of Diseases Control and Prevention, of which 31.5% were associated with illicit drug use. The sharing of needles by addicts carries the risk of direct transmission of hepatitis B and HIV. Drug use also increase a person's risk taking behaviour including unsafe sexual practices[74].

Psychological: Drug abuse leads to depression, anxiety, dementia, Hallucination, moodiness and aggressiveness leading to the degeneration of the individual. Such individual with these characteristics is a waste to himself and the society at large.

Social

Socially the consequences of drug abuse to nation are quite serious. The preponderance of youth addicts roaming the streets negatively affects the economy as a result of low productivity and shortage of efficient manpower. Public safety is subverted as drug addiction is leading to incitement of both sexes to prostitution and criminal behaviour. Attempts to establish a correlation between criminal violence and drug abuse had been made and there are claims that illicit drug users are higher in the population of criminals than non-drug user[78]. Violence witnessed in various communities leading to blood letting, arson, rape, stealing has a link with drug abuse. The human and material resources lost during such violence have their tolls on the stability of the nation[79]. A significant number of deaths from road accidents have also been traced to the act of persons under the influence of drugs[80]. Other negative effects of drug abuse on the family and the society at large can be attributed to the sudden increase in aggression, violence destruction, gangsters, defiance of constituted authority, maladjustment, riots, demonstration etc. among adolescent and young adult,

it therefore becomes imperative to put machineries in place to control the menace of drub abuse.

2.12 Aetiology of Drug Abuse/Risk Factors

Drug abuse is a global practice with several causes of varying origins. Any incidence of drug abuse can be linked to either a precipitating or maintaining factors[81] the former factor refers to the initial and, normally, reasonable excuse for using drugs, while the latter represents reasons for maintaining the use of drugs which marks or leads to physical or psychological dependence on drugs .

There is no simple cause of drug abuse. Must drug users started using drugs as adolescents. Reasons for drug abused are complex. Reports noted that youth today misuse or abused drugs because of so many reasons among which include availability of the drugs, social pressure, peer pressure, curiosity or experimentation, to rebel against constituted authority, for frustration, expression of maturity, vulnerable personality, sleep inducing, to increase work output, search for identity, religious obligations, rejection of society, ignorance of the implications of abuse, etc. [82].

Experimentation/curiosity

Curiosity/experimentation of drugs does motivate youths into drugs use. Youths like experimenting, the first experience may produce a state of arousal such as happiness and pleasure which in turn motivates them to continue. For many youngsters, the desire to experiment with drugs is a passing fancy, and mature decision eventually follows with regard to tobacco, alcohol and other substances which are classified as drugs. Research studies have shown that since there is a thin line between a use and misuse of drugs, individuals who lack maturity, self-esteem, confidence and accurate information are vulnerable to abuse of drugs [53,54,55,83].

Accordingly, adolescent and young adults are most prone to drug abuse. A survey carried out revealed that 2,660 secondary school students in Lagos state abused drugs as early as 11 years (for prescription drugs) and 16 years (for narcotic drugs) [4]. Among the major reasons given by the subjects for their involvement in such behaviour are to feel like adults, to feel good, to get excited, to be like their friends and to be like stars. A compiled records of Mental Health Institutions in Nigeria found that drug abuse patients were almost within the 21 – 30 years age bracket. The findings of these researches, therefore, revealed that there is a higher likelihood that a young person will abuse drugs than an older person [4].

Peer Group Influence

Peer pressure certainly plays a major role in starting many on drugs, and the young are especially vulnerable. Many young persons starts to use drugs through the influence of their friends. Such persons continue to use drugs in order to fit into the group. This practices is particularly common among students, interaction with a member of peer group who engages in drug influences all the group members because of the socio-cultural process, in which experienced users essentially "teach" new users what to anticipate, how to interpret the effects, what effects to enjoy and what effect to reinforce. The idea that a person experiences when misusing a particular drug is influenced by his or her expectation about the drug effects and by who is present in the drug-taking setting[84]. Studies points out that 30% of students reported that they had received a lot of pressure from mates to drink a beer [85].

Two types of peer influence have been identified to make students vulnerable to the risk for substance use. The first is the desire to be popular and to fit in, this internalized peer pressure was found to be less of a risk factor than the external peer pressure of actually being urged or pressured by peers to act in a certain ways, such as

participating in substance use[86,87]. Another study found that Negative peer relationship problems as measured by peer rejection, social isolation, perceived social incompetence at younger age, predispose to drug abuse[88].

Availability of Drugs

In many countries drugs have dropped in price as supplies have [increase89]. This makes drugs relatively available to get. If drugs are readily available in a community, youth will have easy access to them and will invariably used and abuse them. Alcohol and tobacco are good examples of drugs that are readily available and widely used and abused in Nigeria because of their social acceptance. And now the relative ease with which youths are able to obtain all forms of drugs including illicit ones (cannabis, heroin and cocaine) is another factor[4]. Enthusiastic prescription of drugs such as sedatives, tranquilizers, stimulants and narcotics by physicians has been described as instrumental to drug abuse[81]. In a related development, the easiness with which drugs can be obtained and the relative tolerance of drug abuse by community, religions or political leaders have been identified as serious causes of drug abuse in schools and outside the schools. in many countries in the world today [90,91,92].

Mental/Emotional/Personal Factors

Many youth that abuse drugs appear to have personality disorder before taking drugs as shown by poor school record, truancy, delinquency and dropout. Such drug abusers often seem to be without resources to cope with the challenges of day to day life; they are inconsistent in their feelings and critical of society and authority. Some drug abusers give a history of mental illness or personality disorder in the family[12,92]. Studies found a higher risk for those children with a mental disorder to progress from experimentation into problematic usage of substance than those in a community[93,94]. Hospital records from different psychiatric hospitals in Nigeria revealed that drug

abusers were mostly youth (58%) within the 21 – 30 year age bracket, majority of them (91%) were males and were single (58%) and 17% were students[64,74].

Social and Environmental influence

The environment where drug abuse is rampant as well as the category of people who engage in drug abuse strongly influences youth to engage in such activities [95]. The news media also play an important role in introducing and maintaining drug abuse among students[87]. Advertisements and exotic films demonstrate messages that success in both work, sport, leisure is facilitated through the chemistry of drug, and that drugs are effective instruments for success, improving mood and creating euphoria[96]. Unpleasant socio-economic situation and repressive leadership at school or national level have also been marked as contributing factors in the spread of drug abuse among students[97]. The victims have the impression that taking drugs will ward off their misery, show their anger and frustration or challenge any repressive tendency. The gains of modern communication and transportation are obvious factors that contribute significantly to the precipitation and maintenance of the monstrous act of drug abuse. The ease and speed with which drugs and information about them (for example indication, dosage, side effects) is disseminated across the world targeted countries, and the rapid socio cultural changes taking place especially in the third world countries have been identified as an enabling condition for the spread of drug abuse[98,99,100]. This is most relevant to tertiary institutions which are mostly hit hardest by such changes.

The increasing economic deterioration in Nigerian, leading to poverty, unemployment and disempowerment of the poor have contributed to the problem of drug abuse. This situation has been aggravated by the lack of skills and opportunities for training and retraining, and the lack of committed actions to promote job creation by government, private and community entrepreneurs. Frustration arising from these

problems leads to recourse to drug to temporary remove the effect of frustration and problems arising from it.

Family Influence

The family personality patterns, their parenting and socio-economic status tends to influence the culture of drug abuse among youth. Studies have showed that families that witnessed excessive punishment, brutality, incessant harassment, matrimonial divorce/conflict, lack of adequate parental care and love tend to drive youths to seek refuge in drug[92,101]. The family's hold on youths has become loose these days as a result of growing poverty and continuous quest for material gains. In Nigeria toady, like in most developing countries, life is a constant struggle to obtain even the basic essentials of life and many parents have no time to supervise their children's activities both at home and in school[92]. Studies have showed that youth from less intact families (single parent household, single parent with multiple partners, drug/alcohol dependence in a family member) have higher rates of substance abuse[92]. It was found that sons of alcohol parent have 25% chance of becoming alcoholic themselves [102,103].

2.13 Initiatives and Efforts of Combating Substances/Drugs Abuse

The World Health Organization (WHO) has been providing assistance in the systematic collection of this information and meaningful utilization of these data in prevention treatment programmes for some years. These publications reviewed drug epidemiology methods in general and that use of these methods in some specific populations. They described how these methods can be used to collect information necessary for the planning, implementation and evaluation of prevention and treatment programmes.

Since the publication of the guidelines in the early 1980's there have been important changes in trends and patterns of drug use, which present new challenges to public health practitioners and program planners. The International Narcotics Control Board (INCB), an arm of the United Nations, has remarked that the abuse of a variety of drugs/psychoactive substances, alcohol, sedative-hypnotics, stimulants, and other dependence producing drugs remain at a high level in most parts of the world today. The board further noted that the health hazards are even being aggravated by the simultaneous consumption of two or more drugs frequently in combination with alcohol and by the use of more dangerous means of drug use, some remain occasional users while others become dependent on the drugs.

In Nigeria the efforts, to curb and check drug abuse and drug trafficking came with the establishment of the National Drug Law Enforcement Agency (NDLEA) in 1989. It has become the most effective organ for handling drug problems in Nigeria. The NDLEA was established by Decree 48 of 1989 and is responsible, on behalf of the Federal Government of Nigeria, for the prevention of illicit cultivation, production, manufacture and illicit trafficking and the use of drugs in accordance with article 9 of the UN single convention on Narcotic Drugs of 1961, as amended by the 1972 protocol.

The major objectives of the Agency include focused on enlightenment campaign about the dangers of drug abuse and drug trafficking, drug counselling and law enforcement to help the prosecution of drug offenders and their sponsors. The Law Enforcement Wing of the NDLEA has the onerous task of monitoring the demand for the supply of illicit drugs, their production, trafficking and abuse at the national, sub-regional and regional levels. The NDLEA has been serving the nation diligently, especially in recent times. Nigeria, through the activities of the NDLEA, expanded her

drug control programmes by increasing her zonal commands from 12 to 20 and the area commands and field posts from 56 to 99.

2.14 National Drug Control Strategy:

The NDLEA has, in recent times, been working on a master plan which will address all aspects of drug problems in the country. The master plan is aimed at tightening legislative measures and enhancing international co-operation. It is hoped that the national drug control strategy will come forward with strategies for the following components:

i. Prevention of the illicit demand for drugs

ii. Treatment and rehabilitation of drug dependent persons

iii. Control of illicit supply

iv. Forfeiture and transfer of the instrument and proceeds of illicit drug trafficking

v. Prevention of illicit drug trafficking into and through Nigeria.

vi. Sub-regional, regional and international co-operation

vii. Co-operation with non-governmental organizations

viii. Inter-agency co-operation.

The NDLEA's initiative on the development of a National Drug Control Strategy is being encouraged and assisted by the United Nations Drug Control Programme (UNDCP) and some members of the international community. The master plan provides for programme and strategies to ensure identified goals, such as: adequacy and efficacy of penal sanctions; drug demand reduction; control of illicit drug supply; control of illicit drug supply by the National Agency for Foods, Drug Administration and Control (NAFDAC). Other agencies such as Standard Organisation of Nigeria (SON) also play an important role in ensuring the quality of drugs.

To complement the efforts of the government through the NDLEA, a non-governmental organization, People Against Drug Dependency and Ignorance (PADDI), based in the Netherlands, carried its crusade on drug abuse to the Netherlands government. PADDI sough support at an international conference on "Tackling the problems of Drug through Education – the Netherlands Experience" which took place in Amsterdam. The NGO called on the Netherlands to assist with educational materials which would greatly influence Nigerian youths through proper enlightenment and education. Efforts by some churches are also noteworthy, both in the treatment of victims of drug abuse and in their rehabilitation.

It is the fervent wish of every Nigerian that the continued efforts of the NDLEA, NAFDAC, UNDCP, NGOs, religious institutions and the international community will rid Nigeria of all drug problems. It is hoped too that local communities can be made part of the control machinery in both the rural and urban areas.

In conclusion, although drug abuse in schools is a problem that adversely affects students physiological, psychological, emotional and mental mechanism, which, in turn, affect their academic progress, perhaps no comprehensive strategies have been devised either by school authorities or any other superior authorities to tackle it. This may be responsible for the persistent and widespread incidence of this abuse in schools. It may also be linked to the frequent violent demonstration, cultism and other antisocial behaviours by students. Thus for meaningful and peaceful learning atmosphere to prevail, the problem of drug abuse in school need to be controlled. Hence the need for a multi-disciplinary perspective in the management and control of the drug abuse problem, and in counselling the most vulnerable group, i.e the youth.

Since the problem of drug abuse in schools is largely a problem among the student population, the support of the students themselves has to be enlisted in

controlling, preventing or eliminating the problem among them. The more students are involved in anti drug abuses efforts; the more they would be able to use their creative potential toward solving the problem. Thus, the school authorities and others members of the school community can use the registered, societies, clubs, associations, unions, organizations and other students groups to propagate anti-drug abuse messages.

CHAPTER 3

METHODOLOGY

3.1 Background to the Study Area

Kaduna Polytechnic has grown from a humble beginning in 1956 when it started as "Kaduna Technical Institute" to what is today the largest Polytechnic in Africa South of the Sahara in terms of staff, student population and physical infrastructure. It is the second oldest technological institution in Nigeria, the oldest being Yaba College of technology which was established in 1948. Kaduna Polytechnic is also the second largest tertiary institution in Nigeria after Ahmadu Bello University, Zaria.

The Northern Nigeria Executive Council by conclusion No. 1 at its meeting of 17th August, 1962, re-designated the Kaduna technical Institute as the Polytechnic Kaduna. It became Kaduna Polytechnic in 1979 by Decree No. 73. on 27th August, 1991, the federal Government took over the Institution under Decree No. 40 of the same year. The Institution was established with the objective of providing diverse in technology, the Sciences, Commerce, the Humanities and in – service programmes for members of the Public service In Nigeria. In 1968, it amalgamated two formerly independent Training centres namely: the College of Science and technology (formerly Kaduna Technical Institute) and the College of Administrative and Business Studies (formerly staff development Centre). The College of environmental Studies (formerly survey Unit) was integrated in April 1970 to complete the three collegiate structure of the Polytechnic which operate within 1990. The new college, the college of engineering was in 1990 created out of the College of Science and Technology to form the four units of the collegiate structure of Kaduna polytechnic.

The Polytechnic is highly cosmopolitan with students admitted from all over Nigeria and other countries. It has been in the fore-front in the training of high and middle level manpower for the various sectors of the nation's economy. From modest figure of 158 students in 1961 at the Technical institute, student enrolment increased to 894 by 1968 and total of 595 students attending courses on part- time, while 300 were on full – time programmes. Currently, the Polytechnic has over 20,000 students undertaking 173 programmes spread over the 30 academic departments of the four colleges. The courses vary in duration and character, ranging from Certificate, diploma, post – graduate diploma to post High national Diploma, as well as, NCE (Technology) and B.Ed. (technology) which is run in affiliation with the Federal University of Technology, Minna.

The uniqueness of the curricula covered under the various programmes is the emphasis on practicals to ensure that graduates acquire the right skills required by government, Industry and commerce of self – employment. Kaduna Polyetchnic has mounted a number of post –graduate Programmes and post- HND Programmes in diploma. Urban and regional planning, Land surveying and Building. In 1995, the Polytechnic started the first ever NBTE approved post HND programme in Electronics and Communication Engineering.

The four colleges of Kaduna Polytechnic are located within Kaduna metropolis. The College of Science and Technology (CST) and College of Engineering (COE) are located on the main Campus in T/ Wada, the college of Administrative and Business Studies (CABS) along the Golf Course Road, Ungwar Rimi with the department of special and Rehabilitative Education on Kaduna – Kachia Bye pass while the college of environmental studies is located along Aliyu Makama road, Barnawa. Each college is headed by a Director who is responsible to the rector for its day- to –day

administration. The Colleges are organised into Schools and Academic Departments. There are at present nine schools and over thirty departments.

3.2 Materials and Methods

3.2.1 Study Design

The study is a descriptive cross-sectional study in which students in Kaduna Polytechnic were used to determine the prevalence and pattern of drugs use among students in tertiary institution.

3.2.2 Study Population

The study population involved all the students of Kaduna Polytechnic and their population stands at 20,000, the study was carried out in July 2004. A sample was taken out of the study population.

3.2.3 Sample Size Determination

The sample frame was the total number of students of the Kaduna Polytechnic which stands at 20,000. Out of which 360 students were selected as the sample size which was arrived using the formula:

$$n = \frac{z^2 pq}{d^2}$$

Where n = maximum sample size

p = proportion of successes from a previous study.

(it was put at 0.7 (70%) based on the study carried out in 1991 by Ajidual on drug abuse among Nigerian Youths

q = 1 – p

z = value of the standard normal deviation = 1.96

d = sampling error tolerance, taking at 95% confidence interval, the value is 0.05 (i.e 5%)

$$n = \frac{1.96^2 \; x \, 0.7 \, x \, 0.3}{0.05^2} = 322.7 = 323$$

In the event that there may be no response from any respondent an adjustment is made anticipating however that at least 90% students to respond.

Then n_2 which is the sample size to be selected will be

$$n_3 = \frac{n_1}{0.9} = \frac{323}{0.9} = 358.8 = 359 \text{ students}$$

3.2.4 Sample Technique

The list of all the Departments in all the 4 existing Colleges of the Kaduna Polytechnic was obtained from the academic secretaries' office. A total of 360 students were selected through a 3 stage cluster sampling method from the 3 levels of study from the 4 colleges of the polytechnic as follows:

First stage – The whole school was stratified into four existing colleges. Each of the colleges was further stratified into 3 existing levels (Pre - ND, NDI, and NDII)

Second stage – In each of these levels one department was selected by lottery method.

Third stage – In all the departments an average number 70 – 80 students were found to be selected in the classroom. In the selected department the 1st students seated closest to the entrance was selected as the 1st respondent, subsequently every 3rd student in the classroom was administered a questionnaire until the total number of 30 students were obtained.

3.2.5 Data Collection Technique

The data was collected using interviewer administered semi structured questionnaire. The questionnaire was divided into four sections – personal data, knowledge about the drugs, drug use and circumstance of use and family history.

3.2.6 Data Analysis

Computer data processing using Microsoft Excel software was used in the analysis of the data collected. The data was adequately edited to ensure the accuracy of the data entry. The data was reduced into frequency tables and percentages. Chi-square was used where appropriate to measure relationships and associations.

3.3 Ethical Consideration

Permission was sought for to carry out the study in Kaduna Polytechnic. The consent of the students was also sought and to ensure confidentiality of the information obtained, names, addresses, or any mode of identification did not appear in the questionnaire.

3.4 Limitation of the Study

The information obtained in the study may not be actual representation of the prevalence of the drug abuse as some of the questionnaire may not be truthfully answered.

CHAPTER 4

RESULTS

A total of 360 questionnaires was administered and retrieved and the information was analysed under 4 sections as follows:

4.1 Socio-demographic characteristics of the study population

4.2 Knowledge about the drug(s), prevalence and pattern of drugs use.

4.3 Reasons for drug used and factors influencing drugs use.

4.4 Site effect experience by drug users.

The information obtained was presented in the following tables and figures.

4.1 Socio-demographic characteristics of the study population

Table 4.1.1: Age and sex distribution of 360 students of Kaduna Polytechnic.

Age (Years)	Sex					
	Male		Female		Total	
	Freq	Percent	Freq	Percent	Freq	Percent
15 – 19	38	10.6	27	7.5	65	18.1
20-24	152	42.2	42	11.7	194	53.9
24 – 29	56	15.6	27	7.5	83	23.1
30+	16	4.4	2	0.5	18	5.0
TOTAL	262	72.8	98	27.2	360	100

Most of the respondents were concentrated within the ages of 20 – 24 years. 72.8% were males while 27.2% were female. The mean age ($\bar{X}$) was 22.1 years for both the male and the female with standard deviation of 5.83.

Table4.1.2: Ethnic groups of the respondents.

Ethnic groups	**Frequency**	**Percent**
Hausa/Fulani	169	46.9
Yoruba	74	20.6
Igbo	11	3.1
Others	106	29.4
Total	360	100

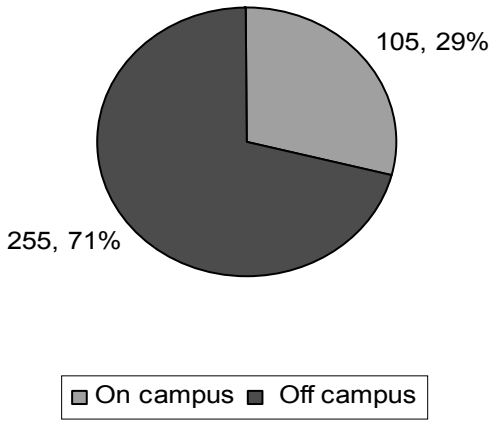
The Hausa/Fulani ethnic group constituted the majority (46.9%) of the respondents. The minority ethnic groups were the next largest group.

Table 4.1.3: Level of study of the respondents

Usage	**level**			
	Pre-ND	**ND I**	**ND II**	**Total**
Yes	88 (51.2%)	35 (20.3%)	49 (28.5%)	172 (47.8%)
No	32 (17.0%)	85 (45.2%)	71 (37.8%)	188 (52.2%)
Total	120	120	120	360

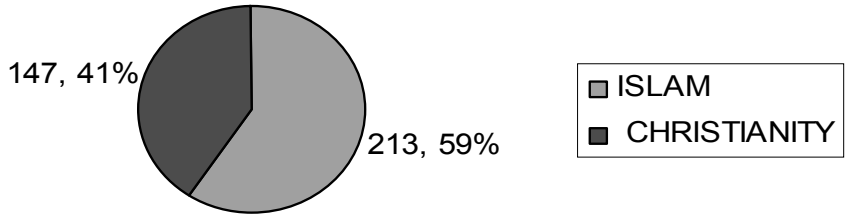
The 360 questionnaires were equally distributed, among the 3 existing levels i.e Pre-.ND, NDI and ONDII with 120 questionnaires each. All questionnaires were retrieved.

Fig. 4.1.1: Place of resident of the respondents



Majority of the respondents lives off campus (71%).

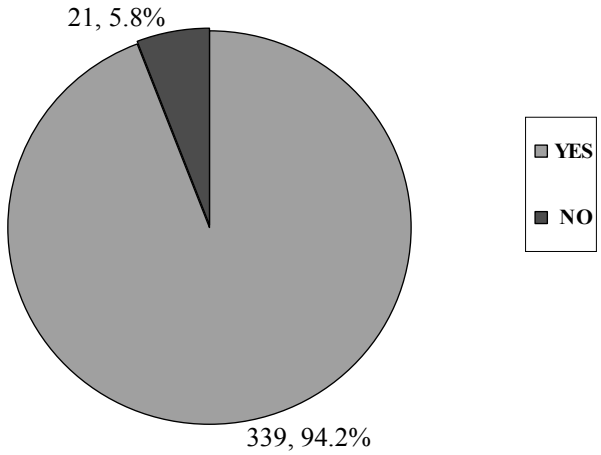
Fig. 4.1.2: Religion of the respondents



Majority of the respondents are Muslim (59%).

4.2 Knowledge, prevalence and pattern of drug use.

Fig. 4.2.1: Respondents knowledge on drug use.



339 respondents have knowledge on drug abuse constituting 94.2% of the respondents.

Table 4.2.1: Source of knowledge on drug abuse

Source	Frequency	Percent
Radio	105	31.0
Television	180	53.1
Newspaper	113	33.3
Parents	109	32.2
Teachers	88	26.0
Friends and Colleagues	109	32.2
Others	19	5.6
Total	723	100

Television constituted the highest source of knowledge on drug abuse with 53.1% while teachers and others constituted the least sources.

Table 4.2.2: Knowledge on specific substances being abuse

Substance	Frequency	Percent
Kolanut	153	45.1
Coffee/Caffeine	114	33.6
Cigarette	134	39.5
Alcohol	143	42.2
Valium	38	11.2
Butazoldine	42	12.4
Solution	66	19.5
Marijuana	70	20.6
Cocaine	91	26.8
Others	19	5.6
Total	970	100

Knowledge on kolanut used constituted the highest (45.1%) followed by alcohol and cigarette with 42.2% and 39.5% respectively.

Table 4.2.3: Use and non use of drug by sex

Sex	Users		Non-users		Total	
	Freq	Percent	Freq	Percent	Freq	Percent
MALE	136	37.8	126	35.0	262	72.8
FEMALE	36	10.0	62	17.2	98	27.2
TOTAL	172	47.8	188	52.2	360	100

37.8% of males among the respondents use drugs while 10.0% of the female respondents engaged in drug use.

Null Hypothesis = H_0 (there is no relationship between drug use and sex of the respondents)

Alternatively Hypothesis = H_1 (there is relationship between drug use and sex of the respondents)

Calculated X^2 = 5.987 at degree of freedom (df) = 1 and precision (P) value = 0.14. At 95% confidence interval and α level 0.05, the critical value = 3.841.

The Null hypothesis is rejected and alternative hypothesis is accepted here, therefore there is a relationship between sex of the respondents and drug use.

Table 4.2.4: Drug use and non use by religion

Use drugs	**Religion**		
	Islam	**Christianity**	**Total**
Yes	103 (59.9%)	69 (40.1%)	172 (47.8%)
No	110 (58.5%)	78 (41.5%)	188 (52.2%)
Total	213	147	360

47.8% of both Muslim and Christian abuse drugs from the total number of 360 respondents.

Null Hypothesis = H_0 (there is no relationship between drug use and religion of the respondents)

Alternatively Hypothesis = H_1 (there is a relationship between drug use and religion of the respondents)

Calculated X^2 = 0.024 at degree of freedom (df) = 1 and precision (P) value >0.05. At 95% confidence interval and α level 0.05, the critical value = 3.841.

So therefore the Null hypothesis is accepted and alternative hypothesis is rejected here, meaning there is no relationship between religion of the respondents and drug use.

Table 4.2.5: Drug use and non use by place of resident

Use drugs	**Residence**		
	On Campus	**Off Campus**	**Total**
Yes	58 (33.7%)	114 (66.3%)	172 (47.8%)
No	47 (25.0%)	141 (75.0%)	188 (52.2%)
Total	105	255	360

66.3% of students that abuse drug reside off campus while 33.7% reside on campus.

Null Hypothesis = H_0 (there is no relationship between drug use and place of resident of the respondents)

Alternatively Hypothesis = H_1 (there is a relationship between drug use and place of resident of the respondents)

Calculated $X^2 = 2.8$ at degree of freedom (df) = 1 and precision (P) value >0.05. At 95% confidence interval and α level 0.05, the critical value = 3.841

So the Null hypothesis is accepted and alternative hypothesis is rejected. Meaning there is no relationship between place of resident and drug use.

Table 4.2.6: Drug use and non use by level of study

Drug usage	level			
	Pre-ND	ND I	NDII	Total
Yes	88 (51.2)	35 (20.3)	49 (28.5)	172 (47.8)
No	32 (17.0)	85 (45.2)	71 (37.8)	188 (52.2)
Total	120	120	120	360

Majority of the respondents that use drugs among the Pre-ND students (51.2%)

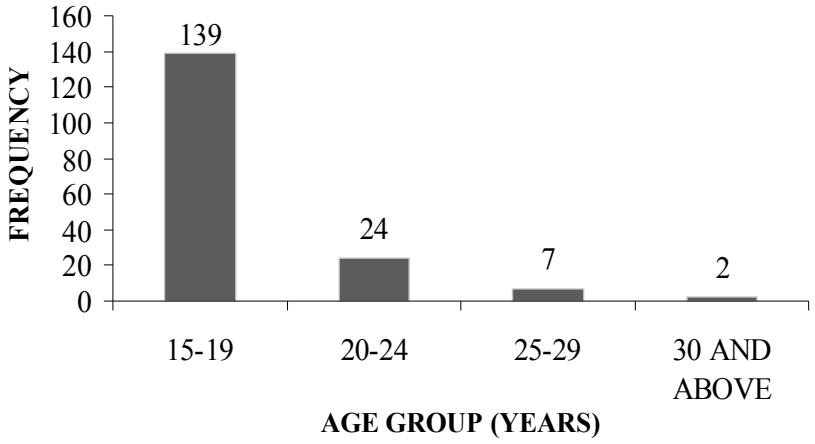
Null Hypothesis = H_0 (there is no relationship between drug use and level of study of the respondents)

Alternatively Hypothesis = H_1 (there is a relationship between drug use and level of study of the respondents)

Calculated X^2 = 50.39 at degree of freedom (df) = 2 and precision (P) value <0.01. At 95% confidence interval and α level 0.05, the critical value = 5.991.

Hence Null hypothesis is rejected and alternative hypothesis is accepted. This means there is a relationship between drug use and level of study.

Fig. 4.2.2: Age at first use of drugs



The age at first use of drug was found to be highest within the age group of 15-19 years (88.8%)

Table 4.2.7: Frequency distribution of the types of drugs used by the respondents

Substance	Frequency	Percent
Kolanut	102	59.3
Coffee/Caffeine	69	40.1
Cigarette	32	18.6
Alcohol	34	19.8
Valium	4	2.3
Butazolidine	7	4.1
Solution	5	2.9
Marijuana	7	4.1
Cocaine	6	3.5
Others	2	1.2
Total	268	100

Kolanut was the most widely used substance (59.3%) this was followed by coffee (40.1%), alcohol (19.8%), cigarette (18.6%).

The figure (268) is higher than the total number of drug users (172) because some students use more than one substance.

Table 4.2.8: Frequency distribution of drug use by sex

Types and drugs	Male (frequency)	Female (frequency)	Total	Percent
Kolanut	79	23	102	38.1
Coffee/Caffeine	54	15	69	25.7
Cigarette	27	5	32	11.9
Alcohol	30	4	34	12.7
Valium	4	-	4	1.5
Butazolidine	7	-	7	2.6
Solution	5	-	5	1.9
Marijuana	7	-	7	2.6
Cocaine	6	-	6	2.2
Others	2	-	2	0.7
Total	221	47	268	100

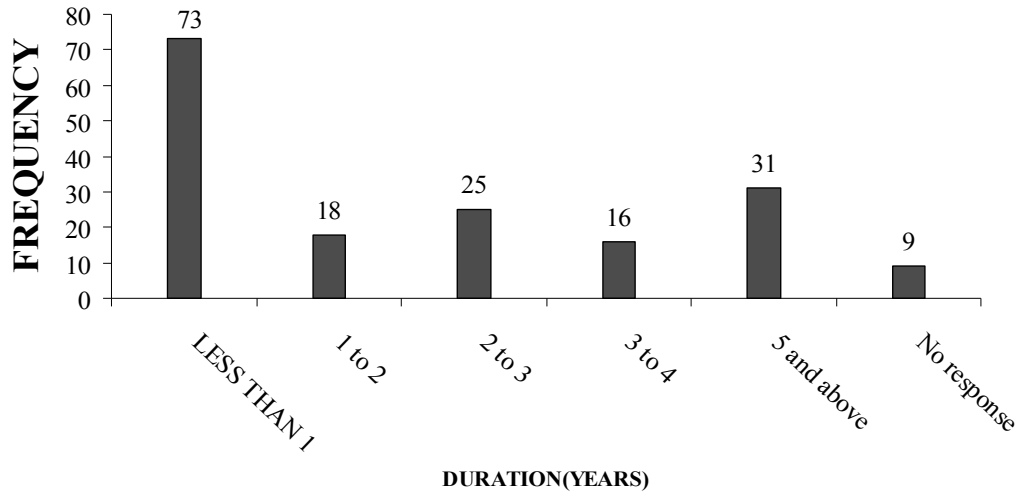
Both the male and female were found to abuse some drugs (88.4%) while only the males were found to abuse some drugs (11.6%).

Table 4.2.9: Frequency of drug use

Frequency of use	Frequency	Percent
Once only	2	1.2
Once daily	18	10.5
Once weekly	14	8.1
Once monthly	4	2.3
Several times in week	23	13.4
Several times in a month	92	53.5
Occasionally	8	4.7
No response	11	6.4

The respondents that use drugs several times in a month have the highest percentage (53.5%) while those that use drug just once have the lowest percentage (1.2%).

Fig. 4.2.3: Duration of drug use by the respondents



Majority of the respondents have been using drugs for more than 4-5 years (42.2%)

4.3 Reasons and factors influencing drug use

Table 4.3.1: Frequency distribution of reasons for using drugs

Reasons	Frequency	Percent
To keep me awake	43	21.0
To stimulate my mood	25	12.2
To enable me read	56	27.3
To satisfy urge	5	2.4
To overcome tiredness	12	5.9
For curiosity sake	13	6.3
Due to sad events	20	9.6
To attend party/festival	19	9.3
Others	12	5.9
Total	205	100

Majority of the respondents (27.3%) use drug to enable them read, followed by 21.0% and 12.2% that used drugs to keep awake and stimulate their moods respectively. The figure 205 is greater than the total number of drug users (172) because some students have more than one reason for using a drug.

Table 4.3.2: Frequency distribution of the sources of introduction to drug use.

Source of introduction	Frequency	Percent
Friend	90	52.3
Relations	10	5.8
Parents	37	21.5
Others	35	20.5
Total	172	100

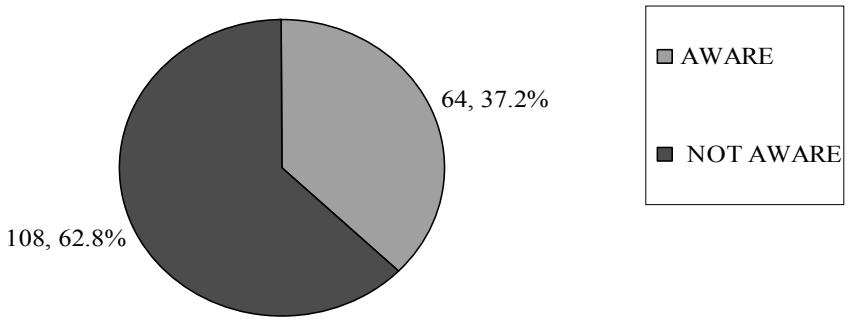
Majority of drug users (52.3%) were introduced to drug by their friends.

Table 4.3.3: Frequency distribution of the source of acquisition of drug

Acquisition	Frequency	Percent
Shops/chemist	97	49.2
Friends	66	33.5
Others	34	17.3
Total	197	100

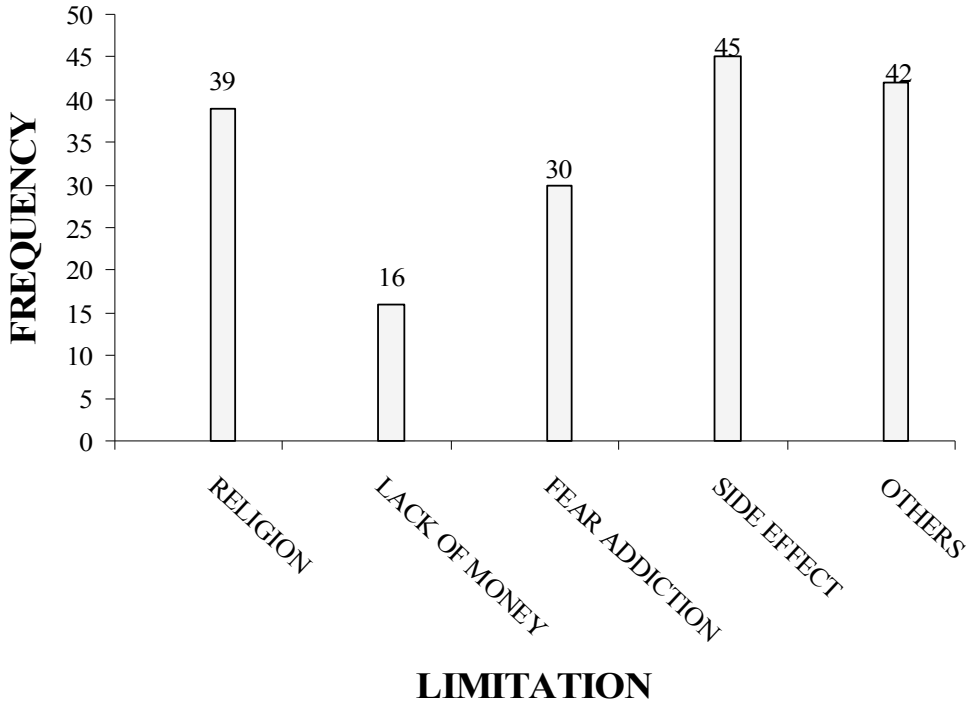
The commonest source of drug acquisition was from the shops/chemist which constituted 49.2%. Some respondents obtained their drugs from more than one source.

Fig. 4.3.1: Parents awareness of drug abused by their children



62.8% of the respondents that used drug admitted that their parents are not aware of their drug use.

Figure 4.3.2: Factors limiting the use of drugs



Side effects are the major limiting factor to drug use 26.2% (45).

4.4 Side effects experienced by drug users

Table 4.4.1: Awareness of the side effects of drug use

Category	Aware		Not aware		
	Frequency	Percent	Frequency	Percent	Total
Abuse drug	141	64.1	31	22.1	172
Do not abuse drug	79	35.9	109	77.6	188
Total	220	100	140	100	360

64.1% of the respondents that are aware of the side effects of the drugs are engaged in drug abuse.

Null Hypothesis = H_0 (there is no relationship between drug use and awareness of the side effect of the drugs)

Alternatively Hypothesis = H_1 (there is a relationship between drug use and awareness of the side effect of the drugs)

Calculated X^2 = 58.67 at degree of freedom (df) = 1 and precision (P) value <0.01. At 95% confidence interval and α level 0.05, the critical value = 3.841.

The Null hypothesis is rejected and alternative hypothesis accepted, meaning that there is a relationship between awareness of the side effect and drug use..

Table 4.4.2: Frequency distribution of the medical side effects experienced by the drug users

Experience	**Frequency**	**Percent**
Headache	13	6.9
Dizzy	20	10.6
Alert/Aware	41	21.8
Sleepy	21	11.2
Tremor/shaky	6	3.2
Strong	34	18.1
Weakness	9	4.8
Blurred vision	7	3.7
Others	37	19.7
Total	188	100

Alertness and general ill-health were the most common effects experienced by the drug users with 21.8% and 19.7% respectively. The figure 188 was more than the 172 figure for the drug users because some students experienced more one side effect.

Table 4.4.3: Frequency distribution of the social effect of drug use

Effect	Frequency	Percent
Failed examination	16	8.2
Missed classes	13	6.7
Committed crime	17	8.8
Financial problems	33	17.0
Stolen money	15	7.7
Road Traffic accident	7	3.6
Fought	21	10.8
Feel happy	39	20.1
Others	33	17.0
Total	194	100

A feeling of happiness was the most common social effect following drug use.

Table 4.4.4: Intension of users to stop drug use

Intension	Male		Female		Total	
	Freq.	Percent	Freq.	Percent	Freq.	Percentage
Wants to stop	91	66.9	30	83.3	121	70
Does not want to stop	45	33.1	6	16.6	51	29.7
Total	136	100	36	100	172	100

70% of abusers had the intension to stop drug use and females were more willing to stop than the males

CHAPTER 6

6.1 Conclusion

6.2 Recommendations

Given the magnitude and detrimental effects of drug abuse on students' academic progress and personality, the need for effective and far-reaching measures to remedy the situation arises. These measures include, first and foremost, conducting comprehensive studies on drug abuse and related issues in schools with a view to obtaining facts and figures to be used in guiding the process of controlling the abuse in question. These studies should be designated to find out, among others, manufacturers, dealers and type of students that take these drugs. The places and occasions in which these drugs are taken, as well as the conditions that lead to drug taking should also be investigated. Similarly, the students should investigate the ways and levels which the home, school, peer group, health workers and others contribute to the occurrence of drug abuse among students in particular and the rest members of the society in general.

Devising and implementing specific drugs control system based on international marketing convention, and excise and import duties on psychoactive and related drugs are another set of strategies that can help control drug abuse generally. Other strategies include the effective maintenance and utilization of conventional and specialized security organs like the nation and international police (Interpol), plain – clothes security operatives and the Nigerian's NDLEA. Similarly, provision of effective social welfare and counseling services as well as establishment of drug abuse control committees is very tertiary institutions and universities can help check the abuse in question. These committees should comprise students, teachers, medical doctors, pharmacists, and religious leaders.

Frequent organization of dramas and debates among students and centered on the dangers of drug abuse is another measure that can contribute in controlling abuse of drugs in schools. Other measures include the broadcast on radio and television programmes that can create awareness of the dangers of drug abuse and misuse. Government and school authorities should organized an issuance of prize award for the best abuse-free university at federal level, such should be extended to the secondary schools at state and local level. Schools at state should provide adequate games facilities and other extra curricular activities to make leisure time of students a nuisance-free time.

A collective multi disciplinary and multisectoral approach is necessary by both governmental and non-governmental bodies on public enlightenment. Awareness about drug abuse should be created through health education and communication programme such as advertisement, postcards, e.t.c.

The parents should make sure that their ward/children are enlightened on drug abuse and its implications especially among students. The parents are to set precedence not to engage in such acts themselves, so that they will avoid setting bad example. This will be a preventive measure because drugs and alcohol consumption are bad habits and once they are started, the user lacks the will power to stop

It is better for parents to counsel their children and monitor their activities right from the home as well as when they are in school, to avoid interacting with dubious characters. It is indeed; better to take preventive measures before the children start than seeking treatment, when it is too late.

6.3 References

1. Packs
2 Folawiyo, A.F.A. (1988): Drug Education for Schools and Colleges, Lagos: Joja Educational Research and Publishers limited.
3. Innerarity Faith☹1999, December): Crime and Drugs as Factors of Societal Disintegration. International Social Science Journal, 162, Blackwell Publisher UNESCO.
4. National Drug Law Enforcement Ageny NDLEA. 1991 Drug Abuse Data Collection By Drug Abuse Data Division Counselling Unit NDLEA.
5. Falope, I.A. (1991): Motorcycle Accidents in a New Group at Risk. West African Journal of Medicine Vol. 10 pp. 187 – 189.
6. Orubu, A. O. (1983): Purpose for which Secondary School Students use Drugs. A Challenge to Guidance Counsellor. Journal of Institute of Education, ABU, 6, 22, 109 – 120.
7. Odejide, A.O., Ohaeri, J.U., Ogunleye, D.A., Ajuwon, A and Ige A. (1990): Illicit Drug Trafficking in Nigeria: An Epidemiological Description of 151 Cases. An NDLEA Report.
8. Essen, A. J.A. (1979): Discipline in Schools. Journal of the Cross River Education, 1, 1, 40.
9. Adesina S. (1975): The Use of Indian Hemp and Drugs Among Secondary School Students in Lagos. Lagos: University
10. Nigerian Guardian Newspaper Publishers on Saturday, the 25th of July, 1992.
11. Garba, A. (1998 – 1999): The Counselling Needs of Drug Abusers in Kano Journal of Educational Studies, Vol. 1, No. 1.

12. Abayomi, O. 1I. (1992): Absenteeism and Truancy Cross-Cultural Perspectives, Leo-Tina Press Limited Onitsha.

13. Abdullahi, S. (2000, December): The Use of Traditional Drugs Amongst the Kano Youth; The Case of Gadagir Youth and Drug Abuse Today.

14. Adegbokun, E.O. et al (1998): Drug of Abuse and their Effects. A Publication of NDLEA Lagos.

15. Obot I.S. (1999): Licit and Illicit Drugs: Essentials of Substance Abuse Malthouse Press Limited, Lagos, Nigeria 1999.

16. Odejide, A.O. (February 1989): A Nation and Risk: Alcohol and Substance Abuse Among Youth Inaugural Lecture Delivered at the University of Ibadan.

17. Pela, O.A. and Ebie, J.C. (1982): Drug Abuse In Nigeria; A Review of Epidemiological Studies, Bulletin on Narcotics. 34 (3 & 4) 91 – 99.

18. Adegbokun, E.O. et al (1998): Drug Data Collection and Research Report. National Drug Law Enforcement Agency (NDLEA Production).

19. New Nigerian, Newspaper Published on Friday the 10th of September 1999 page 15 by M.A.O. Olapa (Checking Drug Abuse in School.

20. Odebunmi, A. (1993) "Drug Probles and Control". In: Adalemo, I.A., and A.B. Mamman (eds) Nigeria: Giant in the Tropics Vol. 1 p. 349 – 354.

21. Kester, T. (1990): Drug Education: An Effective Measure to the Prevention of Drug Abuse. The Adult Education Journal; Vol. 6. No. 5.

22. Edward G. and A. Arif, (eds): Introduction to: Drug Problems in the Socio-cultural context a basis for policies and programme planning. World Health Organization Offset Publication No. 73, Geneva, 1980, p.18.

23. Adesina S.K. (2000): Drug problems and control Nigeria A people united, A future Assured, Abuja: Federal ministry of Information, 335. (A paper presentation.)

24. Abdalla U.A. D. Phil (2003) Youth & Drug Abuse in Nigeria: strategies for counseling, management & control: Kano. Book project Group, Department of Education, Faculty of Education, Bayero University (paper presentation).

25. Auwal M.L. (2003) Review of current Researches on Drug Abuse in Nigeria. A paper presented in Youth and Drug Abuse in Nigeria strategies for counseling, management & control. Book project Group. Department of Education, faculty of Education B.U.K. Kano.

26. National Population Commission (NPC), Federal Republic of Nigeria, [Nigeria]. Nigeria Demographic and Health Survey 2003 Calverton, Maryland, U.S.A.: National Population Commission and ORC/MACRO, 2004 pp.

27. Adelekan M.L (1989) : self- reported drug use amongst secondary school students in Nigeria, state of Ogun. Bulletin on Narcotic 41, PP(109 – 116).

28. Hamid, G. and Douglas M. (1990) substance abuse and dependence. An introduction for caring profession. Great Britain by Anthony Rowe Ltd., Chippenham and Reading.

29. Nwegbu, C.O.E (1977), Teacher Guide for Health Education in primary school, Lagos. Macmillan Nigerian publisher limited.

30. Adeoeye, B (1981), UPE Teacher Education provisional Not Health Education. Ado Ekiti: Omolayo standard press and Bookshop co. (Nig) Ltd.

31. WHO (1964) Thirteen reports of WHO experts committee on addiction producing drugs.Tech. Rep. Ser. No. 273 (Geneva World Health organization)

32. Rang, H.P.M.M., Dale and J.M. Ritter (eds), (1996) "Drug Dependence and Drug Abuse." In: Pharmacology, 3rd ed. Churchill Livingstone, London, 1996 p. 645 – 664.

33. Last, D.M and Halil, I.sl (1991) "preface" in op.cit. pp iv – v.

34. Abdullahi . S. A (1982) "Historic Role of African Youth and the contemporary challenges." In Sokoto service vol 3, No 6. pp 10 – 11.

35. Hurlock, E.B., (1975) Adolescent Development. Tokyo : MC Grew. Hill Kogakusha Ltd.

36. United Nations International Drug control programme (UNDCP). World Drug Report. New York, Oxford University press, 1997.

37. World Health Organization ATLAS Report, Programme on Substance abuse, Geneva, WHO, 1992.

38. Smith, R. (1982) "The Politics of Alcohol," British Medical Journal 284, 1392 – 1395.

39. NIDAR (1978). The Drug Abuse Scene in Nigeria. National Institute on Drug Abuse Research Monograph series 19, 15 – 25.

40. Reuter, P. The mismanagement of illegal drug markets in pozo, S. (Ed), Exploring the Underground Economy, 1996.

41. World Health Organization Regional Office for Europe. Smoking, drinking and drug taking in the European region, Copenhagen, WHO, 1997.

42. World Health Organization Amphetamine – type stimulants Geneva, WHO, 1997a.

43. Stimson, G.V., Des Jarlais, D.C., and Ball, A. (Eds). Drug injecting and HIV infection. Global dimensions and local response

44. World Health Organisation. Multi-City Study on Drug Injecting and Risk of HIV Infection, Geneva, WHO, 1994.

45. World Health Organisation. Opididoverdose: Trends, Risk Factors, Interventions and Priorities for Action, Geneva, WHO, 1997.

46. World Health Organisation Drug Injecting Study Phase II: rAPID Assessment Methods for Drug Injecting, Geneva, WHO forth Coming.

47. World Health Organisation and Point Nations Programme on HIV/AIDS Rapid Assessment Methodology for SUBSTANCE Use and Sexual Behaviour, Geneva, WHO Forthcoming.

48. Smart, R. G. World Trends in Alcohol Consumption. World Health Forum. 1991, 12: 99 – 103.

49. Edwards, G. , Anderson, P., Babor, T.F. et al. Alcohol Policy and the public Good. Oxford, Oxford University Press, 1994.

50. Saxana, S. Alcohol, Europe and the Developing Countries. Addiction, 1996, 92 (Supplementary): 43 – 48.

51. Smart R.G. and Mann, R.E. Alcohol and the Epidemiology of Liver Cirhosis. Alcohol Health and Research World, 1992, 16: 217 – 222.

52. Dogam, V.B. Turkey: Drinking Behaviours in a Changing Society. British Journal of Addiction, 1982, 27:209 – 210.

53. Janshid, A., Melidi O., Shiraz-Iran: "Substance Abuse Among Iranian Male Students; 1999: 1-7.

54. Okasha, A. Young People and the Struggle Against Drug Abuse in the Arab Countries. Bulletin on Narcotics, 1995, XXXVII: 67 – 73.

55. Oshodi o. g. (1984): Journal of Royal Society of Health, Vol. 3.

56. Anumonye, A. (1980): Drug Use Among Young People in Lagos. Nigeria. Bulletin on Narcotics, 32, 39 – 45.

57. Navadomsky, J.J. (1981): Patterns of Self-Reported Drug Use Among Secondary School Students in Bendel State. Bulletin on Narcotics, 33, 1, 9 – 19.

58. Idowu, A. (1987): Prevalence of Smoking and Drug Use Among Students in Ilorin Metropolis: Implications for Counnselling. Ilorin Journal of Education, 7, 85 – 92.

59. Odejide, A.O.., Ohaeri, J.U., Adelekun, M.L. and Ikuesan, B.A. (1987): Drinking Behaviour and Social Change Among Youths in Nigeria – Study of Two Cities Drug and Alcohol Dependence, 20, 227 – 233.

60. International Council on Alcohol and Addictions –ICAA (1988): Reports a Research Project o Substance Abuse in Some Urban and Rural Areas of Nigeria. Funded by United Nations Fund for Drug Abuse Control (UNFDAC).