The socio-economic effects of binge drinking on support networks in the North West Province: A social perspective

B. M. P. Setlalentoa
20254555

Thesis submitted for the degree Philosophiae Doctor
In Social Work

at the North-West University (Potchefstroom Campus)

Promoter: Dr Elma Ryke
Co-promoter: Prof. Herman Strydom

November 2009

ABSTRACT

Keywords: Alcohol abuse; alcohol consumption patterns; binge drinking; social support; social support networks

Binge drinking as one of the alcohol consumption patterns, affects the quality of life of the drinker, significant others and the society in general. It contributes to negative social, economic and health effects on social support networks.

This sub-study of the five year trans-disciplinary Alcohol study analysed the existing quantitative data of the Prospective Urban and Rural Epidemiology (PURE) study. The broad aim of the Alcohol study is to gain a better understanding of the alcohol consumption patterns and the causes and consequences of binge drinking amongst South African. The overarching aim of this sub-study was to identify the socio-economic effects of binge drinking on support networks with a view to contributing to a development of a relevant, integrated and coherent strategy to address alcohol abuse and misuse in the selected areas of the study.

The study adopted a mixed methods approach by combining the qualitative and quantitative paradigms to understand the phenomenon of binge drinking and its effects on support networks more adequately. A literature study was undertaken to firstly understand the broader context of the social aspects of alcohol abuse in South Africa, and secondly, to understand social support, social support networks and social network analysis in relation to binge drinking from a conceptual and theoretical framework. Unpacking of the concepts social support, social support networks and social network analysis provided a base to argue that social support networks are affected by binge drinking because the drinker and networks such as family and service providers are interrelated and interdependent. Relevant theoretical frameworks that support this view that person and environment are related and cannot be separated because one affects the other as well, were used to substantiate the argument.

Binge drinking was further cross tabulated with other relevant variables to further understand the alcohol consumption patterns. The profile of social problems from the PURE data provided a picture of the challenges in the demarcated areas. As such poverty, low educational level and income were used as markers of socio-economic position.

Having identified binge drinking as one pattern of alcohol consumption used in the communities, the study further identified the socio-economic effects experienced by support networks through semi-structured interviews with a schedule and focus groups. The family members and service providers as key informants were identified as support networks. The identified family support network representatives were children, spouse, parents and a sibling and they explained their experiences with a binge drinker. Specific themes of social support were used to describe their experiences of support. These themes are: types of support provided; recipient perception, reciprocal support and behaviour of the provider. The results indicated that support networks are negatively affected by binge drinking because social support is not provided as expected. Performance of roles is compromised and binge drinkers socially constructed views of being justified to abuse of alcohol in that they themselves were exposed to the same situation as children, thus the children are expected to accept their drinking and the socio-economic situation.

The community support networks were interviewed to obtain information on the alcohol abuse and socio-economic conditions in the selected communities and to identify the intervention strategies employed to combat the alcohol abuse problems. Suggestions to enhance intervention strategies are proposed focusing on assessment of risk and risk environment, targeted interventions, multi-level synergistic intervention and multi-disciplinary roles and partnerships.

OPSOMMING

Sleutelwoorde: Alkoholmisbruik, alkoholgebruik, alkoholgebruikspatrone, fuif-drinkery, sosiale ondersteuning, sosiale ondersteuningsnetwerke

Fuif-drinkery, as een van die alkoholverbruikspatrone, affekteer die kwaliteitlewe van die drinker, betekenisvolle andere en die samelewing in die breë. Dit dra by tot 'n negatiewe sosiale, ekonomiese en gesondheidsimpak op sosiale ondersteuningsnetwerke.

Hierdie studie, wat voortvloei uit die vyf jaar transdissiplinêre studie, het bestaande kwantitatiewe data van die Prospective Urban and Rural Epidemiology (PURE) geanaliseer. Die breë doel van hierdie alkoholstudie is om 'n beter begrip van alkoholverbruikspatrone en die oorsake en gevolge van fuif-drinkery onder Suid-Afrikaners te verkry. Die oorkoepelende doel van die studie is om die sosio-ekonomiese impak van fuif-drinkery op ondersteuningsnetwerke te identifiseer met as oogpunt om 'n relevante, geïntegreerde en koherente strategie te ontwikkel wat alkoholmisbruik in die geselekteerde areas kan aanspreek.

Die studie volg 'n gemengde metodologiese benadering waar kwalitatiewe en kwantitatiewe paradigmas gekombineer is om die fenomeen van fuif-drinkery en die impak op ondersteuningsnetwerke meer indringend te verstaan. 'n Literatuurstudie is eerstens onderneem om die breë sosiale aspekte van alkoholmisbruik in Suid-Afrika in konteks te plaas en tweedens om die sosiale ondersteuning, ondersteuningsnetwerke en netwerkanalises vanuit 'n konseptuele en teoretiese raamwerk te verstaan. Die konsepte van sosiale ondersteuning, ondersteuningsnetwerke en netwerkanalises is ontrafel, ten einde 'n basis te lê vir die ondersoek van die navorsingshipotese, naamlik dat sosiale ondersteuningsnetwerke deur fuif-drinkery geaffekteer word omdat die drinker, gesinsnetwerke en diensverskaffers verbind en interafhanklik van mekaar is. Relevante teoretiese raamwerke het die siening dat die persoon en die omgewing nie van mekaar geskei kan word nie, gesubstansieer en ondersteun.

Fuif-drinkery is voorts met ander relevante veranderlikes getabuleer om 'n beter insig in alkoholverbruikspatrone te bekom. Die profiel van sosiale probleme wat die PURE-navorsing uitgewys het, het 'n duidelike prentjie geskets van die uitdagings in die afgebakende areas. Armoede, lae opvoedingspeil en inkomste is as merkers gebruik om die sosio-ekonomiese posisie te bepaal.

Nadat fuif-drinkery as een van die patrone van alkoholmisbruik wat in die samelewing na vore kom, geïdentifiseer is, het die studie die sosio-ekonomiese impak wat deur ondersteuningsnetwerke ondervind word, deur gestruktureerde onderhoude en fokusgroepe ondersoek. Die gesinslede en diensverskaffers is as sleutelinformante en ondersteuningsnetwerke geïdentifiseer. Die geïdentifiseerde familie-ondersteuningsnetwerk-verteenwoordigers het kinders, eggenotes, ouers en sibbe ingesluit wat hulle ervarings met 'n fuif-drinker gedeel het. Spesifieke temas van sosiale ondersteuning is gebruik om hulle belewenis te omskryf. Hierdie temas is: die tipe ondersteuning wat voorsien is, die persepsie van die ontvanger, resiproke ondersteuning en die gedrag van die voorsiener. Die bevindinge het aangedui dat ondersteuningsnetwerke negatief deur fuif-drinkery geaffekteer word omdat sosiale ondersteuning nie voorsien is soos verwag nie. Kompromieë rakende rolle is aangegaan en fuif-drinkers het sosiale sieninge gekonstrueer waar hulle alkoholmisbruik geregverdig het omdat hulle dieselfde blootstelling as kinders gehad het. Sodoende word daar van die kinders verwag om die drinkery en die sosio-ekonomiese situasie te aanvaar.

Die gemeenskapondersteuningsnetwerke is ondervra om inligting te verkry rakende alkoholmisbruik en die sosio-ekonomiese omstandighede in die geselekteerde gemeenskappe, en om intervensiestrategieë aan te wend wat alkoholmisbruikprobleme bekamp. Voorstelle om intervensiestrategieë te bevorder, is voorgestel met as fokus die assessering van risiko and risiko-omgewing, doelgerigte intervensies, veelvlakkige sinergistiese intervensies en multi-dissiplinêre rolle en verhoutskappe.

PREFACE

This manuscript is presented in an article format in accordance with Rules A.11.5.3 and A.11.5.4 that are set out in the calendar of the North-West University: Potchefstroom Campus. The context and technical requirements of the accredited professional journals {*South African Journal of Clinical Nutrition, Social Work/Maatskaplike Werk,* and *Social Science & Medicine*} were used as a basis to formulate the articles. Article 1 (Chapter 2) is co-authored (see letter of permission from co-authors that the articles be submitted for degree purposes - Annexure 3).

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ACKNOWLEDGEMENTS

I would like to thank the following people who have contributed immensely to my study.

- My son Rakgaje, and all my siblings; their love and support made me persevere.
- My promoters Dr. E. Ryke and Prof. H. Strydom for their guidance, supervision, constructive criticism, patience and support.
- Prof. E. Vorster and Prof. A. Kruger for their assistance and leadership in the PURE and Alcohol Study.
- The National Research Foundation for financial support (a grant to Prof. H. H. Vorster for Alcohol, Food Security and Health Project – Reference No. FY2006041100003.
- North-West University for financial support.
- Prof. M. Temane and Mr. N. Maruma for assistance with statistical analysis.
- Faculty of Human and Social Sciences and Department of Social Work, NWU – Mafikeng Campus for affording me leave to pursue my studies.
- Fellow researchers, Ms. G. Phetlho-Thekisho and Ms. R. Gopane for support and stimulating discussions and debates.
- The PURE field workers and participants, their family members and service providers for their willingness to share their experiences with me.
- Prof. L. A. Greyvenstein for the language editing.
- My late parents, Howard and Sarah, who instilled the value of education in me.
- Lastly, I would like to thank my God for His grace, everlasting love, care and protection that engulfed me to see this day.

Psalm 138:3

When I pray, you answer me; you encourage me by giving me the strength I need.

E rile mo letsatsing le ke biditseng ka lona, wa nkaraba, wa nonofisa ka thata mo moeng wa me.

Toe ek na U geroep het, het U my gebed verhoor en my nuwe krag gegee.

CHAPTER 1

ORIENTATION TO THE STUDY

1. CONTEXTUALISATION AND PROBLEM STATEMENT

The misuse or abuse of alcohol is one of the social, economic and health problems faced by many countries. The World Health Organization (WHO, 2004:1) estimates that there are about 2 billion people worldwide who consume alcoholic beverages. The WHO (2000) highlighted that alcohol consumption is the fifth leading cause of death worldwide with about 1.8 million deaths and that intakes of alcohol are increasing, especially in developing countries. Traditional drinking patterns in many developing countries are dominated by continued sporadic episodes of intoxication. The situation is worsened by cash economy and industrialisation of alcohol production and distribution which have led to more frequent drinking, often in the form of weekend binge drinking (Jernigan, 2004:3). His view is that alcohol problems are of global scale that requires global leadership to solve them.

South Africa is one of the countries that are experiencing a problem with alcohol abuse. The apartheid system has contributed to the alcohol problem in South Africa. In response to resisting oppression, alcohol was used. One such indication is the growth of shebeens or illegal outlets that served as a form of resistance. However, the apartheid policies were changed but the alcohol problem continued and has now reached a high level (Parry, 2005:426).

Vorster *et al.* (2005:760) are of the view that South Africa is a country in transition and the rapid urbanization and socio-political changes could also play an important role in use, misuse or abuse of alcohol. The political changes are geared toward addressing problems of inequality, poverty and human rights. These changes that are accompanied by rapid urbanization, lead to changes in economic, societal and family structures. There has been a change in traditional ways of life, value systems and human behaviour.

Alcohol misuse and abuse in South Africa is associated, amongst others, with rapid transition, urbanisation, modernization, availability, accessibility and cultural changes. At the same time, many social ills are experienced and have had adverse effects on support networks like crime, violence, road deaths, injuries, high risk

sexual behaviour, family dysfunction, suicide, unintended pregnancy and many other problems (Butchart *et al.,* 2000:1; Morojele *et al.,* 2006:218; NDMP, 2006-2011; Norman *et al.*, 2007:1753) These negative effects have been experienced in other countries as well (Mokdad *et al.*, 2007:303 & Sorock *et al.*, 2000:194).

In an effort to combat the alcohol abuse problem in particular, different types of legislation were introduced. The objectives of Liquor Act No 59 of 2003 are to reduce the socio-economic and other costs of alcohol abuse by setting norms and standards, regulating the manufacturing and wholesale distribution of liquor, retail sale and micro-manufacturing, providing for public participation in the consideration of applications for registration and promotion of the development of a responsible and sustainable liquor industry (Liquor Act No 59 of 2003:6). The Prevention of and Treatment for Substance Abuse Act of 2008 was introduced to reduce and combat substance abuse in a coordinated manner, to provide vulnerable persons with early intervention, treatment and reintegration programmes and to establish a Central Drug Authority to monitor and oversee the implementation of the National Drug Master Plan (2006-2011). However, alcohol abuse is still rife in many communities.

Even though South Africans drink less alcohol than other countries that are part of WHO database, those who drink consume huge amounts of alcohol. The level of adult, per capita, absolute alcohol consumption was estimated in 2000 at 10.31 – 12.4 litres (Parry, 2005:426). The National Drug Master Plan (NDMP), 2006-2011 states that alcohol is the primary drug of abuse in South Africa. It is abused by men and female adults and youth. For example, Madu and Matla (2003: 121) studied alcohol drinking behaviour among high school adolescents in Pietersburg (Polokwane) in the Northern Province (Limpopo) and the study indicated a prevalence rate of 19, 8% of illicit drug use, 10, 6% of cigarette smoking and 39% for alcohol consumption among the participants.

The former Minister of Social Development, Dr Z. Skweyiya in his media briefing of 20 August 2007, quoting the World Drug Report (2006) also pointed out that dagga and alcohol are still the most abused substances in South Africa and 12 million families of users are emotionally and financially affected. The NDMP states that indications are that between 7.5% and 31.5% of South Africans have an alcohol problem or are at risk of having such a problem (NDMP, 2006-2011). Of concern is the pattern of binge drinking of about a third of South African drinkers and the

problem is worsened by a change in drinking patterns from traditional use of home brews with low alcohol content to more frequent, recreational use of commercial beverages, and availability and easy accessibility of commercial alcoholic beverages (Parry *et al.,* 2005:91).

The South African Demographic and Health Survey (1998) that was conducted by the Department of Health with a sample of 13826 persons showed that 28% of the population (45% of men and 17% of women) consumed alcohol at the time. About a third of the drinkers reported risky or binge drinking over the weekends. Baleta (1998: 465) also mentioned that alcohol is South Africa's most abused drug, and referred to estimates of the South African National Council for Alcoholism and Drug Dependence (SANCA) that there are 1 025 198 alcoholics in South Africa – 5, 8% of citizens over age 15 years. This indicates that the quality of life of many South Africans is adversely influenced directly or indirectly, by binge drinking or abuse of alcohol.

Plant and Plant (2006: ix) provide the meaning of 'binge' that it relates to a single drinking session intended to or actually leading to intoxication and it is risky. They are of the view that binge drinking is self-destructive and unrestrained drinking bouts lasting for at least a couple of days. During this time the heavily intoxicated drinker 'drops out' by not working, ignoring responsibilities, squandering money, and engaging in other harmful behaviours such as fighting or risky sex. The question is who gets affected or suffers the consequences?

Alcohol abuse as a problem leads to many harmful social consequences for the individual drinker, his or her immediate environment and society as a whole (WHO, 2004:59). The environment consists of social support networks of which a family is one. The social consequences of alcohol can best be understood as "changes, subjectively or objectively attributed or attributable to alcohol, occurring in individual social behaviour, in social interaction or in the social environment" (Klingemann, 2001:2). His view is that in some cases alcohol is a direct cause of a social occurrence as in traffic accidents. Other social problems could be family members affected by the drinker's failure to fulfil social role obligations. Children are the most severely affected, since they can do little to protect themselves from the direct and indirect consequences of parental drinking. The drinker's behaviour and mental impairment can profoundly impact surrounding family and friends, possibly leading to

marital conflict and divorce. This can contribute to lasting damage to the emotional development and mental health of the drinker's children, with lasting negative effects even after they reach adulthood.

Social support networks refer to family, work places, service providers and friends or communities. Social support is a unit of social structure that includes all of an individual's social contacts one can turn to for different kinds of resources (Borgatti, 2005:1; Messina & Messina, 1999-2007:1). Social support networks provide social and economic support in varying degrees. The four basic categories of support that one gets from others are emotional aid, material aid, information and companionship (Borgatti, 2005:1; Jukkala *et al.,* 2008:664). The critical question is whether when one abuses alcohol can one provide this kind of support.

It is against this background that this study focused on identifying the socio-economic effects of binge drinking on social support networks in Ganyesa, Tlakgameng Villages and Ikageng Township, North West Province as a sub-study of the Alcohol Project funded by the National Research Foundation (NRF) – FA 2006041100003, over five years with Africa Unit for Transdisciplinary Health Research (AUTHeR), in the Faculty of Health Science at the North-West University, Potchefstroom Campus. The Prospective Urban and Rural Epidemiological (PURE) study is a prospective cohort study that tracks changing lifestyles, risk factors and chronic disease over a period of twelve years using periodic standardized data collection in urban and rural areas of many countries in transition. All the baseline data for the PURE study (South Africa) were collected during 2005.

The aim of the trans-disciplinary Alcohol Study, focusing from society to molecular level, is to gain a better understanding of alcohol consumption patterns and causes as well as consequences of binge drinking, with one of its specific aims being to examine the phenomenon of binge drinking which this study is pursuing. This sub-study seeks to understand the socio-economic effects of binge drinking on social support networks. It was necessary to do a systematic literature review on the social causes of alcohol, misuse and abuse in South Africa. An understanding of the concepts social support, social support networks and social network analysis in relation to binge drinking became imperative. Consequently, an empirical investigation was undertaken to identify the socio-economic effects on social support networks.

The findings of the study would contribute to a better understanding of causes, consequences or effects of binge drinking on social support networks and contribute to development of a relevant, integrated and coherent intervention strategy to address the alcohol abuse problem with a view to improve quality of life and health in South Africa.

The research questions that are answered in this study are:

- What are the social aspects of binge drinking in South Africa?
- What is the meaning of social support and support networks in relation to binge drinking?
- What are the alcohol consumption patterns of the selected areas in the North West Province?
- What are the profiles of the identified binge drinkers in Prospective Urban and Rural Epidemiology (PURE) study respondents and their support networks?
- Which socio-economic effects are experienced by social support networks due to binge drinking?
- Which intervention strategies are used to curb the problem of binge drinking in the selected areas of study?
- What are the recommended appropriate intervention strategies to address the binge drinking?

2. AIM AND OBJECTIVES OF THE STUDY

The overarching aim of the study is to describe the socio-economic effects of binge drinking on support networks with a view to contribute to a development of a relevant, integrated and coherent strategy to address alcohol abuse and misuse in South Africa.

Objectives of the study

- To do a literature review to understand
    - The social aspects of alcohol abuse/misuse.
    - Social support networks in relation to binge drinking from various theoretical perspectives.
- To describe the alcohol consumption patterns in selected areas in the North West Province.

- To explore the socio-economic effects of binge drinking on support networks.
- To identify the profiles of the binge drinkers and their support networks.
- To analyse the strategies used and to recommend appropriate intervention strategies to curb alcohol abuse from a community support networks' perspective.

3. BASIC THEORETICAL STATEMENT

Insight into the experiences of the binge drinkers and their social support networks will provide an understanding of the socio-economic effects of binge drinking. It will also contribute to development of a strategy to address alcohol abuse with a view to improve quality of life and health of South Africans.

4. THEORETICAL FRAMEWORK

The following frameworks shaped the main focus of the study.

- The eco-systems perspective (Compton *et al.*, 2005; Pillari & Newsome, 1998; Poulin, 2005).
- Role theory (Pillari & Newsome, 1998).
- Social constructivism as a postmodern perspective (Poulin, 2005; Narabayashi, 2006).
- These frameworks were used to explain the main argument of the study that binge drinking has negative effects on the drinker and the environment and are discussed in Chapter 3 (Article 2).

5. DEFINITION OF CONCEPTS

Alcohol abuse is defined as use of alcoholic beverages to excess, either on individual occasions ("binge drinking") or as a regular practice (MedicineNet, 2008). Alcohol abuse is also defined as repeated use despite recurrent adverse consequences. It is a pattern of drinking that is accompanied by problems such as failure to fulfil major work, school or home responsibilities because of drinking or having relationship problems that are caused by or worsened by the effects of alcohol (DSM IV- TR, 2000).

Binge drinking - Binge drinking is defined as excessive, immoderate, or heavy drinking of four drinks for women and five or more drinks for men, in a single drinking session, over a short period and within a number of days or weeks (Mokdad, *et al.*,

2007:303; Naimi *et al.,* 2007:188; Plant & Plant, 2006:ix; Szmigin, *et al.,* 2007:2; Wechsler & Nelson, 2001:287). Rocha-Silva (1989a:18) defines heavy drinking as the consumption of a minimum of ten centilitres of absolute alcohol on average per day. The term 'heavy episodic drinking' is also used to explain the extent of drinking alcohol. For the purpose of this study alcohol misuse/abuse and binge drinking are used as synonyms.

Environment is the total elements, factors and conditions in the surroundings which may have an impact on the development, action or survival of an organism or group of organisms (MedicineNet, 2008). **Human environment**, from an ecosystems perspective, includes water, food, a spatial arrangement and other physical entities, and a complex network of human relations. These networks or systems include those of a social, political and economic nature that enables people to sustain themselves and that ensure that their various needs are met (Weyers, 2001:16).

Health is defined as a state of complete physical, mental and social well-being, not merely the absence of disease or infirmity (World Health Organization, 2003:1).

Human ecology is the study of human beings in their environments, the processes and interaction taking place between them and their environments, and the manner in which the social equilibrium is achieved and maintained (New Dictionary of Social Work, 1995:31).

Social network is a set of relationships that provide nurturance and reinforcement for coping with life on a daily basis. It is a complex and multi-dimensional construct, consisting of social network resources, types of supportive exchanges, perceptions of support availability, and skills in accessing and maintaining supportive relationships (Tracy & Whittaker, 1990:462).

Social support is the existence and availability of people on whom one can rely, people who let others know that they care about, value, and love one another (Compton *et al.* 2005:259). Tracy and Whittaker (1990) refer to social support as "responsive acts of assistance between human beings".

Social support system/network is individuals, families, groups or services in the community that support, complement or promotes the social functioning of the client or potential client (New Dictionary of Social work, 2003:59).

6. METHODS OF INVESTIGATION

The study used the following methods of investigation.

6.1 Analysis of the literature

A literature study was conducted throughout the total study. The topics that were critically analysed and interpreted included social aspects of alcohol misuse, social support, social support networks and social network analysis.

Databases consulted: Academic Search Database; EBSCOhost; ScienceDirect-Biological Psychology, Journal of Adolescence, Alcohol, Social Science & Medicine, TDnet, The Lancet; and Public Health Nutrition were consulted throughout the study.

6.2 Demarcation of the research study

The study was conducted in Ganyesa, Tlakgameng (Bophirima district) and Ikageng both formal and informal areas (Southern District) in the North West Province. It focuses on binge drinkers and their support networks, their biographical profile including gender, age, marital status, education, occupation and their socio-economic profile as well.

6.3 Empirical Investigation

6.3.1 Research Design

This study followed triangulation mixed method procedures by employing both quantitative and qualitative approaches to understand a research problem more completely and capture the best of both approaches (Ivankova *et al,* 2007:261) using the sequential mixed design (Tashakkori, 2009:288). The study started with the quantitative approach and followed by the qualitative approach. According to Denscombe (2008:272) the mixed methods approach uses quantitative and qualitative methods within the same research project, the design clearly specifies the sequencing and priority is given to quantitative and qualitative elements of data collection and analysis.

Ivankova *et al.* (2007:263) support the use of mixed methods study that both numerical and text data are collected and analysed to address different aspects of the same general research problem and provide a more complete understanding of

the phenomenon. Tashakkori (2009:288) states that scholars who follow the mixed methods approach agree on the importance of identifying a sequence of quantitative and qualitative phases, type of data collection procedures and type of data needed for answering the research questions.

The researcher used existing quantitative data from the PURE study to identify binge drinkers, to determine their alcohol consumption patterns, support networks and socio-economic status. The goal of the quantitative phase of the study was to acquire data on the extent of the problem in the selected areas and identify their socio-economic profile, causes and consequences of binge drinking on drinkers and support networks.

Qualitative methods were used to obtain the views about binge drinking from the drinkers. The support networks provided their views about how they are affected by binge drinking in terms of support they expect from the drinker. The goal of the qualitative aspect of the study was to obtain the meaning that support networks hold about binge drinking and how it affects their life. The researcher compared the two types of data to understand the research problem better and draw well-validated conclusions.

6.3.2 Population and Sample

When the PURE study sample was selected, the main criterion was that there should be migration stability within the chosen communities as this study was part of the South African leg of the PURE study which is planned to run for twelve years. All the baseline data were collected during 2005 in the two rural areas in Ganyesa and Tlakgameng and two urban areas in Ikageng (formal and informal areas). From a population of 2000 from the PURE study respondents who are residents of the two areas, 1000 respondents were selected using probability sampling procedure, where specific characteristics of respondents such as gender, employment, education age, education, marital status amongst others, were examined. 118 respondents presented with missing links, were therefore, excluded and a total of 882 respondents were selected and analysed. The quantitative study was used for the mixed methods approach as an aid to sampling to screen potential participants for inclusion in the interviews (Denscombe, 2008:272).

For the qualitative part of the study non-probability sampling for qualitative data was used and participants were purposefully selected (Creswell, 2009:178) to help the researcher to understand the binge drinking problem and its effects on social support networks. Creswell (2003:220) supports purposive sampling individuals because they have experienced the central phenomenon, either as binge drinkers or social support network.

6.3.3 Methods of collecting data

Data in this study were collected using a variety of methods which included the following:

- Analysis of selected PURE study data from 882 questionnaires (Annexure 9)
- Two focus groups consisting of seven members each, four men and three women were conducted. Furthermore, semi-structured interviews with an interview schedule were held with binge drinkers to gain more data and to validate the PURE study data. The main question was on description of the binge drinking episodes and providing social support. Other questions emerged as the interview continued.

Open-ended semi-structured interviews with an interview schedule (Nieuwenhuis, 2007:87) were conducted with family members of binge drinkers to obtain information on the socio-economic effects experienced due to binge drinking. Focus was on social support provided by the binge drinker and how it is perceived. The questions were pursued to ensure that all aspects of social support were covered.

Interviews were conducted with key informants in the South African Police Services in Ganyesa and Ikageng, one social worker per region and one principal at Huhudi High School (Ganyesa) and a principal at Ikageng High School.

Methodological triangulation was used to measure the phenomenon using qualitative and quantitative approaches (De Vos, 2005:362).

Documents that focus on reducing harm were studied and intervention strategies used in the selected areas were analysed.

6.3.4 Data Analysis

The information sought was situated at the individual, family and general population level of the demarcated areas hence the use of a mixed method approach. Corden and Hirst (2008:211) state that this kind of information is both circumstantial and experiential. Both quantitative and qualitative data were interpreted once all data were collected, captured, processed and results condensed.

Data analysis method used for quantitative study is secondary analysis because baseline data was collected for the PURE study. According to Boslaugh (2007:1--excerpt) "secondary analysis of existing data may involve the analysis or reanalysis of data originally gathered by others for research purposes." The Statistical Package for Social Sciences 16.0 (Levesque, 2007) was used to analyse quantitative data, using nominal, ordinal and ratio levels of measurement. The data code sheet was used to import data from the Microsoft Exel spreadsheet to SPSS. Data were translated into a frequency distribution tables with percentages. The quantitative data provided information on the drinking patterns, socio-economic position and effects of alcohol abuse on the drinker and qualitative data indicated how the drinking affected the networks.

Content analysis was used for qualitative data which is a systematic approach to analysis that identifies and summarises message content. Neuman (2000:292) defines content analysis as a technique for gathering and analysing the content of text. The content refers to words, meanings, pictures, symbols, ideas, themes or any message that can be communicated. The collected data were coded and themes that helped to understand were identified and interpreted (Nieuwenhuis, 2007:101).

Data from the two approaches were compared to validate the socio-economic position of the research participants, to establish how it contributes to binge drinking and also how support networks are affected. Creswell (2007:266) states that triangulation mixed methods design affords one an opportunity to analyse quantitative and qualitative data separately and results are then compared and interpreted. Trustworthiness and consistency were established through repeated visits.

6.3.5 Procedures

The researcher acquainted herself with the project by visiting the identified areas to meet the PURE study field workers to clarify roles and planned how the study would be conducted

The PURE study field workers were engaged because they were familiar with the research setting and knew the homes of the research participants. They were informed about the selection criteria used to select the binge drinkers focusing on the definition and explanation on selection of members for inclusion in the focus groups.

Meetings were held with leaders of the PURE study and Alcohol Project to brief the researchers about the study. The other authors were also consulted during the course of the study. The formal support networks were identified and permission to conduct the study was requested and granted.

6.3.6 Ethical considerations

In order to undertake the study the following ethical considerations were attended to:

Ethical clearance was sought from the North-West University Ethics Committee because human subjects are involved (Annexure 1). This study is covered by the ethical clearance of the Alcohol Project no. NWU-00047-07-S7. The Prospective Urban and Rural Epidemiological (PURE) Study, which provided baseline data for Chapters 4 and 5, was ethically approved by the North-West University – Reference no. 04M10, (Annexure 2a and b).

Informed consent was obtained from the participants that were selected from the PURE study. The field workers introduced the researcher to the participants and explained that she was part of the Alcohol Project team. Clarification was provided on the specific research being conducted, that it is voluntary and information provided is confidential. Consent forms were signed or thumb print was inserted by the participants (Strydom, 2005:59) (Annexure 8).

Because of the nature of information required, binge drinkers and family members as support networks were informed about psychosocial services that are available and that the researcher made herself available should the need arise to intervene. The researcher provided the participants with debriefing after an interview. Those who

were identified for further assistance were referred to social workers and the South African Social Security Agency to access grants and pensions. The area social worker was informed about the study and referrals were made.

The social worker, police and teachers were identified to participate in the study as community support networks. Letters requesting permission to conduct the study and ethics clearance were sent to the manager of the identified department (Annexure 4). Permission was granted and contact names of local representatives were provided.

All information and responses shared during the study were kept private and results are presented in an anonymous manner in order to protect the identities of participants.

7. LIMITATIONS OF THE STUDY

Participation in PURE study data collection

The researcher was not part of a team when data were collected. It could have created a problem for participants if a working relationship was not properly established. One had to rely on data as presented. On the other hand, it also could lead to more objectivity in terms of the qualitative part of the study.

Small sample size

It would not be possible to generalise the quantitative findings for the entire North West Province because the sample is not representative. For the qualitative study, generalisation is in any case not possible.

8. CONTRIBUTION TO THE FIELD OF SOCIAL WORK

The trans-disciplinary nature of the study contributes to the field of social work in that in order to address the problem of alcohol abuse; all aspects need to be considered. It further emphasises that the definition of health should be understood broadly as well-being. Most importantly, the study re-emphasises that interventions should be informed by proper assessment and off-the-shelf strategies would not yield good results.

9. STRUCTURE OF THE THESIS

The research report comprises of the following chapters:

Chapter 1: Orientation to the study

The chapter provides a background to the phenomenon of alcohol abuse globally and locally with specific emphasis on binge drinking and its effects on social support networks as a problem area.

Chapter 2 (Article 1): Social aspects of alcohol misuse/abuse in South Africa.

A systematic literature review is undertaken to present in brief the history and possible causes and consequences of alcohol abuse in South Africa.

Chapter 3 (Article 2): Understanding social support networks in relation to binge drinking.

This chapter sets out the conceptual and theoretical frameworks in order to *understand* the concepts social support, social support networks and social network analysis.

Chapter 4 (Article 3): The alcohol consumption patterns of binge drinkers in the North West Province, South Africa.

A quantitative analysis of alcohol consumption patterns in the demarcated areas of study was undertaken and provided biographical and socio-economic profiles. Binge drinking was identified as a problem.

Chapter 5 (Article 4): The socio-economic effects of binge drinking on the social support networks in selected areas of the North West Province, South Africa.

Narratives of the binge drinkers and social support networks were analysed.

Chapter 6 (Article 5): Intervention strategies to combat/curb the effects of binge drinking: A community support networks' perspective.

Analyses of the effects of binge drinking in the selected areas of study together with provision of services by community support networks were pursued. Ultimately, appropriate intervention strategies are recommended.

Chapter 7: Summary, conclusions, implications and recommendations.

Consolidation of the thesis is made with specific reference to conclusions about the objectives, implications of the study and recommendations regarding future research.

Chapter 2, 3, 4, 5 and 6 were written in article format. The author guidelines of the *South African Journal of Clinical Nutrition* – Article 1 (Chapter 2), *Social Science and Medicine* – Articles 3, 4, and-5 (Chapters 4, 5 and 6), and *Social work/Maatskaplike Werk* – Article 2 (Chapter 3), were taken into consideration in preparation of these chapters. (Annexures 5, 6 and 7 respectively).

However, for the purpose of this research report, the following deviations were made:

The report is typed in 1½ line spacing.

The font size is 12.

The font used is Arial.

10. AUTHOR'S INPUT TO THE SEPARATE ARTICLES IN THIS THESIS

The study reported on in this thesis was planned and executed by a team of researchers and the contribution of each is listed in Annexure 5. A statement from the co-authors is also included, confirming their role in the study and giving their permission for the inclusion of the articles in this thesis. The statement is as follows: "I declare that as co-author I have approved the co-authored article, that my role in the study, as indicated in Annexure 5 is a representation of my actual contribution and that I hereby give consent that the article may be used as part of the PhD thesis of Ms Boitumelo Marilyn Patience Setlalentoa.

11. REFERENCES

AMERICAN PSYCHIATRIC ASSOCIATION. 2000. Diagnostic and Statistical Manual of Mental Disorders (4th ed.). Washington, D. C.: APA.

BALETA, A. 1998. South Africa takes steps to restrict smoking and alcohol consumption. *The Lancet*, 352: 9126.

BORGATTI, S. 2005. Social Support. UCINET 5 for Windows: software for social network analysis. Natick; MA: Analytic Technologies. http://www.analytictech.com/networks/socsup.html. Date of access: 22 Aug. 2007.

BOSLAUGH, S. 2007. Secondary Data Sources for Public Health: A Practical Guide (Practical guides to Biostatistics and Epidemiology). Excerpt. London: Cambridge University Press.

BUTCHART, A., KRUGER, J. & LEKOBA, R. 2000. Perceptions of injury causes and solutions in a Johannesburg township: implications for prevention. *Social Science & Medicine*, 50(3): 331-344.

COMPTON, B. R., GALAWAY, B. & COURNOYER, B. R. 2005. Social Work Processes, (7th ed). CA: Brooks/Cole.

CRESWELL, J. W. 2003. Research design: qualitative, quantitative, and mixed methods approaches, (2nd ed). Thousand Oaks, California: Sage Publications.

CRESWELL, J. W. 2007. Qualitative Inquiry & Research Design. California: Sage Publications.

CRESWELL, J. W. 2009. Research design: Qualitative, Quantitative, and Mixed Methods Approaches, (3rd ed). California: Sage.

CORDEN, A. & HIRST, M. 2008.Implementing a Mixed Methods Approach to Explore the Financial Implications of Death of a Life Partner. *Journal of Mixed Methods Research,* 2(3): 208-220.

DENSCOMBE, M. Communities in Practice: A Research Paradigm for the Mixed Methods Approach. *Journal of Mixed Methods Research*, 2 (3) 270- 283.

DE VOS, C. S. L. 2005. Combined quantitative and qualitative approach (*In* de Vos, A. S., Fouché, C. B., Delport, C. S. L. & Strydom, H. (3rd ed), Research at grass roots: for the Social Sciences and Human Services) Professions. Pretoria: Van Schaik Publishers, 357 – 366).

IVANKOVA, N. V., CRESWELL, J. W. & PLANO CLARK, V. L. 2007. Foundations and approaches to mixed methods research (*In* Maree, K. (ed). Creswell, J. W., Ebersöhn, *l.*, Eloff, R., Ferreira, N. V., Jansen, J. D., Nieuwenhuis, J., Pietersen, J., Plano Clark, V. L. & van der Westhuizen, C. First Steps in research. Pretoria: Van Schaik Academic, 254 – 282)

JERNIGAN, D. H., 2004. Alcohol in Developing Societies: A Public Health approach, Summary. Finland, World Health Organization.

JUKKALA, T., MÄKINEN, I.K., KISLITSYNA, O., FERLANDER, S. & VÅGERÖ, D. 2008. Economic strain, social relations, gender, and binge drinking in Moscow. *Social Science and Medicine*. 66: 663-674.

KLINGEMANN, H. 2001. Alcohol and its social consequences – the forgotten dimension. World Health Organization – Regional Office for Europe.

LEVESQUE, R. 2007. SPSS Programming and Data Management: A Guide for SPSS and SAS Users, (4th ed.), SPSS Inc., Chicago I11. www.spss.com/spss/SPSSdatamgmt_4e.pdf. Date of access: 13 September 2009.

MADU, S.N. & MATLA, M.P. 2003. Illicit drug use, cigarette smoking and alcohol drinking behaviour among a sample of high school adolescents in the Pietersburg area of the Northern Province, South Africa. *Journal of Adolescence*, 26 (1): 121-136.

MEDICINENET 2008 The alcohol and alcoholism glossary of terms- MedineNet.Inc. www.medicinenet.com/alcohol. Date of access: 1 September 2009.

MESSINA, J.J. & MESSINA, C.M. 1999-2007. The SEA's tools for recovery lifestyles – Social Support in recovery. http://www.coping.org/selfesteem/lifestyle/support.htm. Date of access: 22 Aug. 2007.

MOKDAD, A.H., BREWER, R.D., NAIMI, T. & WARNER, L. 2007. Binge drinking is a problem that cannot be ignored. *American Journal of Preventive Medicine,* 44 (4) 303-304.

MOROJELE, N.K., KACHIENG, M.A., MOKOKO, E., NKOKO, M.A, PARRY, C., NKOWANE, A.M., MOSHIA, K.M. & SAXENA, S. 2006. Alcohol use and sexual behaviour among risky drinkers and bar and shebeen patrons in Gauteng province, South Africa. *Social Science and Medicine*, 62 (1): 217-227.

NARABAYASHI, R. 2006. Family therapy in Japan- context and development. *International Congress Series*, 1287: 150-153.

NAIMI, T.S., BREWER, R.D., MILLER, J., OKORO, C. & MEHRTRA, C. 2007. What do Binge drinkers drink? Implications for alcohol control policy. *American Journal of Preventive Medicine,* 33 (3) 188-193.

NEUMAN, W. L. 2000. Social Research Methods: Qualitative and Quantitative Approaches. Boston: Allyn and Bacon.

NEW DICTIONARY OF SOCIAL WORK, 1995. Cape Town: CTP book Printers.

NIEUWENHUIS, J. 2007. Analysing qualitative data (*In* Maree, K. (ed). Creswell, J. W., Ebersöhn, I., Eloff, R., Ferreira, N. V., Jansen, J. D., Nieuwenhuis, J., Pietersen, J., Plano Clark, V. L. & van der Westhuizen, C. 2007. First Steps in research. Pretoria: Van Schaik Academic, 99 -117).

NORMAN, P., ARMITAGE, C.J. & QUICKLEY, C. 2007. The theory of planned behaviour and binge drinking: Assessing the impact of binge drinking prototypes. *Addictive Behaviors,* 32(9): 1753-1768.

PARRY, C. D. M. 2005. South Africa: alcohol today. *Addiction,* 100:426-429.

PARRY, C. D. H., PLŰDDEMAN, A., STEYN, K., BRADSHAW, B., NORMAN, R. & LAUBSHER, R. 2005. Alcohol use in South Africa: Findings from the first demographic and health survey. *Journal of Studies in Alcohol,* 66: 91-97.

PILLARI, V. & NEWSOME, Jr. M. 1998. Human behaviour in the Social Environment of families, Groups , Organizations and Communities. Pacific Grove: Brook/Cole Publishing.

PLANT, M. & PLANT, M. 2006. Binge Britain – Alcohol and National response. London: Oxford University Press.

POULIN, J. 2005. Strengths-based Generalist Practice: A Collaborative Approach. (2nd ed), Belmont, CA: Brooks/Cole Publishing.

ROCHA-SILVA, L. 1989. Attitudes towards drinking and drunkenness in the RSA. Pretoria: Institute of Sociological and Demographic Research, Human Sciences Research Council.

SOROCK, G.S., CHEN, L., GONZALGO, S.R. & BAKER, S. 2006. Alcohol-drinking history and fatal injury in older adults. *Alcohol*, 40 (3): 193-199.

SKWEYIYA, Z. 2007. Statement by the then Minister of Social Development, Dr Zola Skweyiya, Substance Abuse Media Briefing, Pretoria, 20 August 2007. http://www.dsd.gov.za. Date of access: 4 Oct. 2007.

SOUTH AFRICA. Department of Social Development, National Drug Master Plan (NDMP), 2006 - 2011.

SOUTH AFRICA. Liquor Act No 59 of 2003. Gazette No. 26294. Cape Town: Government Printers.

SOUTH AFRICA. Prevention of and Treatment for Substance abuse Act No 70 of 2008. Gazette No. 32150. Cape Town: Government Printers.

STRYDOM, H. 2005. Ethical aspects of research in the social sciences and human service professions (In de Vos, A. S., Fouché, C. B., Delport, C. S. L. & Strydom, H. 3rd *ed.*, Research at grass roots: for the Social Sciences and Human Services) Professions. Pretoria: Van Schaik Academic, 56 – 70).

SZMIGIN, I., GRIFFIN, C., MISTRAL, W., BENGRY-HOWELL, A., WEALE, L. & HACKLEY, C. 2007. Re-framing 'binge drinking' as calculated hedonism- Empirical evidence from the UK. *International Journal of Drug Policy,* 19:359-366.

TASHAKKORI, A. 2009. Are We There Yet? The State of the Mixed Methods Community. *Journal of Mixed Methods Research*, 3 (4):287 – 291.

TRACY, E. M. & WHITTAKER, J. K. 1990. The Social Network Map: Assessing Social support in clinical practice. *Families in Society: The Journal of Contemporary Human Services*, 8: 461- 470. Date of access: 10 September 2009

VORSTER, H. H., MARGETTS, B. M., VENTER, C. S. & WISSING, M. P. 2005. Integrated nutrition science: from theory to practice. *Public Health Nutrition*, 8 (6a), 760-765.

WECHSLER, H. & NELSON, T. F. 2001. Binge Drinking and the American College Student: What's five drinks. *Psychology of Addictive Behaviors,* 15(4):287-291.

WEYERS, M. L. 2001. The theory and Practice of Community Work: a South African Perspective. Potchefstroom: Keurkopie Publishers.

WHO see WORLD HEALTH ORGANIZATION

WORLD HEALTH ORGANIZATION, 2000. Global status report on alcohol. Geneva, Switzerland.

WORLD HEALTH ORGANIZATION. 2003. WHO definition of health. www.who.int/about/definition/en/print.html: Date of access: 19 August 2009.

WORLD HEALTH ORGANIZATION. 2004. Global status report on alcohol. Geneva, Switzerland.

CHAPTER 2

SOCIAL ASPECTS OF ALCOHOL ABUSE/MISUSE IN SOUTH AFRICA: AN AFROCENTRIC PERSPECTIVE

Article 1

BM Setlalentoa, PT Pisa, GN Thekisho, EH Ryke, DT Loots

BM Setlalentoa, MA (Soc Sc) Social Work, NG Thekisho, M (Soc Sc) Social Work
Department of Social Work, North-West University, Mafikeng Campus, Mmabatho, South Africa

PT Pisa, PhD

DT Loots, MSc, PhD

Centre of Excellence for Nutrition, North-West University, Division of Biochemistry, School of Physical and Chemical Sciences, Potchefstroom 2520, South Africa

EH Ryke, PhD

Department of Psychosocial Behavioural Sciences, North-West University, Potchefstroom Campus, South Africa.

Address correspondence and reprints requests to:

Pedro T Pisa
Centre of Excellence for Nutrition
Faculty of Health Sciences
North-West University
Potchefstroom campus
Potchefstroom 2520
South Africa
Tel +27 18299 2466, Fax +27 18 299 2464,
E-mail: vgeptp@nwu.ac.za//pedropisa2005@yahoo.com

ABSTRACT

Use of alcohol in Africa, particularly in South Africa, has a long history and is part of human life regardless of socio-economic background. Alcohol abuse has much

negative health, economic and social consequences. The objective of this review is to present in brief the history of alcohol use and the social and economic causes and consequences of alcohol abuse in South Africa. The harmful socio-economic effects of alcohol abuse in South Africa are discussed by emphasising that social and economic changes stemming from urbanisation account for new patterns of drinking among most Africans. Research has shown that socio-economic effects including unemployment, violence, crime, sexual risk behaviour, family disruption and work performance are associated with alcohol abuse. The South African legislation on alcohol is also incorporated to highlight the need to change or amend certain Acts in a bid to reduce alcohol abuse.

Keywords: Social aspects, Psychological aspects, Alcohol abuse/misuse, South Africa.

1. INTRODUCTION

Alcohol has played a major role in the lives of many South Africans. Besides having significant direct and indirect effects on health and nutrition, it also affects social and economic aspects of the South African community. Traditionally, in rural areas alcohol served many purposes. Not only was it used as a means of payment, and strengthening friendship, but beer was also associated with manhood and with the strengthening of the body.[1] Similarly in other African communities such as Kenya, alcohol was used to celebrate important occasions such as marriages and success in harvests. Drinking was moderated and subjected to certain guidelines as to when, how much, why and who should drink. Alcohol was mainly for domestic consumption.[2]

With the arrival of the European farmers (traders) in the 1800s there was a move by Africans to drink European liquor called "Cape Smoke". This was highly unacceptable to many farmers because they believed alcohol made Africans disobedient.[1] Apparently the disobedience was displayed when one was under the influence of liquor and would not take orders, absent oneself from work or even talk back, which was unacceptable. This led to many new laws in the 1900s which controlled drinking of mainly Africans. One of the controlling measures was the introduction of beer halls around 1908 which seemed to be based on the idea that it was wrong for the 'native' to have his beer hall.[1] Proliferation of illegal shebeens

during this time increased, ultimately leading to unmonitored drinking patterns and abuse. One could argue that the prohibitions resulted in Africans wanting more and finding ways of acquiring more of both home brewed and European liquor (brandy). These are some of the traces that led to the misuse of alcohol, for one would have to consume more because there was no guarantee that one would get a drink again.

African beer was fermented from locally grown food such as sorghum and maize. This kind of beverage took about four to fourteen days to brew. In some other parts of Sub-Sahara Africa the alcoholic beverages available were fermented honey water, fermented fruits and juices, fermented sap of various species of palm and beers. The brewing of alcohol had economic spin offs for women who sold it as a way of supplementing the meagre wages their husbands were earning. In order to meet the high demands, people tried different ways of brewing beer easily and quickly, often compromising quality. This is how "concoctions" started, most of which are brewed in less than a day.[3] It was a time during which South Africa as a country was entering an industrial age which accounted for a change in the traditional use of alcohol.

Also with the coming of Dutch Settlers and later the French Huguenots in the Cape as wine farmers from around 1652 onwards, African slaves mainly comprised the labour force. In addition to their salary, the labourers were given wine. This system became known as the 'tot' or 'dop' system.[1,4,5] Through this system heavy drinking became entrenched in the lives of workers, and their families for generations.[6] Alcohol was used by the colonizers as a mechanism to seize power – a form of political, economic and socio-cultural domination.[7] These were micro level practices that went unchecked. Since the problem is predominantly in the Western Cape the system has even managed to perpetuate racial stereotypes and inferences that the problem of over drinking is biologically determined and not socially constructed.[8] The 'dop' system was formally outlawed by the South African government in 1961 though its effects still linger. In more recent years it has taken a variety of forms, including that of a 'gift' or supplement to remuneration, or as alcohol provided on credit.[9] Currently, there are still traces of the earlier problems. People are exposed to misuse and abuse that could be traced to drinking patterns of the 1600s. Parry and Bennets[8] in their study among South Africans found significant consumption differences by population group and gender with intake higher in urban than rural areas, individuals with ages between 35-44 and 45-54 years consumed more and there seemed to be

a high rate of misuse over weekends. Similar trends were also observed in countries like Kenya.[10] This review forms part of a series of papers[11,12,13,14] which examine the role of alcohol in the South Africa society. A holistic, integrated approach is followed, focusing on the metabolism of alcohol,[11] the health consequences of consumption of alcoholic beverages[11,12,13,14] as well as the social aspects of alcoholic misuse/abuse, the major objective of this paper.

Because this review is limited to discussing the causes and consequences of alcohol abuse in South Africa from a social and economic perspective, a very brief summary of the relationships between alcohol abuse and malnutrition is given below to put this paper in context of the series.

From a nutritional point of view, alcohol abuse is a major cause of malnutrition. The reasons are threefold. Firstly, alcohol affects the mechanisms that regulate appetite and food intake, causing intake of food among alcohol abusers to decrease. Alcohol inhibits the breakdown of nutrients into usable molecules by decreasing the secretion of necessary digestive enzymes causing nutrient absorption to decrease. Additionally, alcohol damages the cells lining the stomach and intestines, further disturbing the digestive and absorption system.[15] Secondly, alcohol is rich in energy, but like many other pure sugars, most alcoholic beverages are empty of nutrients. Thus chronic alcohol ingestion causes primary malnutrition by displacing other dietary nutrients.[16,17] It is important to note that although ethanol is rich in energy, its chronic consumption does not produce a directly proportional gain in body weight. This may be attributed to damaged mitochondria and the resulting poor coupling of fat oxidation metabolically with energy production. [16,17] Thirdly, alcohol abuse is associated with gastrointestinal and liver complications, ultimately interfering with digestion, absorption, metabolism, and activation of nutrients and there by causing secondary malnutrition.[15,18] There is agreement that amongst populations in the Western world, moderate alcohol consumption is associated with better cardiovascular health and longevity.[19] Alcohol is a central nervous system depressant. It acts on many sites, including the reticular formation, spinal cord, cerebellum and cerebral cortex, and on many neurotransmitters. Increased turnover of norepinephrine and dopamine in the brain, are is responsible for the pleasure and relaxing sensation.[20]

The most common factors leading to alcohol abuse in South Africa are urbanisation, stressful jobs, affordability and cultural beliefs. These factors are discussed below.

2. MODERNISATION AND URBANISATION

Rapid social and economic changes stemming from urbanisation account for new patterns of drinking in most African settings. The emerging patterns are often not built upon traditional drinking behaviours where there was social control. Instead these are influenced by factors such as easy access to alcohol which has a higher ethanol content as well as rigorous advertising in the media, which disregard traditional constraints on when alcohol may be consumed by whom and where.[8] Jernigan *et al.*[21] explains a pattern where people used to drink until the "beer ran out," but this is being radically replaced by a pattern of drinking "until the money runs out". As Willis[22] asserts, alcohol consumption is highly commoditised, and is no longer restricted to adults or to certain restricted occasions.

The traditional culture of drinking which seemed to have been obtained and determined by 'proper' drinking patterns appears to be eroded and replaced by multiple drinking cultures which vary from one community to the other. Most of these drinking cultures openly challenge earlier ideas of temperance, age and gender restrictions. Migration has also contributed to this problem. Urbanisation appears to have impacted negatively on rural areas as some of the urban ways diffuse back to it. For instance traditional home brewed beverages known for their nutritional value have been replaced by deadly concoctions which pose a health hazard.[22]

3. STRESSFUL AND HIGH RISK JOBS

Although characteristics and properties endemic to occupations may shape workers alcohol use, explanations of alcohol abuse rarely take into account the impact of the occupational setting.[23] Roman[24] found that workers with mobility and task independence at work are more prone to alcoholism. While there are contradictory and inconclusive results concerning the direct effects of specific job and occupational characteristics on alcohol abuse by workers, researchers are unequivocal in their findings that negative work experiences often lead to problem drinking.[25] No field of occupation is exempted from the negative effects of alcohol abuse, yet the following are identified as some of the high risk and stressful jobs that predisposes workers to alcohol misuse: brewing and distilling industry, hoteliers and barmen/women, as well

as those in the armed services – the police in particular.[26] The alcohol industry happens to be a major source of employment.[8] Risk is caused by availability of alcohol, high levels of responsibility and performance anxiety, alertness, as well as stress. With the South African Police Service stressors range from violence that is endemic in the country, high crime levels, emotional strain caused by organisational transformation, lack of resources, bureaucracy and family responsibilities.[27] Risky drinking in these high risk and stressful jobs is mainly to cope with social pressure and as an escape from reality, a form of 'letting off steam'.

4. AVAILABILITY AND AFFORDABILITY

One of the causes of alcohol abuse and misuse is its availability in terms of location, time and affordability. In 1997 in South Africa there were about 22 900 licensed outlets, including liquor stores, restaurants, taverns and supermarkets compared to about 20 000 informal liquor sectors, such as shebeens, which are mostly unregulated and operate outside the confines of the law. After nearly a decade these outlets have multiplied.[8] The South African Liquor Act of 2003[28] regulates times of operations for liquor trading. However, more outlets such as supermarkets and taverns follow different times of trade. Some of the unregulated outlets operate depending on demand. The age restriction is known to be 18 years and this information is displayed in bottle stores and supermarkets, but there are no proper measures to ensure that this is adhered to. This makes alcohol easily and widely available and affordable to all races, genders, and ages – amidst restrictions.

5. CULTURAL BELIEFS

Traditionally it was not acceptable for native African women to drink alcohol. This view is supported by Mphi,[29] who asserts that women in Lesotho are not allowed to drink alcohol at all, despite the fact that many are brewers and traders of traditional beer. A woman who indulges in alcohol is subject to derision, condemnation and even divorce. In colonial Zimbabwe, male members even fought against what they termed "joint drinking", that is, women and men drinking together at the municipal beer halls.[30] The danger of such practices tends to subject women to private drinking that can produce public hazardous results. These inhibiting cultural practices are entrenched through socialisation in most South African communities. In the western culture such inhibitions appear to be absent. Both men and women from all socio-

economic backgrounds are allowed to enjoy their alcohol intake in public places.[8] The young African women tend to emulate this behaviour presumably because of the influence of urbanization and acculturation. Based on the findings of the Department of Health's South African Demographic and Health Survey (SADHS) conducted in 1998, the majority of risky weekend drinkers are African women (42.1%) and their age range is between 15-24 years (30,1%).[31] Morojele *et al.*[32] in their study on 'Alcohol use and sexual behaviour among risky drinkers in Gauteng Province, South Africa revealed gender differences in that men's drinking is traditionally and currently accepted as pleasure, recreational and sensation seeking. Their drinking is encouraged by their peers, and heavy drinking symbolises masculinity. Such behaviours perpetuate binge drinking.

6. CHILDREN LIVING ON THE STREET

Although it is widely recognized that drug and alcohol misuse is associated with homelessness, there is debate and speculation about whether problematic alcohol use is a cause or consequence of youth homelessness.[33] Homelessness and alcohol use have similar root causes, namely stress at home and school. Family conflict, violence and abuse are critical factors for both experiences. In a study conducted in Australia, a quarter of the sample under investigation indicated that familial drug and alcohol use was the critical factor that led them to leaving home.[34] Clearly a gap exists in our knowledge about the relationship between young people's alcohol use and their pathways into homelessness.

As pointed out by Maree,[35] children living on the street constitute one of the fastest growing problems in Africa. Children live on the streets due to varied reasons. Some would do so as an escape from reality or as a coping mechanism because of family disorganization, divorce, poverty, loneliness, boredom, unemployment and crime. South Africa is equally plagued by this problem where children leave home to live on the streets.[36] Curiosity, delinquency and peer pressure also play a role. Because they live on the streets far from their parents, they have no boundaries that guide their behaviour. This is how they start sniffing glue, smoke dagga and other drugs and use and misuse alcohol.

Based on these causes people tend to be affected psychologically and socially.

7. PSYCHOLOGICAL EFFECTS

Alcohol misuse and abuse could lead to negative effects such as depression, stress and anxiety. This could cause the individuals to increase their dosage in order to cope with their problematic situations, only to experience the same disillusionment when the effects wear off. People experience depression for various reasons. Bezuidenhout[37] states that some people may experience stress and anxiety because of alcohol abuse. It could be because of personal problems or failure to control their drinking. If not attended, he or she might commit suicide.[34] Findings of the research undertaken by the Medical Research Council shows that one in four of those who killed themselves in South Africa were over the blood alcohol limit of 0,05g/100ml.[38] Chronic stress caused by alcohol abuse was also found to be related to youth suicide.[39] Some adolescents become aware of the adverse effects of alcohol and try to stop taking it but more often than not, they fail to do so especially without professional help and resort to committing suicide.

8. SOCIAL EFFECTS

8.1 Unemployment

Alcohol abuse at the work place potentially lowers productivity. Sickness absence associated with abuse and dependence entails a substantial cost to employees and social security systems. Ample evidence has demonstrated an association between alcohol abuse and unemployment.[38] The causal association may go in either direction. Heavy drinking may lead to unemployment, but loss of work may also result in increased drinking.[40] South Africa is plagued by a high unemployment rate. The Statistics South Africa report in September 2006[41] indicated that 4 391 000 persons were unemployed, 12 815 000 were not economically active and 3 217 000 were discouraged work seekers (unemployed but had not taken steps to find work or start a business in the four weeks prior to the interview). Unemployed people may drink to escape reality and to cope with harsh situations they find themselves in. These views are supported by Ettner[42] whose results provided literature evidence that a recessionary environment or lay-offs resulting from harsh environmental regulation will increase alcohol abuse. Poverty as one of the end results of unemployment is high in South Africa. It is to be noted that communities living below the poverty datum line tend to spend the little bit of money they have on alcohol.[38]

8.2 Violence and crime

Alcohol abuse has been shown to be a significant risk factor for domestic violence, though the relationship is complex.[38] Drinking frequently has been additionally associated with intra-family violence. Evidence suggests a strong association between abuse and marital violence, but that violence rates vary based on research design, methodologies, and samples.[38] A study conducted in Nigeria showed a significant relationship between violence and alcohol use. Alcohol use was involved in 51% of the cases in which a husband stabbed a wife.[43] In a 1998, South African cross-sectional study of violence against women undertaken in three provinces, it was found that domestic violence was significantly positively correlated with the women drinking alcohol and conflict over the partner's drinking.[44]

It is stated that alcohol is present in offenders and victims in many violent events. The results of Phase 3 of the 3-metros (Cape Town, Durban, and Gauteng) in South Africa Arrestees Study conducted during August/September 2000 continue to show a high level of drug usage including alcohol use among arrestees. Over all sites, 50% or more of persons arrested for the following crimes tested positive for at least one drug: drug and alcohol offences (75%), housebreaking (66%), motor vehicle theft (59%) and rape (50%).[45] Exposure to violence and alcohol is identified as one of the developmental factors that contribute to violence. Withdrawal symptoms can develop to aggressive behaviour towards family members, friends or members of the community. One of those violent behaviours often results into sexual assault.[46,47]

8.3 Risky sexual behaviour

A study conducted by Morojele *et al.*[32] confirms that heavy alcohol consumption is a major health concern in South Africa and there is a link between alcohol consumption and risky sexual behaviour. The study also revealed that there were high levels of alcohol consumption and unprotected sex among some members of the communities who engaged in casual relationships. Alcohol use is prevalent in South Africa and alcohol use may be associated with higher risk for human immunodeficiency virus (HIV) transmission. Olley *et al.*[48] argued that some HIV-infected individuals, despite knowledge of their status, continue to practice unsafe sex which places them and their partners at considerable risk. A partner who is under the influence of alcohol could be at risk because of such practices. According

to the 2004 report by the Medical Research Council of South Africa, more than five million South Africans out of a total of 46 million were HIV infected.[49] Kalichman *et al.*[50] confirmed the association between alcohol use and HIV risk-related behaviour among 134 men and 92 women receiving sexually transmitted infection (STI) clinic services in Cape Town, South Africa. The study concluded that the association between alcohol use and sexual risk behaviours in a population at high-risk for HIV transmission demonstrates the need for integrating alcohol risk reduction counselling with HIV prevention counselling among STI clinic patients in South Africa.

The 2004 report by the Medical Research Council of South Africa further indicates that 37 000 children were infected with the HIV virus at or around birth (through vertical transmission) and 26 000 were infected through breast feeding. A quarter to a third of the vertically infected children died before they reached one year of age.[49] HIV/AIDS aggravates the already existing poverty especially when breadwinners lose their jobs because of ill health or death. In South Africa there were approximately 3.3 million orphans as of 2004. Almost two thirds of children living in child-headed households were 13 years of age. Poverty, ill health, teenage pregnancy, delinquency, alcohol and drug abuse is a common occurrence in such homes.[49]

8.4 Family disruption

The function of a family as a system is to provide shelter, as well as emotional, economic and psychological support. But when one member abuses alcohol, the family becomes destabilised or the balance is affected. Alcohol abuse tends to retard the efforts of a family to maintain its balance. Money that should be used for the family is misused in alcohol and this could contribute to violence and poverty. Relationships are affected because the perpetrator is under the influence of alcohol and is not able to give love and care. A 1998 cross-sectional study on violence against women was undertaken in three South African provinces. This study showed how domestic violence was significantly (positively) associated with women drinking alcohol and conflict over the partner's drinking.[38] Lack of parental control due to the fact that parents do not provide clear boundaries could lead to disarray in the family and alcohol abuse. It exposes children to anti-social behaviours since parents become negative role models.[36,37]

Excessive intake of alcohol could also lead to divorce affecting the partners who have to go through emotional traumatic experiences and adjustments which could be social, economic and sexual, as well as children who might experience difficulty in dealing with divorce. They could be confronted with social, psychological, educational and economic adjustment.[37] Abuse of alcohol also affects social networks. A network can provide supportive environmental help as well as instrumental help. It provides sources for human relationships, recognition, affirmation and emotional support.[51] Social networks such as kin, friends, neighbours, extended family, work mates and acquaintances are affected by divorce as well. The divorced are at risk of social and/or emotional isolation and stigma. Social isolation is loneliness as a result of a distance they do not choose, or when they are without a social network. This could worsen the problem of alcohol abuse.

8.5 Work performance

Any working environment has certain expectations from its employees. They have to be productive in order to realise profits. Those employees who abuse alcohol are not likely to perform well. Some of the problems identified are absenteeism, low production (inability to meet deadlines, inability to follow procedures) and proneness to job related accidents. This could lead to dismissal that would affect the person and his family.[8] More Employee Assistance Programmes should be introduced to deal with alcoholism that affects job performance. It was noted that enhanced production cannot be achieved if people have psycho-social problems because one cannot be separated from his/her environment.

9. THE ECONOMIC COST AND INJURIES

The annual economic cost of alcohol misuse in South Africa could range between 0.5% and 1.9% of the gross domestic product (GDP). This is utilising a middle-of-the-range estimate that considers costs associated with treatment, trauma, mortality and crime, which is about 1% of GDP. This translates to about R 8.7 billion per year, an amount almost twice exceeding the one received in excise duties on alcoholic beverages in the period 2000/01.[52] Motor vehicles crashes in the country also account for approximately 11 deaths per 100 million kilometres travelled. Traffic crashes that involve pedestrians account for about 40% of annual mortality on the

roads in South Africa. Alcohol abuse and poor roads are cited as the main contributory factors.[53]

10. LEGISLATION ON ALCOHOL

The Department of Social Development is South Africa's leading government institution in combating alcohol and drug abuse. The vision of a society free from the abuse of alcohol and other forms of drugs is the driving force behind the introduction of various policies in the country. Some of these include: the Liquor Act No 59 of 2003, which covers all relevant aspects including production, distribution, and consumption of alcohol; the Prevention and Treatment of Drug Dependency Act No 70 of 1992, which provides for the establishment of a Central Drug Authority, the development of programmes and the establishment and management of treatment centres. The revised National Drug Master Plan 2006-2011 spells out strategic objectives to guide service providers in the provision of relevant and appropriate services. The strategies outlined in the policy include prevention, early intervention, treatment, aftercare and reintegration. In addition, the policies also include community-based intervention, capacity building, management of treatment practices and information management. International collaboration forms an integral part of the policies as South Africa sees the need to join the global fight against alcohol and drug abuse.[52] Gaps in the implementation and monitoring of these policies have been evident. However, concerted effort by all remains the obvious route to victory over the scourge of alcohol misuse and abuse.

The taxation of liquor also serves as a restrictive measure. A word of caution from Parry and Bennets[8] is that the taxes are not to be so huge as to promote a possibility of smuggling alcohol from neighbouring states or drive consumers to unhygienic concoctions. In terms of cultural intervention, religion seems to contribute to abstinence. A typical example is of people who follow Islam teachings which forbid alcohol intake. Most Africans are also socialised to reserve drinking of alcohol for adults.

The Food Based Dietary Guidelines for South Africa was developed to help South Africans over the age of 5years to choose an adequate but prudent diet. Vorster *et al* (2001:S3) state that the guidelines are based on the existing consumption of locally available foods and aim to address identified nutrition –related public health

problems. One of the guidelines is that if one drinks, drink sensibly. They recommend that the guidelines should be regularly reviewed, based on the ir impact, changes in South African society due to socio-economic transition, and as new knowledge of nutrition-health relationships becomes available.

11. DISCUSSION AND CONCLUSION

Historically alcohol consumption contributed towards the strengthening of the socio-cultural fibre of African communities. Alcohol was regulated by social rules and used in moderation.[1] However, with time the pattern changed. The use of alcohol today poses a major threat to the quality of life of many South Africans, ultimately causing detrimental public health effects as well as negative socio-economic effects on the country. Alcohol abuse/misuse has become an everyday reality which directly or indirectly, impairs peoples' lives, not only individually, but also on a family, societal and national level.[8]

One of the most important public health and social issues facing South Africa is how to deal effectively and compassionately with persons and communities who are struggling due to alcohol abuse. Although significant achievements have been noted in the policy and legislative domain, the impact does not seem to match the extent of the disruption caused by alcohol abuse. There is an urgent need to re-address these policies and strategies to combat abuse. Moderate alcohol consumption has been shown to have significant health benefits[54] but, the disruption caused by alcohol abuse on different society levels, ranging from family breakdown to crime remains overwhelming. This presents policy-makers of South Africa with a dilemma whether to encourage moderate consumption of alcohol or promote total abstinence. The Food Based Dietary Guidelines for South Africa does not clearly stipulate to the population how much alcohol it should consume so as to retain these attributed health benefits. There are indications that the African population is increasingly being prone to alcohol dependency, due to abuse. It seems necessary to define moderate drinking in no uncertain terms.

Besides the current policies put in place to curb alcohol abuse, a systematic programme for monitoring and evaluating the impact of these policies should be established. Conclusively, there is need by policy makers to weigh the scientific findings that show health benefits due to light/moderate consumption of alcohol and

the destructive effects of abuse before championing the way forward for this population. After such an exercise, the Food Based Dietary Guideline concerning alcohol use for South Africans[55] might need to be revised.

12. REFERENCES

1. La Hausse P. Brewers, Beer halls and Boycotts. A History of liquor in South Africa. Johannesburg: Ravan Press, 1988: 2-12

2. Nielson MFJ, Resnick CA, Acuda SW. Alcoholism Among Outpatients of a Rural District General Hospital in Kenya. *Br J Addict* 1989; **84:** 1343-1351.

3. Adelekan M L. Substance use, HIV infection and the harm reduction approach in Sub-Saharan Africa. *Int J Drug Policy* 1998; **9:** 315-323.

4. D'Souza VP. These grapes aren't sour. *The New York Amsterdam News* 2003; November 27 – December 3: 2.

5. McKinstry J. Using the past to step forward Fetal Alcohol Syndrome in the Western Cape Province of South Africa. *Am J Psychol* 2005; **95(7):** 1097-1099.

6. May PA, Gossage JP, Brooke LE, Snell CL. et al. Maternal Risk Factors for Fetal Alcohol Syndrome in the Western Cape Province of South Africa: A Population-Based Study. *Am J Public Health* 2005; **95(7):** 1190-1199.

7. Schler L. Looking Through A Glass of Beer: Alcohol in the Cultural Spaces of Colonial Douala, 1910-1945. *Int J Afr Hist Stud* 2002; **35 (2-3):** 315-334.

8. Parry C, Bennets A. *Alcohol policy and public health in South Africa.* United Kingdom: Oxford University Press, 1998: 5:9:10:16:47:67:82:99:118.

9. London L. Alcohol consumption amongst South African farm workers: a challenge for post-apartheid health sector transformation. *Drug Alcohol Depend* 2000; **59(2):** 199-206.

10. Partanen J. Failures in alcohol policy: Lessons from Russia, Kenya, Truk and history. *Addiction* 1993; **88:** 129S-134S.

11. Pisa PT, Loots DT, Nienaber C. Alcohol metabolism and the health hazards associated with alcohol abuse in a South African Context: a narrative review. *S Afr J Clin Nutr* 2008: {Submitted}.

12. Pisa PT, Loots DT. The cardioprotective effect and putative mechanisms of light to moderate consumption of alcohol: a narrative review. *S Afr J Clin Nutr* 2008: {Submitted}.

13. Gopane RE, Pisa PT, Vorster HH, Kruger A, Margetts BM. Relationships of alcohol intake with biological health outcomes in an African population in transition: the Thusa study. *S Afr J Clin Nutr* 2008: {Submitted}.

14. Serfontein M, Venter C, Kruger A, MacIntyre U. Alcohol intake and micronutrient density in a population in transition: the THUSA study. *S Afr J Clin Nutr* 2008: {Submitted}.

15. Feinman L. Absorption and utilization of nutrients in alcoholism. *Alcohol Health & Res W* 1989; **13(3):** 207-210.

16. Gruchow HW, Sobocinski KA, Barboriak JJ, Scheller, J.G. Alcohol consumption, nutrient intake and relative body weight among U.S. adults. *Am J Clin Nutr* 1985; **42(2):** 289-295.

17. Colditz GA, Giovannucci E, Rimm EB, *et al*. Alcohol intake in relation to diet and obesity in women and men. *Am J Clin Nutr* 1991; **54(1):** 49-55.

18. Sato M, Lieber CS. Hepatic vitamin A depletion after chronic ethanol consumption in baboons and rats. *J Nutr* 1981; **111:** 2015-2023.

19. De Gaetano, G, Di Castelnuovo A, Donati MB, Iacoviello L. The Mediterranean lecture: wine and thrombosis-from epidemiology to physiology and back. *Pathophysiol Haemo T* 2003; **33(5/6):** 466-71.

20. Valenzuela CF. Alcohol and neurotransmitter interactions. *Alcohol Health Res W* 1997; **21(2):**144-147.

21. Jernigan DH, Monteiro M, Room R, Saxena S. Towards a global alcohol policy: alcohol, public health and the role of WHO. *Bulletin of the World Health Organization* 2000, **78(4):** 491-499.

22. Willis J. Drinking Crisis: Change and Continuity in Cultures of Drinking in Sub-Saharan Africa. *Afr J Drug Alcohol Stud* 2006; **5(1):** 1-15.

23. Trice HM, Roman PM. Spirits and demons at work: Alcohol and other drugs on the job, 2 nd ed. Ithaca, New York: Cornell University 1978.

24. Roman PM. Job characteristics and the identification of defiant drinking. *J Drug Issues* 1981; **Summer:** 357-364.

25. Ducharme LJ, Martin JK. Unrewarding work, coworker support, and job satisfaction. *Work Occupation* 2000; **27:** 223-243.

26. Rose-Innes O. Drugs don't Work at Work. *City Press* 2007; February 25:31.

27. Pienaar J, Rothmann S. Suicide ideation in the South African Police Service. *S Afr J Psychol* 2005; **35(1):** 58-72.

28. Republic of South Africa. *Liquor Act No. 59 of 2003.* Gazette No. 26294: South Africa Government Printers, 2004. 10-16.

29. Mphi M. Female alcoholism problems in Lesotho. *Addiction* 1994; **89:** 945-949.

30. West MO. Liquor and Libido: "Joint Drinking" And The Politics of Sexual Control in Colonial Zimbabwe, 1920s – 1950s. *J Soc His* 1997; **30(3)**: 645-667.

31. Department of Social Development. National Drug Master Plan 2006-2010. South Africa. Unpublished.

32. Morojele NK, Kachieng'a MA, Mokoko E, Nkoko MA, Parry CDH, Nkowane AM, Moshia KM, Saxena S. Alcohol use and sexual behaviour among risky drinkers and bar and shebeen patrons in Gauteng Province, South Africa. *Soc Sci Med* 2006; **62(1):** 217-227.

33. Pathways. Causes and consequences. *Parity* 2001; **14(8):** 27-29.

34. Mallet S, Rosenthal D, Keys D. Young people, drug use and family conflict: Pathways into homelessness. *J Adolescence* 2005; **28:** 185-199.

35. Maree A. Criminogenic Risk Factors For Youth Offenders. In: Bezuidenhout C, Jourbert S, eds. *Child and Youth Misbehaviour in South Africa A holistic view.* 1st ed. Pretoria: Van Schaik, 2003: 43-63.

36. Strijdom JL. A drug policy and Strategy for Namibia. DPhil thesis, University of Bophuthatswana, 1992. 30.

37. Bezuidenhout FJ. Substance abuse and addiction: drugs and alcohol. In: Bezuidenhout FJ, ed. *A Reader on Selected Social Issues.* 3rd ed. Pretoria: Van Schaik, 2004: 127-128.

38. World Health Organization. *Global Status Report on Alcohol.* Department of Mental Health and Substance Abuse. Geneva: WHO, 2004.

39. Bezuidenhout FJ. Divorce. In: Bezuidenhout FJ, ed. *A Reader on Selected Social Issues.* 3rd ed. Pretoria: Van Schaik, 2004:13 -30.

40. Gallant DM. Unemployment and alcohol consumption. *Alcohol Clin Exp Res* 1993; **17(3):** 722-3.

41. Statistics South Africa. Labour force survey P0210, 9, 2006. http://www.statssa.gov.za (accessed 14 April 2007).

42. Ettner SL. Measuring the Human Cost of a Weak Economy: Does unemployment lead to alcohol abuse? *Soc Sci Med* 1997; **44(2):** 251-260.

43. Obot IS. The measurement of drinking patterns and alcohol consumption in Nigeria. 2000. *J Subst Abuse* 2000; **12(1-2):** 169-181.

44. Jewkes R, Levin J, Penn-Kekana L. Risks factors for domestic violence. Findings from a South African cross sectional study. *Soc Sci Med* 2002; **55(9):**1603-1617.

45. Parry CDH, Louw A, Plüddemann A. *Drugs & Crime in South Africa The MRC/ISS 3- Metros Arrestee Study (Phase 3).* Medical Research Council: Institute for Security Studies, 2004.

46. Boles SM, Miotto K. Substance abuse and violence a review of the literature. *Aggress Violent Be* 2003; **8:** 155-174.

47. Rasool S, Vermaak K, Pharaoh R. Louw A, Stavrou A. *Violence against Women A National Survey.* Pretoria: Institute for Social Security Studies, 2002: 42-43.

48. Olley BO, Seedat S, Gxamza F, Reuter H, Stein OJ. Determinants of unprotected sex among HIV-positive patients in South Africa. *AIDS Care* 2005; **17(1):** 1-9.

49. Jacobs M, Shung-King M, Smith C. eds. *South African Child Gauge* 2005. University of Cape Town: Children's Institute, 2005: 22.

50. Kalichman SC, Simbayi LC, Cain D, Jooste S. Alcohol expectancies and risky drinking among men and women at high-risk for HIV infection in Cape Town South Africa. *Addict Behav* 2007; **32(10):** 2304-2310.

51. Germain CB. Social Work Practice in Health Care: An ecological perspective. New York: Columbia University Press. 1980: 145.

52. Department of Social development. Policy on the Management of Substance Abuse. Approved by MINMEC, March 2007: 1-2. Unpublished.

53. Brysiewicz P. Trauma in South Africa. *Int J Trauma Nurs* 2001; **7(4):** 129-132.

54. Agarwal DP. Cardioprotective effects of light –moderate consumption of alcohol: a review of putative mechanisms. *Alcohol Alcohol* 2002; **37(5):** 409-415.

56. Van Heerden IV, Parry CDH. If you drink alcohol, drink sensibly. *S Afr J Clin Nutr* 2001; **14(3):**S71-S77.

57. Vorster, H. H., Love, P. & Browne, C. Development of Food-Based Dietary Guidelines for South Africa – The Process. *S Afr J Clin Nutr* 2001; **14(3)**: S3-S6.

CHAPTER 3

Article 2

SOCIAL SUPPORT NETWORKS IN RELATION TO BINGE DRINKING FROM VARIOUS THEORETICAL PERSPECTIVES

B.M.P. Setlalentoa – PhD student - School of Psychosocial Behavioural Sciences (Social Work), North-West University, Potchefstroom Campus

E.H. Ryke – Senior Lecturer – School of Psychosocial Behavioural Sciences (Social Work), North-West University, Potchefstroom Campus

H. Strydom – Professor – School of Psychosocial Behavioural Sciences (Social Work), North-West University, Potchefstroom Campus

ABSTRACT

The objective of this article is to conceptualise social support networks in relation to binge drinking from various theoretical perspectives. In order to gain an understanding, it was necessary to examine social support and social support networks, specifically informal and formal support networks that are likely to be affected by the problem of binge drinking. The value of social support networks is highlighted to demonstrate how they contribute to growth and development of the network and its members. Social support network analysis is explained to demonstrate the ecological world with emphasis on interrelatedness and interdependence. Attention was given to themes that describe social support such as type of support, recipient perception, reciprocal support and behaviour of providers. The eco-systems perspective is used as a base to justify the argument that people and environments are inseparable. Because of this close link, any problem that affects one system, also affects others in the social environment. An assumption is made that binge drinking or risky drinking affect drinkers to an extend where they are unable to cope with work, family and other roles, and causes harm to those in the drinker's social support network. Role theory is discussed to substantiate the argument that performance of roles could be affected by alcohol abuse that could ultimately lead to suffering of social networks. Social constructivism as a post-modern perspective is discussed to demonstrate that perceptions about alcohol consumption are socially constructed and these views

could contribute to alcohol abuse. A conclusion is drawn that provision of social support such as emotional, material, instrumental and informational support is important for the optimal functioning of social support networks and binge drinking could inhibit provision of such support and lead to social dysfunctioning.

Keywords: Binge drinking; Social support; Social support networks; Social support analysis

1. INTRODUCTION

The misuse or abuse of alcohol is one of the social and health problems faced by many countries. According to the World Health Organization (WHO) (2000) alcohol consumption is the fifth leading cause of death worldwide and intakes are increasing, especially in developing countries. Different alcohol consumption patterns have been noticed such as binge drinking and it causes many problems. Mokdad *et al.* (2007: 303) and Norman *et al.* (2007:1753) support this view that binge drinking is associated with myriad health and social problems and negative consequences, including unintentional injuries, interpersonal violence, alcohol poisoning, sexually transmitted diseases, unintended pregnancy and sudden infant death syndrome. South Africa is no exception and the concern about alcohol abuse has been highlighted by many authors and politicians. For instance, the former Minister of Social Development Dr Z. Skweyiya in his media statement on Substance abuse (2005) states that the high rate of binge drinking is a cause for concern given the significant association between alcohol abuse and academic failure, binge drinking and high-risk sexual behaviour. The consumption of a large amount of alcohol places the drinker and social support networks at increased risk of experiencing alcohol-related problems.

2. PROBLEM STATEMENT

Alcohol has played a major role in the lives of many South Africans, causing family disruption and a host of individual and societal problems (Parry *et al.*, 2005:91). Alcohol abuse results in negative health, social and economic consequences that are harmful consequences for the individual drinker, his or her immediate environment and society as a whole. Alcohol abuse impairs the individual's functioning in various social roles, as a father, mother, spouse, community member,

or employee. Members who are part of one's social support network are placed at increased risk of experiencing various detrimental effects.

The social consequences affect individuals other than the drinker, for example, passengers in an accident caused by a driver under the influence of alcohol, family members affected by failure to fulfil social role obligations or incidences of violence in the family that could lead to premature death. A parent or spouse can spend time with drinking networks rather than with the family. Alcohol abuse also costs money and can impact upon resources particularly of a poor family because needs are not met. The family could also experience mental health problems due to problems experienced because of alcohol abuse (WHO, 2004:59-60). The economic consequences could be linked to low productivity, absenteeism, an increased need for resources for social security and health care and job loss. For instance, heavy drinking could lead to loss of job and being unemployed may result in increased drinking which may lead to a serious drinking problem. Having considered the social causes and consequences of alcohol abuse in Chapter 2, it is necessary to understand the conceptual and theoretical perspectives that underpin the focus of the study.

It is against this background that a literature review on social support, social support networks and social network analysis is done to understand the concepts and how they relate to binge drinking. It would assist in determining how the social support networks are affected by binge drinking. The eco-systems' perspective is used to elucidate the interconnectedness and interrelatedness of binge drinkers and their social support networks. Role theory clarifies the importance of role performance and how role obligations contribute to balance of a systems and how failure to perform roles destabilises a system or network. It is also imperative to consider how socially constructed views could contribute to abuse of alcohol and in turn affect social networks. The research question guiding this article is based on what is the meaning of the concepts, social support, social support networks and social network analysis in relation to binge drinking. It also describes the theoretical perspectives that support the argument that social support networks are negatively affected by binge drinking are discussed.

3. OBJECTIVE

The objective of this article is to do a literature overview to understand social support, social support networks and social network analysis in relation to binge drinking from a conceptual and theoretical framework.

4. UNPACKING THE CONCEPTS SOCIAL SUPPORT, SOCIAL SUPPORT NETWORKS AND SOCIAL NETWORK ANALYSIS

In this section the concepts binge drinking, social support, social support networks and social network analysis are analysed and explained in the context of the social and economic effects of binge drinking.

4.1 Binge drinking

Binge drinking is defined by (Mokdad, *et al.,* 2007:303; Naimi *et al.,* 2007:188; Plant & Plant, 2006:ix; Szmigin, *et al.,* 2007:2; Wechsler & Nelson, 2001:287) as excessive, immoderate, or heavy drinking in a single drinking session, over a short period and within a number of days or weeks.

4.2 Social support

Compton *et al.* (2005:256), and Seed (1990:30), define social support using different terminology but focusing on common characteristics such as a positive interaction or helpful behaviour provided to a person in need of support or entitled to it. This has a connotation that social support is a general and directly beneficial quality of relationships. Tracy and Whittaker (1990: 462) refer to social support as many different ways in which people render assistance to one another.

According to Veiel and Baumann (1992:2) social support is defined as an abstract characteristic of persons, behaviours, relationships or social systems. Social support can represent a characteristic of the recipient, of his environment or of a social system including both the recipient and the environment. The environment could represent different social networks like family, friends, kin, work or the community. This is supported by Seed (1990:37) who emphasises that network features refer to the specifics of an individual network, that is, people, places and activities that take place in ones' environment.

As an individual characteristic it is the individual who influences the size and composition of the social network and hence, its capacity to provide support, who seeks support, who does or does not accept it, who evaluates it and who integrates this evaluation into a relatively enduring and encompassing cognitive-emotional representation of the social world (Veiel and Baumann, 1992:4). As a characteristic of the social environment social support may denote behaviour regarded as supportive because of its obvious helping or comforting nature. It could be defined as supportive because of the subjective convictions of being loved or esteemed. Social support may refer to a particular attitude of members of the social network, whether expressed in specific behaviours, nonverbal clues or otherwise. This is viewed as their subjective reality which has meaning for recipients.

Social support is viewed as support accessible to an individual through social ties, which are networks, to other individuals. Hupcey (1998:1232) refers to Vaux's argument that social support encompasses social networks, perceived support and supportive behaviours. This view supports the fact that people are interrelated and interdependent and therefore, are inseparable and have expectation from one another. If one person is affected, others get affected as well. These ties determine the type and exchange of support between the role players. One could make an assumption that excessive drinking could cause an imbalance in any system or network because of the interrelatedness and interdependence of the sub-systems. Failure to perform roles and expectations that others have about support they should get from others could have negative effects for the systems or sub-systems.

According to Barker (2003:357) social support includes "formal and informal activities and relationships that provide for the needs of humans in their efforts to live in society. These needs include a network of other individuals and groups who offer encouragement, access, role models and social identity". Social support therefore is expected from others, provided by role players for significant others who are part of the social environment. It is provided to satisfy needs with a view to enhance social functioning.

Having examined the theoretical definitions of social support, four themes as identified by (Hupcey, 1998:1232), are used to further unpack the definition of social support. These themes are *types of support provided*, *recipient perception*,

reciprocal support and *intentions or behaviours of the provider of support.* A discussion of these four themes follows.

4.2.1 Types of support

The types of support could be resources or material help in terms of money or food which is mainly beneficial for survival or is matched with the need provided at the appropriate time and for the proper length of time. It could be determined by the role played by the provider, for example, parents providing for children who are dependent on them.

Collins *et al.* (in Reis and Rusbult, 2004:36) describe four broad types of support, namely, emotional support, (expressions of caring, esteem, concern, caring, love and trust by family and friends), informational support (advice, suggestions or guidance that assist a person to respond to personal or situational demands), instrumental support (tangible goods such as money or assistance with tasks and other explicit interventions on the person's behalf) and appraisal support which involves transmission of information in the form of affirmation, feedback and social comparison and is often evaluative.

One would have an expectation to receive some kind of support from others and also provide it to others. The type of support that is provided and/or expected is also determined by a member's role and status in the network. These types of support are expected by members of the networks and failure to receive it can affect others negatively. Because of the nature of relationships that demands support, be it emotional or material, any negative or positive deeds have a bearing on the support networks.

The social networks are therefore critical to provide the different types of support that are needed by others in the social environment. Survival of systems or networks depends on provision of all types of support.

4.2.2 Recipient perception

In defining social support a distinction can be made between the quality of support perceived and provided. The recipients' positive perception of the support provided, information and feedback would maximise positive effects. The individual needs to

believe that his or her needs are fulfilled. Social support is the extent to which an individual believes that his/her needs for support, information and feedback are fulfilled. The support expected and provided should match; otherwise it will serve no purpose as the need would remain unsatisfied.

Hupcey (1998:1234) is of the view that not all social support is perceived as positive. The provider may provide support that is intended to be positive but may be perceived negatively by the recipient. The recipient may perceive support as negative if there is interpersonal conflict that makes the recipient not to accept the support provided. If a person who is a provider is abusing alcohol, even if he/she provides support, it may be viewed negatively because of the effect alcohol abuse has on the interpersonal relationships.

There are varied reasons for providing support. One important reason is that it is a social obligation or role because of the status one holds. Hupcey (1998:1233) states that in terms of social obligation, an individual may feel required to provide support. If it is not provided willingly the recipient may not feel positively about the support received.

It is deduced that the type of support provided should satisfy the recipient because it is congruent with the requirements or needs of the situation. Providers need to be responsive to the changing needs as well. It is acknowledged that perceptions are subjective, but are influential in determining the satisfaction about support given.

4.2.3 Reciprocal support

Reciprocal support is an exchange of resources between recipient and provider (Hupcey, 1998:1232). The actual giving, receiving and exchange of support is commonly referred to as the function of social support. The support that is not reciprocated may be considered negative support. A person could perceive that he/she is providing more support than he/she receives. It becomes a problem if there is a non-reciprocal network because one could feel unappreciated. The person could also receive more support than what he/she provides. For example, a father who fails to support the family but expects them to provide for him. It could be a demand for respect from family members; food to be prepared yet fails to buy it because he spends money on alcohol or he is an absent father, always with his drinking networks.

Collins *et al.* (in Reis and Rusbult, 2004:36) agree that social support involves the exchange of social resources between individuals. They further argue that the definition of social support emphasise interpersonal exchange of resources which also relate to whether people have received from others and also whether it is available. The two aspects of social support, that is, its availability and receipt, are likely to be important in understanding the various ways in which social relationships may influence health and well-being. Gottlieb (in Braude and Francisco-La Grange, 1993:15) states that a person's well-being depends largely on the amount and quality of supportive provisions received from his or her network, be it emotional or material. Hupcey (1998:1232) cites Cobb by stating that social support is information leading a person to believe that he/she is cared for and loved, esteemed and valued and that he/she belongs to a network of communication and mutual obligation. The assumption is that if a person receives social support, his well-being will be enhanced. The person who abuses alcohol may not be in a position to provide the needed support even if others support him in one way or the other. The view is supported by Tracy and Whittaker (1990:462) that not all networks are socially supportive, nor do they always reinforce positive social relationships.

4.2.4 Intentions or behaviours of the provider of support

Hupcey (1998:1234) states that the intentions or behaviours of the provider of support determine the satisfaction or dissatisfaction, or survival, functioning or dysfunctioning of a system. The provider would provide social support not as an obligation but with an understanding that it is his/her responsibility. In that case it will be properly received and appreciated. If the behaviour of the person who is supposed to provide is not acceptable, it might not be appreciated. Of importance, is that the behaviour of the provider contributes to the normal functioning of a system.

In a nutshell, the categories of social support as outlined by Hupcey (1998:1232) namely, type of support, recipient's perception, reciprocal support, and intentions or behaviours of the provider of support are used to understand the support provided and received. The type of support whether it is material, emotional or social, that one gets from the network could enhance cohesion and improve and maintain quality of relationships because support networks will be satisfied now that their needs are met. Recipient's perception of the provided support is also critical, it is indicative of

concern and commitment in the family or any system clearly showing the intention or behaviour of the provider to provide the resources needed. Support between the recipient and the provider should be reciprocal. That would also encourage expressiveness about needs; wishes or feelings and this kind of environment would reduce conflict in a system.

Parents who abuse alcohol are often unable to provide their children with adequate care and support. Abuse of alcohol contributes to them spending time away from home when visiting drinking venues. Their role as parents is affected by alcohol abuse in many ways. Children are more likely to suffer from physical, mental or emotional problems because of lack of social support.

It is within this context that the study attempts to understand how binge drinking affects support networks. The critical questions asked during data collection in the empirical part of the study, are based on these categories (see Chapter 5).

4.3 Social support networks/ systems

While *social support* describes specific functions of a network *social network* describe the structure of the social relationships and quantity of a set of interconnected relationships (Tracy & Whittaker, 1990:462; Veiel & Baumann, 1992:36). It is defined as a unit of social structure that represents people's patterns of living, includes all of an individual's social contacts and ties, or individual's interaction with other persons and their relationships and connections (Bopape, 1993: 8; Seed, 1990:30; Veiel & Baumann,1992:34). Bopape (1993:8) further states that in the course of normal human growth and development, people's network changes, expands, and contracts according to their changing physical, social and emotional needs.

According to Tracy and Whittaker (1990:462) a social network is a set of relationships that provide nurturance and reinforcement for coping with life on a daily basis. It is a complex and multi-dimensional construct, consisting of social network resources, types of supportive exchanges, perceptions of support availability, and skills in accessing and maintaining supportive relationships. They further acknowledge that not all networks are socially supportive, nor do they always reinforce positive social behaviours. It could be attributed to many negative deeds such as failure to perform roles because of alcohol abuse. There is an assumption

then that personal contacts have a particular role to play in ones life. There are different expectations by role players be it emotional, material or any other type of support. This view is expressed by Bopape (1993:6) that social support is a feeling and attitude, as well as an act of concern and compassion that one expects or is provided by, or exchanged with friends, good neighbours and relatives. When these link together for the purpose of helping, they form a social support network.

Veiel and Baumann (1992:36) argue that to define a person's support network, one must examine a person's potential or actual supporters. These are also defined as "network resources" which are the part of a social network to which the person routinely turns to or would turn to for support and help. They further cite Moos (1984) who refers to a supportive climate or environment as the quality of social relationships and systems: the family, the working place, or groups (such as drinking networks) and these are often defined by a high degree of interpersonal *cohesion*, *involvement*, *expressiveness* and a low degree of *conflict*. *Cohesion* means the degree of mutual help and support in that system. One could relate this to a family of a binge drinker to determine the help and support he gives or fails to give because of misuse of alcohol. *Involvement* characterises the degree of concern and commitment in the system. It goes with how one perceives his family and show concern by putting them first before binge drinking. *Expressiveness* refers to the degree of mutual encouragement for an open expression of wishes, feelings, and needs. Family members or friends could express their wish on how the relationships should be or their needs that have to be provided by an actor of a particular role. *Conflict* means the degree of stressful interactions and aggressive arguments. A balanced family or organisations where members are involved and free to express their views, has a greater chance of being cohesive.

These definitions and explanations indicate that networks are structured, are connections of individuals linked to their society primarily through relations with other individuals: (with kin, friends, and co-workers) and provide support in one way or the other. Social support is provided by two different types of social support networks, which are formal and informal. The quality of the social support can be evaluated in terms of the degree of cohesion, involvement, expressiveness and conflict in the system. The study focuses on the family as the primary system but also refers to the role played by formal systems.

4.3.1 Family system as a social support network

In order to understand the type of support provided, how it is perceived, behaviour of provider and whether there is an exchange of resources, it is important to analyse the family as a system.

Traditionally a family is seen as a long-term, legal and social relationship that meets physical, emotional and economic needs of its members. Pillari and Newsome (1998:35) identified a family as made up of subsystems being members who can be divided into siblings and parental subsystem/s. It should be noted that structures of families are also different such as single parent families. However, there are implicit and explicit rules that govern roles, power and authority. The family would also provide information about different forms or channels of communication and these are useful for network analysis. According to Maguire (1991:98) a healthy family structure meets the new and developing needs of infants and children, provides feedback and responds appropriately to their needs. The family also serves as protection against forces in the environment. This could be classified as type of support that the child needs and should be provided with. It is through a family that a child learns to learn. It is within a family system that one first learns how to make linkages, connections or bonds with others. Successful bonding based on open and accurate communication leads to strong social support systems. Of importance is that the capacity to develop these systems in later life is invariably begun in the family system.

Children also model their parents' behaviour and learn how to develop social support systems and relationships by imitating or reacting to parental behaviour. Parents who are actively engaged with other adults in appropriate community, social cultural or religious activities model the same healthy interactions for their children. The family provides socialisation for children. Families are responsible for identification that shapes values, attitudes and social skills. It is also important to note that an individual is a product of his or her family because of socialisation, and that family and its dynamics is a product of the community, culture and society in which it is based (Maguire, 1991:99).

The issue is whether a person who misuse alcohol or engage in heavy episodic drinking would be available to provide this guidance or bonding to a developing child.

The drinking affects the balance or homeostasis of the family system, as well as the growth and healthy development of subsystems. Parental drinking is correlated with child abuse and impacts a child's environment in many social, psychological and economic ways (Gmel & Rehm in WHO, 2004:60). As system theory explains that a system is a whole with interrelated and interdependent parts. For instance, if a binge drinker loses his/her job, or die in an accident children and spouse are affected.

The families would also adopt patterns of coping because of their needs and exposure to some behaviours. Children of binge drinkers would be forced to choose between parents because of the negative behaviours displayed by the drinker or a bad financial situation they are in. They would develop coping skills that exclude the drinker. Maguire (1991:102) says children feel that they must choose between parents especially if one is abusing alcohol and not able to provide emotional, material or instrumental support, and indeed, when the parents are polarised the children often are forced to make that choice. The spouses also suffer because of the partner who is a binge drinker. Failure to provide any form of support could affect the spouse negatively and the consequences could be detrimental for individuals involved and the system as well. The situation is worsened when both parents abuse alcohol. Children become more exposed to child abuse and neglect.

The spouses are affected by binge drinking in many ways like lack of emotional, material or instrumental support from spouses. This could lead to depression, anger, anxiety or divorce. At times spouses, and other family members (social support networks) have to attend Al-anon group sessions to deal with the negative effects of alcohol that are caused by their partners or parents who abuse alcohol. The WHO (2004:61) states that the effects of men's drinking on spouses has risks such as violence, HIV infection and an increased burden in their role of economic providers.

The family system is affected by the degree of support or lack of it in the neighbourhood, or work environment. The negative behaviour displayed by drinkers does affect them as individuals and their families as well.

4.3.2 Workplaces and organisations as social support networks

Many organisations have introduced Employee Assistance Programmes (EAP) or Employee Assistance Support (EAS) as social support vehicle to help employed individuals and families who struggle with drug and alcohol misuse, family problems,

domestic violence and emotional problems. Prevention programmes are put in place to avoid these problems before they manifest into serious problems that could be detrimental to employees and their families. These companies or organisations are also focusing on return of investment because a healthy workforce would assist in that regard. Some of the benefits are improved productivity, increased morale, reduced on the job accidents and injuries, and retention of staff.

Many organisations established the EAP as part of their social responsibility or social capital. Social capital describes the particular features of social relationships within a group or community and it is an important resource for supporting communities to take action on issues of concern to them and can contribute to social and economic growth (Victorian Health Promotion Foundation Research, 2005:1). The organisations take the responsibility to care of workers, their families and their communities as well. This view is emphasised by Ott (2008:2) that family support is growing attention across a wide range of organisations. She further cites Mitchell and Everly that it is necessary to support the entire environment in which a person operates, including the person's family. Donovan (2007:1) supports this view in her article on coaching- creating a work environment full of support, encouragement and truth that employees should be helped to become aware of their blind spots. It is an indication that social support is provided for care, nurturance and improved quality of life. The Victorian Health Promotion Foundation Research (2005:6) indicates that higher social capital may protect individuals from social isolation, create social safety, lower crime levels, improve schooling and education, enhance community life and improve work outcomes. It is for these reasons that work environment is regarded as a social support network.

The government and non-profit organisations also provide services to communities. Attention is given in developing programmes or projects that support growth and development of these communities. Maguire (1983:13) refers to community support networks as those that provide support or services within a particular community neighbourhood for helping residents to meet their own social-emotional needs, as well as general welfare concerns. Community support systems consist of resources within any given community that can be potentially tapped by individuals in meeting their needs. It could be an alcohol rehabilitation centre or a welfare organisation that provide services to a particular community.

4.3.3 The value of support networks

Maguire (1991:xv) is of the view that social support provides five resources, namely, a sense of self, encouragement and positive feedback, protection against stress, knowledge, skills and resources and socialisation opportunities. Support systems play a critical role in maintaining the psychological integrity of the individual over time. This view is supported by the study on adolescent peer networks as a context for social and emotional support that was undertaken by Staton-Salazar *et al.* (2005: 379) in California using a combination of qualitative and quantitative methodologies, in which participating adolescents found in their friends the support necessary to withstand emotionally challenging circumstances and to cope in effective ways.

Borgatti (2005a:2) is of the view that social support networks provide social and economic support at varying degrees. This view is echoed by Strathdee (2005:1) when he states that social networks are used to assist young people by facilitating transition into work. He argues that the presence of familial and community-based social networks, are deeply rooted in the social infrastructure and prepared the young people for integration in the labour market. Familial networks also play an important role in transmitting skills between generations. This supports the view that networks contribute to development of its members.

Compton *et al.* (2005:267) identify the benefits of informal support as physical and psychological well-being, satisfying of social and emotional needs, socialisation, recreation, protection against loneliness and isolation, and as a buffer against stress and hardships. It also promotes mental health which refers to one's perception of the quality of one's life and functioning or role performance relative to one's capabilities. According to Maguire (1991: 98) the foundation for mental health is invariably laid in the family. Social support networks enhance personal well-being, life satisfaction and quality of life and it also contributes to individual feelings of self-esteem, connectedness or belonging. The significance of social support is that it has protective or buffering effect on an individual's health or mental health. Social support may also reduce delinquency by providing a conducive environment in which children feel supported and loved. The essential element of a family is respect for the needs of all members. The Victorian Health Promotion Foundation (2005:2) make reference to a study of 2000 people in Finland found that social support

strengthened mental health in all respondents. Kawachi and Berkman (2001:458) are also of the view that social networks and social ties have a beneficial effect on mental health outcomes, including stress reactions, psychological wellbeing.

Fu *et al.* (2007:285) undertook a study on the relationship between culture, attitude, social networks and quality of life in mid life Australian and Taiwanese citizens. The results have shown that there is a significant relationship. The research found that good social support networks and a healthy optimistic disposition may significantly enhance men and women's quality of life. They further state that social networks can be defined as the subjective feeling of belonging, of being accepted, loved, wanted, esteemed, valued and needed for oneself (Fu *et al.*, 2007:286). On the other hand a study by Litt and Mallon (2003: 3) has shown that social network that reinforces drug use leads to more drug use and networks that reinforce being clean and sober yield greater drug abstinence. These networks play an important role in the lives of people. Litt and Mallon further refer to a study by Gordon and Zrull (1991) indicating social network data on 156 alcoholics that active support of non-drinking friends and co-workers was the most influential factor in recovery. Most predictive of poor outcomes was encouragement of drinking by co-workers, some of whom were co-drinkers.

Cunningham *et al.* (2008:193) in their study of an online support group for problem drinkers undertaken in Canada have identified that social support networks can help people resolve their problem drinking. Groh *et al.* (2008: 430) support this view in their study of social network variables in alcoholics anonymous: a literature review. They reviewed 24 papers to examine the relationship between AA and social network variables. They considered various types of support, namely, structural, functional, general and alcohol-specific support and recovery helping. The review found that AA involvement is related to a variety of positive qualitative and quantitative changes in social support networks. Of relevance from this study is the fact that social support networks play a major role in the life of the drinker and vice versa.

The importance of social support networks is also demonstrated by Olagnero *et al.* (2005: 53) in their study of social support networks in impoverished European neighbourhoods. Of significance in this study is that social support networks are reinforced or further weakened by factors such as economic hardship,

unemployment and neighbourhood dereliction. The significance of support networks is highlighted by Gass *et al.* (2007:501) in their study of defining social support systems for women with breast cancer. Their view is that cancer being a life-altering event with pervasive effects impact the patient, her spouse, children, extended family and entire social structure. Respondents were asked to describe what primary support meant for them, 52% characterised it as emotional and 23% defined it as a combination of roles, usually emotional and structural in nature. Less than 10% defined primary support as purely structural or informational in nature. The point is that social support networks have a role to play and in return are affected by situations, negative or positive, that others are exposed to. Binge drinking fit in this scenario because of its negative effects on the networks that have expectations in terms of provision of material aid, emotional support, socialisation or even information giving.

It is concluded that the social support networks provide care and assistance because they are a resource that one needs in life to contribute to well-being. Insight into the value or significance of social networks in peoples' life is critical to be able to understand how a person who abuses alcohol affects those networks who are expecting support from him or her. Social support is closely related to the concept of a social network, or the ties to family and significant others. Social support therefore, can be provided spontaneously through natural helping networks of family and friends, or can be mobilised through professional intervention.

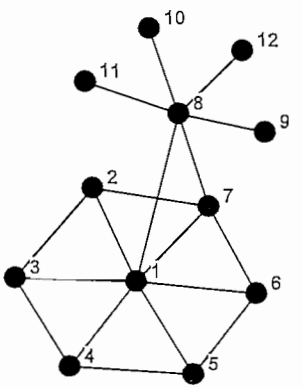
4.4 Social network analysis

Based on the descriptions and definitions of social support networks, it is clear that when one wants to understand how a network functions or any matter pertaining to it, an analysis needs to be done. It would help to understand the structure, the linkages, communication lines and roles. Freeman (2004: 2) states that the study of interaction among social actors is called social network analysis. He is of the view that the social network approach is grounded in the intuitive notion that the patterning of social ties in which actors are embedded has important consequences for those actors. Network analysts, then, seek to uncover various kinds of patterns. They try to determine the conditions under which those patterns arise and to discover their consequences. This view is supported by Tracy and Whittaker

(1990:462) that analysis of the social network could assess various types of supportive exchanges, describes the existence or quality of relationships, determine the frequency of specific supportive events, perceived availability or evaluate adequacy of support.

Wellman and Berkowitz (1988:4) state that network analysis is a tool for the study of social structures that can be represented as networks, that is, as sets of nodes or social system members and sets of ties depicting their interconnections and associate nodes with individual people, groups, corporations, households or other collectivities. These ties are used to represent flows of resources, friendships or structured relationships between nodes. Social network analysis is more general and can be used to analyse any network. Everett and Borgatti (2005:31) refer to ego networks (Figure 1) which represents a network of a single actor (ego -1) together with actors (2-12) they are connected to (alters) and all the links among those actors. The ego networks are used to study social support.

Figure 1. The Key Player Problem (KPP) – The Centrality Approach



Source: (Borgatti (2005b:2) – (Permission granted for use)

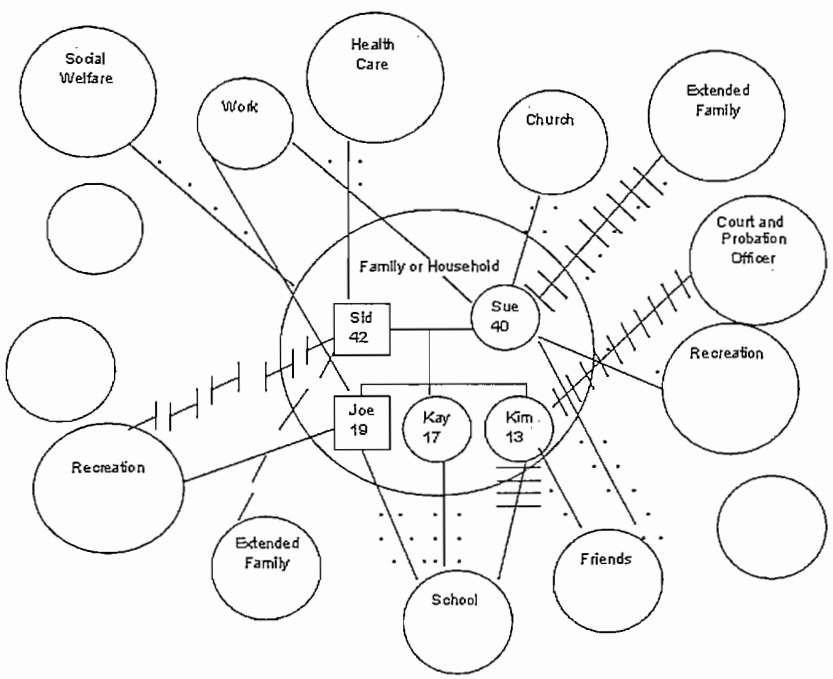
Social network analysis provides a way of identifying and understanding the features of social networks and how clients value other people in their daily living.

Maguire (1991:46) is of the opinion that based on analysis of the structure of networks, their interactional patterns and functions of intimate, socially supportive relationships strategies can be developed that strengthen networks where they exist, develop new ones when they are needed and leave them alone when they are working. The social network analysis is used to establish more precisely the

specific purposes and functions of different types of networks or network configurations and use of that information assist in assessment and intervention.

The social support network can also be analysed by means of an Eco-map (Figure 2), also called a socio-gram is used. It is a visual assessment tool depicting the relationships of family and its network (Hartman, 1995:111) and portraying the ecological context in which people live because it provides a diagrammatic representation of a person's world (Cournoyer, 2000:40 cites Hartman & Wickley). It is a drawing of the client or client family in its social environment that indicate the main systems which form part of the person's life and the nature of the relations with other systems and also provide an overview of the family in their situation, giving a picture of important nourishing or conflict-charged links. It is then used to analyse the family in order to understand how it functions. It is in this analysis that one can depict the responses of members of a support network regarding the support that is provided or not.

Figure 2: Eco-map



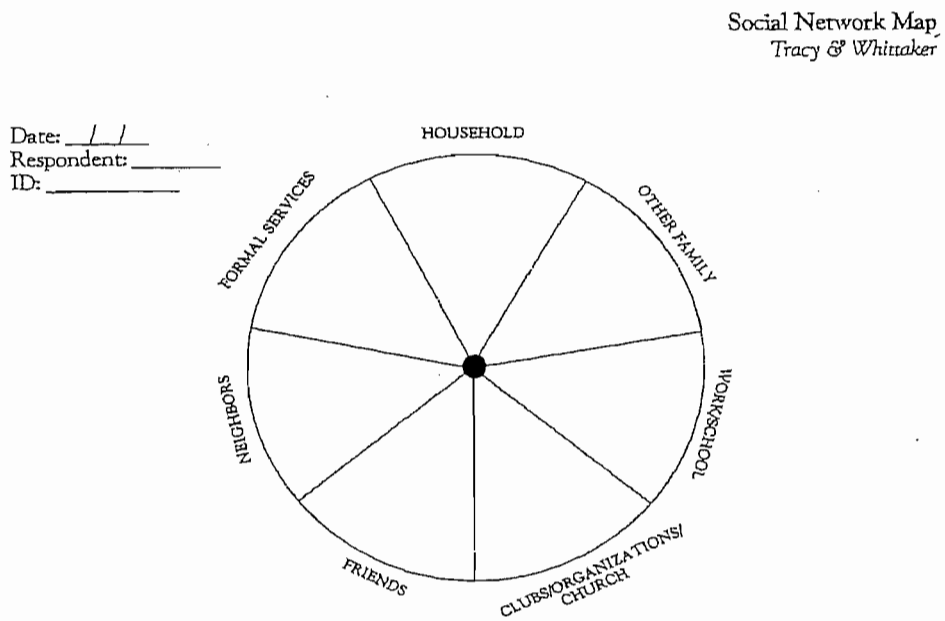
Source: Wonderware (Permission granted for use)

The Eco-map could be used to achieve a holistic or ecological view of the client's family life and the nature of the family's relationships with groups, associations, organisations, other families and individuals. A major value of an eco-map is that it helps to view the environmental context from a systems and ecological perspective. Identifying the connections clarifies data on a family's environment; highlights energy that flows into and out of the family. It also provides information on aspects such as network size, reciprocity of relationships and access to or deprivation from resources (Cournoyer, 2000:40).

Of importance is that it also identifies the energy-enhancing and energy-depleting relationships between members of a social system and the outside world, and highlights social strengths and social deficiencies, identify conflict and compatibility that could be caused by excessive drinking. In that case it is a tool that one could use for social network analysis to understand system dynamics and in this particular study, it would help in identifying the social and economic effects of binge drinking on support networks (Hartman, 1995:112). A study of families and binge drinkers as central figures would provide a picture of, for example, how the family is structured, its strengths and weaknesses, balance and available resources in the community.

Tracy and Whittaker (1990: 462) acknowledge that the eco-map is an extremely useful method for portraying client-environment relationships, its ability to demonstrate the flow of energy into and from the family and its depiction of nurturing as well as conflicted relationships. However, one disadvantage is its imprecise terms which make it difficult to determine the exact nature of the relationships portrayed. Their view is that the eco-map provides a much more complete portrayal of structure than it does of function. They introduced a social network map (See Figure 3) that identify and visually display network composition and membership. It attends to both structure and function. It is a tool for systematically gathering specific information on the size, composition, structure and functioning of a person's social support network. Their view is that social network mapping techniques are fully compatible with eco-map procedures but provide more detailed, anchored responses regarding the quality and functioning of social connections. The social network map is constructed for an individual and lists each person known to that individual.

Figure 3: Social network map



Source: Tracy and Whittaker (1990:463)

An accompanying grid (Annexure 10) is used with the social network map to record responses about supportive and non-supportive functions of network relationships, for example, which network provided what type of support, what relationships were reciprocal, and what relationships were conflicted. Their view is that the network grid is specific about network functions and the fact that relevant information about the target population can be directly collected. Morris (2003:1) states that social network map is useful for people who are experiencing special circumstances such as serious illness, disability, divorce or job loss. The person would make a list of needs and break them into categories that are meaningful to that person, focusing on instrumental, expressive and emotional needs as well as concrete practical tasks. A person then identifies the people who have helped with each of these needs and those one could ask for assistance with each need. One would then see if there are any holes (needs going unmet). It is important to then consider why this is happening. A pattern should be identified. It is also important to note the ways a person reciprocate by meeting the needs of the people in the social network.

The social network map and the grid are useful tools that could be used to get information to understand how binge drinking affects family members, work environment, or friends. Tracy and Martin (2007:81) state that given the social

nature of substance abuse, assessment of social networks is helpful in understanding addictions. This view was expressed in their study to document the role of children in the social networks of women in substance abuse treatment. Their argument is that there is an association between substance use patterns and women's relationships with significant others. Reference is made to the study by O'Dell, Turner and Weaver (1998) that found that drug-misusing women had very small social networks and received minimal support for sobriety from partners and parents.

An assumption is made that the binge drinker as a family member, a worker, a friend has connections with other systems and they do affect one another as they are interrelated and interdependent. There are interactions and transactions that take place among actors. Whittaker and Garbarino (1983:9) refer to it as the ecological niche of an individual and his or her immediate environment and both affect and respond to each other. They further states that the individual's environment is multifaceted and multileveled. Therefore concepts 'social support' and 'social network' are useful to understand the supportive environment of the binge drinker.

In order to further understand the concepts social support, social support networks and social support network analysis in relation to binge drinking, three supporting theoretical frameworks are discussed to highlight the person-in-environment paradigm, social functioning and reality as described by participants.

5. THEORETICAL PERSPECTIVES

The eco-systems perspective, role theory and constructivism perspective as a post-modern perspective are explained to unpack the relation between people and environments and how they influence and affect one another, the roles performed by members of networks and how failure to perform could affect others and understanding of peoples' reality and how it affects others.

5.1 Eco-systems perspective

The eco-systems perspective is a conceptual scheme consisting of layers and sets of interrelated concepts that can explain human behaviour in the context of the environment (Compton *et al.,* 2005:38; Pillari & Newsome, 1998:6). Compton *et al.,* (2005:23) and Poulin (2005:27) are of the view that the person – in – situation is a

whole in which the person and the situation are both cause and effect in a complex set of relationships. In order to understand the dynamic interactions and transactions, the whole system should be considered. The rationale is that systems are interrelated and interdependent. Hull and Mather (2006:12) support this view with the family –in –environment practice approach in that one cannot adequately assess a family without recognising the multiple influences that affect the lives of family members of any family system. According to Whittaker and Garbarino (1983:9) the word ecological is used to convey an interest in the way the organism and its immediate environment (the ecological niche) effect and respond to each other. Their view is that intimate relationships cannot be understood without understanding how the conditions surrounding the social interaction affect interaction between individuals, how these conditions shape and "press" patterns of interaction. They further explain that "environmental press" refers to the combined influence of forces working in an environment to shape the behaviour and development of individuals in that setting.

McGregor *et al.* (in Becker and Vanclay, 2003:108) refer to the ecological model of wellbeing that assumes that a healthy ecological system is the foundation for a functional economy and social system that can sustain a high quality of life for its residents. They argue that different ecological models explain the effects of environment on personal identity and predispositions, family structure and roles and communal networks and patterns. Seed (1990:11) argues that the idea of "system" overlaps with the idea of "network". A system is often represented as a network like client or action systems. He further state that social network analysis gives landscape to these systems.

Compton *et al.* (2005:7) and Pillari and Newsome (1998:7) state that a focus on a person-in-environment, assist people to address problems, needs and aspirations that are associated with obstacles that impede successful accomplishment of transitional and environmental tasks. The transactions between people and environments are viewed in a constant state of reciprocity, each affecting the other. They further state that people experience problems when there is a poor fit between their needs and wants and the resources available in their environments like family, community or society. Binge drinking with its devastating effects, could impede successful accomplishment of transitional and environmental tasks.

The ecological theory is selected as a cornerstone of the strengths model (Long *et al.,* 2006:34). The rationale is that the social environment component of ecological theory involves the conditions and interpersonal interactions that permit people to survive and thrive in hostile circumstances. The concept social environment includes people's homes, communities, and financial and/or other resources, as well as laws and expectations that govern social behaviours. A binge drinker is aligned with these as he is part of home, community and could be a provider of financial and/or other resources. Binge drinking is seen as a behaviour that transgresses alcohol intake limits as set out by law as well as the expectations of a particular community. The ecological theory also supports the value of transactions as a forum to build on the strengths of informal and formal support systems.

The social support networks are seen as an important part of persons' environment that has an influence on their growth and development. Based on the ecological perspective, a person who is a binge drinker needs to be understood in the context of his environment. Those who are part of his networks are also affected by his binge drinking because they are, as subsystems of a system, affecting each other. As a unit, the social support network could become unbalanced because of binge drinking that is out of control.

5.2 Role theory

A role refers to the expected behaviour for a person occupying a particular social status or position (Turner, 1996:581). It could be a role of a breadwinner, father, mother, employee or employer and if a system is to enjoy stability and integration there must be some reciprocity of expectations between role partners. One could also have a role set, for example an employee, husband, brother, friend or father. Performance of these roles is meant to contribute to homeostasis of a family, work environment and community. Non-performance has detrimental effect on a system's ability to fulfil major role obligations at work, school or home (DSM IV – TR, 2000). Pillari and Newsome (1998: 16) are of the opinion that all family members play different roles in the family and depending on the need and desires of the family, these different roles seek to fit into the family system. They further assert that "the manner in which a family functions and it deals with its members depends on both internal family conditions and external demographic and economic situations".

Gans (2003:1) states that alcohol abuse is defined as a pattern of drinking that is accompanied by failure to fulfil major work, school or home responsibilities. A binge drinker whose drinking is out of control could fail to perform roles and responsibilities and this could then affect the family relations, work or school socially, psychologically or financially.

5.3 Constructivism as a post-modern perspective

Postmodernism is based on the assumption that language is used to construct perceptions of reality. Jansen (2007:22) says that postmodernism assigns value to multiple meanings rather than a single, authoritative voice of the expert. It values "voice", the subjective and multiple voices of individuals and communities rather than predetermined rules for action. Social constructivists maintain that people invent the properties of the world rather than discover them. Dean is cited by Poulin (2005:26) that "constructivism is the belief that we cannot know an objective reality apart from our views of it". This perspective put emphasis on the experiences of individuals and their perceptions of experiences, as well as on the social aspects of knowing and the influence of cultural, historical, political and economic conditions. Individuals' perceptions are influenced by their communities and social environment. The individual cannot be separated from his or her interactions with others (Poulin, 2005: 26). He further sums it up that postmodernism highlights the importance of clients' subjective perceptions of their experiences and are shaped by culture and social experiences. It places clients in the role of expert about their life experiences and potential solutions that can be reached through the process of interaction with a social worker. Reality is constructed through conversation between people and socially constructed and this idea is known as social constructivism (Narabayashi, 2006:152).

Constructivism as a postmodernism perspective is therefore relevant in understanding the effects of binge drinking on social support networks in that the members of networks could explain the causes and effects of binge drinking on their lives in a manner that makes sense to them taking into account how these views influence and are influenced by social, culture, political or economic conditions. It does provide insight when one goes into the community to dialogue and communicate with social networks to understand their own problems and challenges.

It is only through listening to their experiences and exploring the cultural, political and economic influences that together with them strategies could be developed. Saleebey (2006:10) identified six principles of the strength based perspective and one of them is about an acknowledgement that every individual, group, family and community has strengths, regardless of the situation, their assets, resources, wisdom and knowledge should be discovered. These views are in line with postmodernism thinking that people have their subjective reality that they have constructed which could be seen or used as their strength when tackling the challenges.

The strengths perspective moves from a premise that the micro and macro interventions would then be relevant to address the challenges. The views pertaining to socio-economic effects, as expressed by binge drinkers and their families as support networks would be discussed in Chapter 5 and 6.

6. DISCUSSION AND CONCLUSION

The literature reviewed has provided an understanding of the concepts, social support, social support networks and social network analysis. Hupceys' categories provided a detailed explanation about types of support that are needed by others in a social environment, how others perceive support, reciprocal support and exchange of resources and the behaviour of the person who provides support. These categories are indicative of the relations between people and environment and how they are supported and the detrimental effects that are experienced due to failure to support those who are suppose to receive support. Emphasis is placed on meeting the needs of others in the social environment. This is supported by the eco-systems perspective that states that the person and environment are interdependent and interrelated. The social and negative consequences of binge drinking affect the drinker, his family and his employment as well. It clearly indicates that social support networks play an important role in the lives of individuals and others in their immediate environment. This view is supported by a study of 2000 people in Finland that found that social support strengthened mental health in all respondents (Victorian Health Promotion Foundation, 2005:1).

Wechsler and Nelson (2001:288) state that binge drinking is a good indicator of the problems binge drinkers produce for those around them. Failure to receive material

or emotional support could lead to negative social or economic effects especially if a binge drinker does not perform a role as expected. Role theory illustrates the importance of role performance and how it enhances a balance of a system which could lead to cohesion that also promotes expression of their views because they are involved. It is a given then that for a system to be balanced, roles have to be performed, needs have to be satisfied and high quality of relationships should be maintained. This is possible if social support is provided by all actors.

Social network analysis provides a holistic understanding of the people, places and activities that take place in a system. It provides a comprehensive, broad and detailed understanding of a system in terms of support and what social constructs they have about social support. It then assists the social worker together with the client system to come up with strategies to address the problem. Some expectations flow from this understanding that certain behaviours and deeds are expected from social support networks and should be fulfilled. They add value to life of people. Social support network play a very critical role in the lives of a drinker, and others in his environment. Belonging to a social network of communication and mutual obligation makes people feel cared for, loved, esteemed and valued.

It is concluded that the social support networks are negatively affected by binge drinking. In order to address the problem of binge drinking, a detailed analysis of the social support networks is critical because it assists in understanding how these networks are structured and how they function in their ecological world in terms of performance of roles, their views about alcohol and provision of emotional, material and instrumental support, how support is perceived and reciprocated. It then provides a detailed picture that leads to an understanding of the social and economic effects that are experienced by social support networks. This information is critical and could be contributed to development of a relevant, integrated and coherent strategy to address alcohol use, misuse or abuse in South Africa.

7. REFERENCES

AMERICAN PSYCHIATRIC ASSOCIATION. 2000. Diagnostic and Statistical Manual of Mental Disorders (4th ed.). Washington, D. C.:APA.

BARKER, R. L. 2003. The Social work dictionary (5th ed). Washington, DC: NASW Press.

BECKER, H. A. & VANCLAY, F. 2003. The International Handbook of Social Impact Assessment: Conceptual and Methodological Advances. Northampton, MA: Edward Elgar Publishing.

BOPAPE, M. 1993. Social networks and social support as a basis of community development in Lebowa. Pretoria: Human Sciences Research Council.

BORGATTI, S. P. 2005a. *Social Support.* UCINET 5 for Windows: software for social network analysis. Natick; MA: Analytic Technologies. http://www.analytictech.com/networks/socsup.html. Date of access: 22 Aug. 2007.

BORGATTI, S.P. 2005b. The Key Player Problem (KPP) – The Centrality Approach. UCINET 5 for Windows: software for social network analysis. Natick; MA: Analytic Technologies. http://www.analytictech.com/networks/socsup.html. Date of access: 22 Aug. 2007

BRAUDE, D. & FRANCISCO-LA GRANGE, F.H. 1993. Support systems in the life situation of children of divorce. Pretoria: Human Sciences Research Council.

COMPTON, B. R., GALAWAY, B. & COURNOYER, B. R. 2005. Social Work Processes. (7th ed). Pacific Grove: Brooks/Cole.

COURNOYER, B. 2000. The Social Work Skills Workbook. Pacific Grove: Wadsworth Publishing.

CUNNINGHAM, J. A., VAN MIERLO, T. & FOURNIER, R. 2008. An online support group for problem drinkers: AlcoholHelpCenter.net. *Patient Education and Counselling*, 70(2): 193-198.

DONOVAN, J.H. 2007, July. Coaching: Create a work environment full of support, encouragement and truth. *BizTimes*.

EVERETT, M. & BORGATTI. S. P. 2005. Ego network betweenness. *Social networks*, 27: 31-38.

FREEMAN, L. N. 2004. The development of social network analysis: A study in the Sociology of Science. Cambridge: Empirical Press.

FU, S. K., ANDERSON, D., COURTNEY, M. & HU, W. 2007. The relationship between culture, attitude, social networks and quality of life in midlife Australian and Taiwanese citizens. *Maturitas,* 58: 285-295.

GANS, S. 2003. What is alcohol abuse? Alcohol – Getting the Facts. About.com.Alcoholism. Date of access: 4 February 2008.

GASS, J.S., WEITZEN, S., CLARK, M. & DIZON, D.S. 2007. Defining social support systems for women with breast cancer. *The American Journal of Surgery,* 194 : 501-503.

GROH, D. R., JASON, L. A. & KEYS, C.B. 2008. Social network variables in alcoholics anonymous: A literature review. *Clinical Psychology Review,* 28(3): 430-450.

HARTMAN, A. 1995. Diagrammatic Assessment of Family Relationships. *Families in Society: The Journal of Contemporary Human Sciences.* 76 (2): 111-112.

HULL, Jr. G.H. & MATHER, J. 2006. Understanding Generalist Practice with Families. Belmont, CA: Brooks/Cole.

HUPCEY, J. E. 1998. Clarifying the social support theory - research linkage. *Journal of Advanced Nursing*, 27: 1231- 1241.

JANSEN, J.D. 2007. The language of research (*In* Maree, K. (ed) Creswell, J. W., Ebersöhn, L. Eloff, I., Ferreira, R., Ivankova, N.V., Jansen, J. D., Nieuwenhuis, J., Plano Clark, V.L. & van der Westhuizen, C. 2007. First steps in research, Pretoria: Van Schaik, 15 – 22).

LONG, D. D., TICE, C. J. & MORRISON, J. D. 2006. Macro social work practice: A Strengths Perspective. Belmont, CA: Brooks/Cole.

LITT, M D. & MALLON, S. D. 2003. The design of social support networks for offenders in outpatient drug treatment. *Federal Probation,* 67 (2) 15 - 21.

KAWACHI, I. & BERKMAN, L. F. 2001. Social ties and mental health. *Urban Health*, 78 (3):458-467. Date of access: 17 October 2009.

MAGUIRE, L. 1991. Social Support Systems in Practice: A Generalist Approach. Silver Springs, MD: NASW Press.

MOKDAD, A.H. BREWER, R.D. & WARNER, L. 2007. Binge drinking is a problem that cannot be ignored. *American Journal of Preventive Medicine*, 44:303-304.

MORRIS, D. H. 2003. Encouraging plus coaching: Mapping your social network. *The Encourager Newsletter*, 2. Date of access: 30 September 2009.

NAIMI, T. S., BREWER, R.D., MILLER, J. W., OKORO, C. & MEHROTRA, C. 2007. What do binge drinkers drink? Implications for Alcohol Control Policy. *American Journal of Preventive Medicine*, 33(3): 188-193.

NORMAN, P., ARMITAGE, C.J. & QUICKLEY, C. 2007. The theory of planned behaviour and binge drinking: Assessing the impact of binge drinking prototypes. *Addictive Behaviors,* 32(9): 1753-1768.

NARABAYASHI, R. 2006. Family therapy in Japan- context and development. International Congress Series, 1287: 150-153.

OLAGNERO, M., MEO, A. & CORCORAN, M. 2005. Social support networks in impoverished European neighbourhoods. *European Societies,* 7(1): 53-79.

OTT, K. 2008. Family Support: An important dimension of CISM for emergency workers. *Emergency support network,* www.emergencysupport.com. Date of Access: 22 April 2009.

PARRY, C. D. H., PLŰDDEMAN, A., STEYN, K., BRADSHAW, B., NORMAN, R. & LAUBSHER, R. 2005. Alcohol use in South Africa: Findings from the first demographic and health survey. *Journal of Studies in Alcohol,* 66: 91-97.

PLANT, M. & PLANT, M. 2006. Binge Britain – Alcohol and National response. London: Oxford University Press.

PILLARI, V. & NEWSOME, Jr., M. 1998. Human Behavior in the Social Environment Families, Groups, Organizations and Communities. Pacific Grove: Brooks/Cole Publishing

POULIN, J. 2005. Strengths-based Generalist Practice: A Collaborative Approach. 2nd (ed). Belmont, CA: Brooks/Cole.

REIS, H.T. & RUSBULT, C. E. 2004. Close relationships. New York: Psychology Press:

SALEEBEY, D. 2006. The strength perspective in social work practice. (4th ed) Boston: Allyn and Bacon.

SEED, P. 1990. Introducing Network Analysis in Social Work. London: Jessica Kingsley Publishers.

STANTON-SALAZAR, SPINA, R. D. & URSO, S. 2005. Adolescent peer networks as a context for social and emotional support. *Youth & Society*, 36 (4): 379-417.

STRATHDEE, R. 2005. Social exclusion and the remaking of social networks. London: Athenaeum Press.

SZMIGIN, I., GRIFFIN, C., MISTRAL, W., BENGRY-HOWELL, A., WEALE, L. & HACKLEY, C. 2007. Re-framing 'binge drinking' as calculated hedonism- Empirical evidence from the UK. *International Journal of Drug Policy.* 1-8.

TRACY E. M. & MARTIN, T. C. 2007. Children's roles in the social networks of women in substance abuse treatment. *Journal of Substance Abuse*, 32: 81 – 88.

TRACY, E. M. & WHITTAKER, J. K. 1990. The Social Network Map: Assessing Social support in clinical practice. *Families in Society: The Journal of Contemporary Human Services,* 8: 461- 470.

TURNER, F. J. 1996: Social work treatment: interlocking theoretical approaches. New York: Free Press.

VEIEL, H.O.F. & BAUMANN, U. 1992. The Meaning and Measurement of Social Support. New York: Hemisphere Publishing Corporation.

VICTORIAN HEALTH PROMOTION FOUNDATION – Research summary, 2005: Social inclusion as a determinant of mental health and wellbeing. www.vichealth.vic.gov.au/MHWU/. Date of Access: April 2009.

WECHSLER, H. & NELSON, T. F. 2001. College Student: What's five drinks. *Psychology of Addictive Behaviors,* 15(4):287-291.

WELLMAN, B. & BERKOWITZ, S. D. 1988. Social Structures: a network approach. New York: Cambridge University Press.

WHITTAKER, J. K. & GARBARINO, J. 1983. Social support networks: informal helping in the human services. New York: Aldine.

WHO see WORLD HEALTH ORGANIZATION

WORLD HEALTH ORGANIZATION. 2000. Global status report on alcohol. Geneva, Switzerland.

WORLD HEALTH ORGANIZATION. 2004. Global status report on alcohol. Geneva, Switzerland.

CHAPTER 4

Article 3

THE ALCOHOL CONSUMPTION PATTERNS IN SELECTED AREAS OF NORTH WEST PROVINCE, SOUTH AFRICA

B.M.P. Setlalentoa – PhD student - School of Psychosocial Behavioural Sciences (Social Work), North-West University, Potchefstroom Campus.

E.H. Ryke – Senior Lecturer – School of Psychosocial Behavioural Sciences (Social Work), North-West University, Potchefstroom Campus.

H. Strydom – Professor – School of Psychosocial Behavioural Sciences (Social Work), North-West University, Potchefstroom Campus.

ABSTRACT

***Objective**: This sub-study of the Alcohol Study, using the baseline data of the Prospective Urban and Rural Epidemiological (PURE) study (South Africa) examined the alcohol consumption patterns in Ganyesa, Tlakgameng villages and Ikageng Township in the North West Province, South Africa. The rationale was to identify binge drinking as one form of alcohol abuse. It was necessary to pursue such a study because there are many studies on alcohol consumption patterns, but it seems nothing has been reported about the binge drinking patterns in these particular rural and urban areas.*

***Method**: A mixed methods research approach was adopted. In the quantitative part of the study 882 (44%) questionnaires of former users and currently using respondents from a PURE population of 2000 were selected and analysed to determine alcohol consumption patterns in the selected areas of study. Non-probability purposive sampling was used and binge drinking was adopted as a central phenomenon. The quantitative approach was also used to further understand the pattern of binge drinking focusing on frequency, quantity and types of drinking of the identified binge drinkers. Descriptive statistics and content analysis were used for data analysis.*

***Results**: The results have shown that men and women of the demarcated rural and urban areas abuse alcohol and 75% of respondents are binge drinking. The respondents were identified as currently weekly, (45%) and monthly, (30%) binge drinking. The socio-economic profile of the sample has shown that 79% of respondents are unemployed, 21% do elementary work, and also depend on pensions and grants for a living, their level of education seem to be low and these are markers of low socio-economic position and conditions.*

***Conclusion**: Based on the results of the study, it is concluded that moderate, problem or risky drinking and binge drinking are prevalent in the demarcated areas of the study. The majority of respondents occupy a low socio-economic position which could also contribute to binge drinking. This could put drinkers and others such as families at risk. Heavy episodic drinking also exposes the binge drinkers to further health, social and economic challenges – a situation that calls for an integrated multi-disciplinary and multi-sectoral intervention approach.*

Keywords: Alcohol abuse; alcohol consumption patterns; binge drinking.

1. INTRODUCTION

The Prospective Urban and Rural Epidemiological (PURE) study is a prospective cohort study that tracks changing lifestyles, risk factors and chronic disease over a period of twelve years using periodic standardized data collection in urban and rural areas of many countries in transition. All the baseline data for the PURE study (South Africa) were collected during 2005. The PURE study makes reference to a number of additional sub and auxiliary studies such as the Alcohol study. The general aim of the Alcohol study with sub-studies is to gain a better understanding of alcohol consumption patterns and the causes and consequences of binge drinking in the North West Province, South Africa. This sub-study of the Alcohol study focuses on the socio-economic effects of binge drinking on social support networks, that is investigated in depth in this research – hence a link between the two research projects (Vorster, 2007).

This article focuses on identifying the alcohol consumption patterns in the demarcated areas of the study using the baseline data of the original PURE study. Emphasis is particularly on binge drinking as one form of alcohol consumption

pattern in Ganyesa, Tlakgameng Villages and Ikageng Township, North West Province.

2. PROBLEM STATEMENT

According to the World Health Organisation (WHO, 2000, 2004), the intake of alcohol is increasing in the developing countries. Although South Africans drink less than in 44 other countries, those who drink consume huge amounts of alcohol. The same views have been expressed by Parry (2005:426) and Rehm *et al.* (2003:153) that South Africa has among the world's highest levels of alcohol consumption per drinker: 16.61 litre of pure alcohol a year. There is a concern about the observed pattern of binge drinking of about a third of South African drinkers and the prevalence of heavy drinking and a very high alcohol-related harm in South Africa (Baleta, 1998: 465; Parry, 2005:426; Rataemane & Rataemane; 2006:373).

The South African National Council for Alcoholism and Drug Dependence (SANCA) estimates that in 1998, there were about 1 025 198 alcoholics in South Africa. A review of the five national surveys, (South African Demographic and Health Survey (DHS) (1998), Youth Risk and Behaviour Survey (2002), World Health Survey (2003), Human Sciences Research Council (2004) and South African National HIV, Prevalence Behaviour and Communication Survey (2005) focusing on tobacco and substance use such as alcohol, indicated that the numbers of those who abuse alcohol is increasing, drinkers drink at risky levels over weekends and drinking to intoxication is common (Peltzer & Ramlagan, 2009:4, 10). All these concerns are indicative of the problem of binge drinking that could be detrimental to society.

The former Minister of Social Development, Dr Z. Skweyiya also, in his media statement of 20 August 2007, referred to the World Drug Report (2006) that dagga and alcohol are still the most abused substances with risky drinking affecting 17.5 million South Africans. Van As (2004:1) supports the view that alcohol abuse is a problem in South Africa and the cost is estimated at R9 billion per year. Alcohol is abused by adult males and females and young people of both genders living in rural and urban areas.

Some studies have been undertaken in South Africa that indicated binge drinking as one of the lifestyle practices of learners. For instance, the 2002 National Youth Risk Behaviour Survey of 10699 learners indicated that 29% of black males and 17% of

females in grades 9-11 reported binge drinking (Reddy *et al.*, 2003). Parry *et al.* (2002:431) provided the results of a study of learners drinking that indicated prevalence of heavy drinking in three cities, namely Cape Town, Durban and Port Elizabeth. The results have shown that learners in grade 11 in Cape Town reported 36.5% for male and 18.7% for female while Durban had 53.3% of male and 28.9% of female, and Port Elizabeth had 58% of male and 43% of female learners in grade 9-11 who reported consuming alcohol.

In the rural areas homebrewed alcohol is mostly used because it is cheap and easily accessible. However, it presents with its own challenges because of the methods used during fermentation which have a potential of causing harm. Special Assignment (SABC3, 2009) focused on consumption of alcohol that is fermented with dangerous substances like batteries. It was indicated that a low socio-economic position does contribute to high and dangerous alcohol consumption. Dr Tim Laurens from the University of Pretoria, Department of Chemistry, reported that laboratory tests have proved that this type of home brewed alcohol is dangerous. Ms. Mugwena, Director of SANCA Soweto, supported that there are many people who abuse homebrew alcohol prepared with these dangerous substances. People who take this type of alcohol were interviewed and while they acknowledged that it is dangerous, they still enjoy it and will continue to do so irrespective of the effects, because it is cheap and easily accessible, (R4,50 per 2 litres) compared to other alcohol beverages.

The dangerous substances were identified in a study named *Analysis of Homebrewed "Concoctions"* (2003) undertaken by the Department of Health and the Council for Science and Industrial Research. This study revealed the high alcohol content accompanied with some harmful substances. These home brews are shared at drinking venues (drinking networks) and at occasions such as weddings, funerals or cultural events. It is in these venues and occasions where communal drinking is mostly used. Peltzer and Ramlagan (2009:1) state that alcohol consumption should be understood in the context of how it is drunk. It has been confirmed that the traditional forms of alcohol are usually poorly monitored for quality and strength and in most countries, health consequences relate to harmful impurities and adulterants (WHO, 2004:18). In the urban areas, beer and distilled beverages are mostly used.

These studies have indicated that there is a problem of alcohol abuse in South Africa that could affect individuals, families, workforce, and the economy of the country. North West Province is no exception and this article seeks to answer the following research question: What are the alcohol consumption patterns of former and current alcohol users in the selected areas of the North West Province?

3. OBJECTIVE OF THE STUDY

The objective of the chapter is to identify the alcohol consumption patterns of identified PURE study respondents.

4. THE DEMARCATED AREA OF THE STUDY

The North West Provincial Growth and Development Strategy 2004-2014, (North West Provincial Government, 2004) profiles the province as mostly rural in nature, with about 65% with a low population density and relatively inadequate infrastructure, especially in the remote rural areas. The population is predominantly poor, with high levels of illiteracy and dependency that seriously affect productivity and peoples' ability to compete for jobs. The province is characterised by great inequalities between rich and poor, disparities between urban and rural areas, available resources are unevenly distributed, and offer limited potential for improving the delivery of services and generating growth.

The selected two areas of the study are Ganyesa and Tlakgameng villages and Ikageng Township, North West Province. The former are in the Bophirima district and mainly rural with a population of about 439 637 and the latter area is in the Southern district and mainly urban. The rural area is on tribal land, poorly developed with few basic services. Unemployment in the region is reported at 77% of the population in the 15 - 65 year age group and most people live below poverty datum line. Most of the community members do not have formal education and training which have a bearing on the socio-economic situation of the community (Msengana-Ndlela, 2006:1).

Ikageng is peri-urban and most of the economic activity takes place in the nearby towns, Potchefstroom and Klerksdorp. It is a mining area, therefore, attracting migration of rural males to urban areas giving rise to the establishment of informal settlements. High alcohol consumption levels are recorded at 34-68 litres per capita per year in most of the informal settlements. Children of the alcohol abusing parents

in these areas are vulnerable and have a 60-80% chance of developing alcohol dependence (SANCA Annual Report, 2004/2005:31; Walmsley & Walmsley, 2002:2). The North West Province was identified in the 2005 Demographic Health Survey as the province with the second highest level of hazardous or harmful drinking (Peltzer & Ramlagan, 2009:4).

5. RESEARCH METHODOLOGY

In this part of the study a mixed methods approach was followed to produce a more complete picture by combining information from complementary kinds of data (Denscombe, 2008:272; Ivankova *et al.*, 2007:260). Sequential quantitative and qualitative analysis was used to follow-up groups of individuals who were initially identified on the basis of their residual scores (Teddlie &Tashakkori, 2009:276). In this case, alcohol use was identified in the quantitative study and descriptive in nature (Ivankova *et al.*, 2007:255). Existing quantitative data from the PURE study were analysed, therefore a secondary analysis was done (Corden & Hirst, 2008:213 & Boslaugh (2007:1). Questions from the adult questionnaire were selected for analysis that covered socio-economic background, area of residence, history of alcohol use, community of participants, frequency of drinking and quantity of alcohol, gender and categories of age at which participant started drinking.

In the second part, a qualitative approach was used to understand frequency of drinking by participants further describing their binge drinking episodes. Teddlie and Tashakkori (2009:276) state that qualitative data are collected on the individuals identified from the quantitative data and might be analyzed through content analysis. Emphasis was on variables such as the type of alcohol consumed and frequency of consumption for further analysis. Data from the two approaches were triangulated to understand the phenomenon of binge drinking best.

5.1 Respondents

Existing data from a sample of 2000 of the PURE study were analysed to identify alcohol users (both current and former users). From these 882 qualified and were analysed for this study. The age range of the PURE sample was 32-94 years.

Alcohol use was the central phenomenon for selection using a non-probability (purposive) sampling (Nieuwenhuis, 2007:79). Inclusion in the qualitative study was

based on the definition of binge drinking of four or five drinks per session for males and females respectively who drank heavily in a single drinking session, especially during weekends. Binge drinkers were identified from the PURE data and recruited to participate in the focus groups and in-depth interviews as part of the qualitative part of this study.

5.2 Methods of data collection

For the quantitative study the existing data of 882 adult questionnaires of former and current users, inclusive of males and females from both areas were selected. For the qualitative part, two methods of data collection were used, namely focus groups and semi-structured interviews with an interview schedule. The two focus groups consisted of four males and three females in each area of study and fourteen in-depth interviews were conducted with the same focus groups participants to understand their drinking patterns further. The information acquired in the focus groups and semi-structured interviews reached saturation point as no new information was emerging. It was, therefore, not necessary to include more participants.

5.3 Procedure

The leaders of the PURE and Alcohol project briefed the researcher on the study. The PURE adult questionnaire was studied and the variables that served the purpose of the study were selected for analysis (Annexure 9). Arrangements were made with the data capturer to access the data. Subsequently, the two demarcated areas were visited to familiarise the author with the research site. A meeting was held with the trained PURE study field workers to brief them about the author's role and how the qualitative study would be conducted.

The field workers were provided with the names of participants who matched the definition of binge drinking to recruit them to participate in the focus groups and in-depth interviews for further investigation. Fourteen participants responded positively and the researcher met with them to brief them on the process of partaking in the study.

5.4 Ethical considerations

Ethical clearance was granted for the PURE study by the North-West University, (no. NWU – 04M10) (Annexure 2a). Permission was also granted to analyse PURE data for use in the Alcohol study (Annexure 2b). For the qualitative study, participants consented by signing a form or appending a thumb print (Annexure 8).

5.5 Data analysis

PURE data was captured on the Microsoft Exel programme and imported to Statistical Package for Social Sciences (SPSS) 16.0 (Levesque, 2007) to analyse selected responses from the PURE adult questionnaire. Descriptive statistics was used for the quantitative data to identify frequencies, focusing on minimum, maximum and means for variables. The qualitative content analysis was used to get deeper probing into subjective meanings. Babbie and Mouton (2004:491) state that content analysis employs the presence or repetition of certain words or phrases in texts in order to make inferences about the author of the text. Babbie (2009:333) is of the view that content analysis is well suited for the study of communications to answer questions of "who says what, to whom, why, how and with what effect". Field notes were kept and audio-recordings were transcribed, coded and themes were identified. Specific focus was on types alcohol consumed, frequency of intake and drinking networks.

6. RESULTS

The results of both quantitative and qualitative studies are presented focusing on the following themes:

- The biographical profile of respondents
- The profile of results pertaining to socio-economic problems that are experienced in the selected areas.
- The alcohol consumption patterns focusing on the age distribution and categories of age at which respondents started drinking alcohol, area of residence, history of alcohol use, frequency of alcohol abuse and consumption of more than five drinks per day.

6.1 Biographical profile of respondents

The biographical information of the 882 questionnaires is presented in Table 1 below focusing on gender, age, marital status, education, occupation and employment.

Table 1: Biographical profile of respondents

Gender		Age range	Marital Status		Education		Occupation		Employment
Male 493	55.9%		Never Married	42.9%	No education	36.5%	Home makers	79.1%	Employed 11,2%
Rural	Urban	32 – 94							
195	298		Currently Married	20.2%	Primary education	39.8%	Elementary Occupa-tions	6.8 %	Unemployed 37.5%
Female 389	44.1%		Living together	22.6%	Secondary and high school	20.4%	Others	6.4%	Not answered 51.2%
			Widowed	5.6%					
			Separa-ted	3.3%	Trade	0.5%			
Rural	Urban				College	0.6%			
138	251		Divorced	2.9%	Not answered	2.3%			
882			Not answered	2.6%			Not answered	7.7%	
100%				100%		100%		100%	100%

Gender: Table 1 shows that the majority of respondents are males, (55.9%) with females comprising of (44.1%). This implies that both males and females use alcohol and males drink more than females. These results are consistent with the alcohol consumption study conducted in the African Region by Zawaira (2009:3) that highlighted that Uganda has the highest per capita consumption in the world and alcohol consumption is high with 55% male and 30% female drinkers. Presumably, 15% of respondents in the study in Uganda are abstainers or are not currently using alcohol or did not respond.

Patel (2007:89) also is of the view that males consume more alcohol than females and in the form of binge drinking. The 1998 South African Demographic and Health Survey (Department of Health, 2002), a survey of 13826 persons, also showed that 45% of males and 17% of females who are 15 years and older, consumed alcohol at the time. The age of respondents at the time data were collected is discussed later.

The Inserm Collective Expert Report (2003) states that consumption surveys show that males consume alcohol more than females, for example, in France, 7 out of 10 males consume alcohol at least once a week compared to 4 out of 10 females. The studies in Russia have also found that males drink alcohol in general, and binge drink in particular more often than females (Jukkala *et al.,* 2008:664).

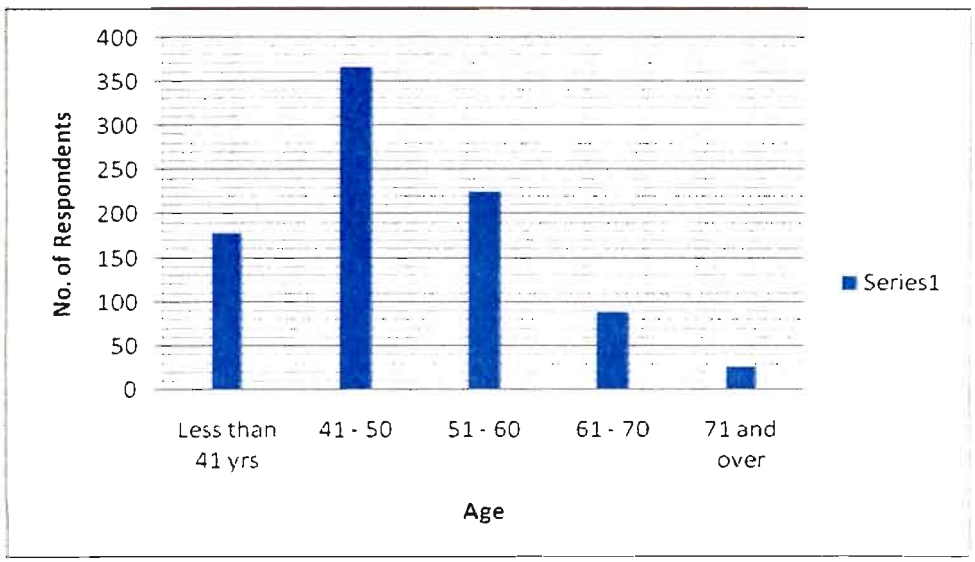
Kerr-Corrêa *et al.* (2007:265 - 267) are of the view that alcohol use by males and females is influenced very much by social habits and customs. They further refer to a Brazilian study by Almeida *et al.*, (2004) that found that excessive alcohol consumption was related to gender, marital status, migration, education and social position. Their view is that males drink to demonstrate their masculinity as a way of escaping from control, ignoring social differences and improving male bonding. It could be stated that both males and females abuse alcohol. The selected areas of study present with the similar characteristics of males and females consuming alcohol as with other areas in South Africa and other countries.

Of significance and concern in this study is alcohol consumption by a high percentage of females. It shows a cultural change that women are now taking alcohol whereas in the past, they prepared it but did not consume it as it was

unacceptable (see Chapter 2). The results are also consistent with the view that is expressed by Soul City (2007:15) that females in South Africa drink much more than they used to. It is consistent with the views by Plant and Plant (2006:44) that in the UK a change has been noticed that women consume more alcohol than in the past. The practice of abstinence is not observed as it was. This could be attributed to many women living in the cities and towns where traditions are not observed as they used to; particularly in the rural areas. Modernisation and urbanisation could have contributed to this change (see Chapter 2).

Age distribution: Figure I below indicates the ages of respondents at the time the study was undertaken.

Figure 1: Number and Ages of respondents



It is evident that alcohol is taken by all ages but the 41-50 category is the highest followed by 51-60 ages. The ages 61 and older show a decline in alcohol use. A conclusion is reached that the respondents in the 41-50 age range use and abuse alcohol the most and this is a period at which they could contribute to the economy of the country. It is also an age at which they have to provide for families because children are still dependent on them. The abuse of alcohol affects their performance of roles as, specifically provision of resources and setting of boundaries for the developing children.

Marital status: Table 1 also indicates that the majority of respondents are not married, followed by those who are living together. It is only 20.2% who are currently married which is an indication of change in this regard in that marriage is no longer practised as before. It is a sign of transition from people who used to get married rather than cohabit or stay unmarried.

Education status: It is indicated in Table 1 that the majority of respondents have a primary education, followed by those who never went to school and 20% have secondary education. The level of education is a marker of socio-economic position (Lynch & Kaplan, 2000:20). The significance of this situation is that respondents are unskilled and this contributes to low types of employment or unemployment. According to Kuunders (2008a:1), binge drinking is associated with unemployment or a low level of education in adults. Jukkala *et al.* (2008:664) report on a binge drinking study in Russia that people with a lower level of education and who do manual work, often suffer as a result of poverty and loss of income, and this group has been found to binge drink more. Economic strain has been related to binge drinking as well. Kuunders (2008a:1) refers to Kuntsche that alcohol dependence and alcohol-related mortality is most prevalent among adults with lower socio-economic status.

London (2000:199) conducted a cross-sectional study amongst farm workers in South Africa and also found high levels of alcohol consumption. It was discovered that close to half of the sample of 87 had a problem with drinking. They consumed more than 490 grams of alcohol per week. The farm workers earn very little, are extremely poor and lack many facilities like houses and also present with low education levels or illiteracy. The former Minister of Social Development, Dr. Z. Skweyiya, in his media update of 28 May 2008, states that high levels of alcohol abuse are reported amongst persons in certain occupations such as farming and mining, and in disadvantaged communities, where ease of access to alcohol is a contributing factor to abuse.

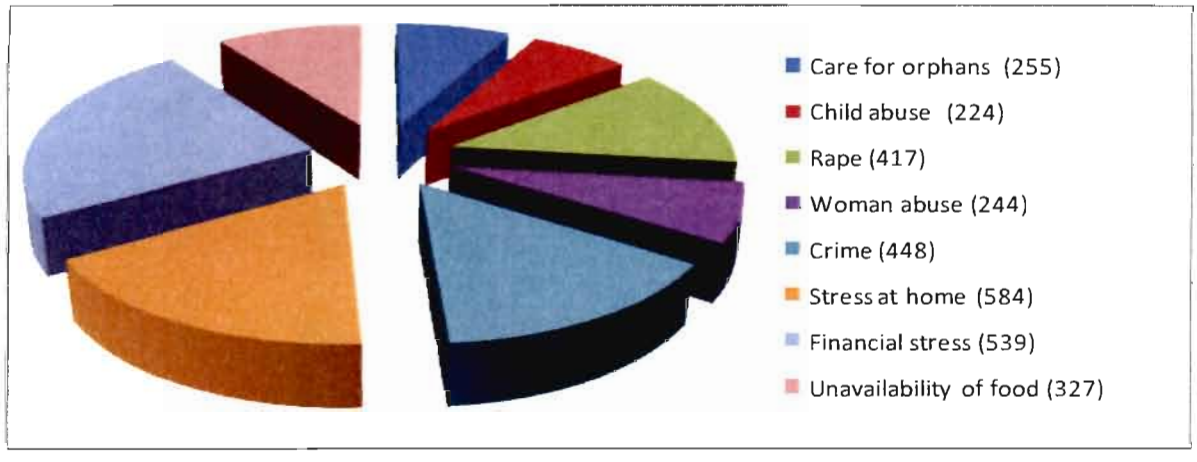
Occupation: The results have shown that respondents are from a low socio-economic class. The communities are expressing a high percentage (79%) of unemployed adults of between 32-60 years. Of significance is that many people have no formal education. Even if they could find employment it would be at a low level because they are unskilled. Lack of education could contribute to alcohol

abuse because of little or no understanding of causes and consequences associated with alcohol abuse.

6.2 Profile of social problems in the selected areas

The PURE study indicated some of the social problems or challenges (see Fig 2) that are experienced in the selected areas of study. The rationale for presenting this data is to understand the context and challenges that people who use alcohol could be exposed to. The premise is that people and environment cannot be separated and therefore, those who abuse alcohol and their support networks could be vulnerable.

Figure 2: Profile of social problems



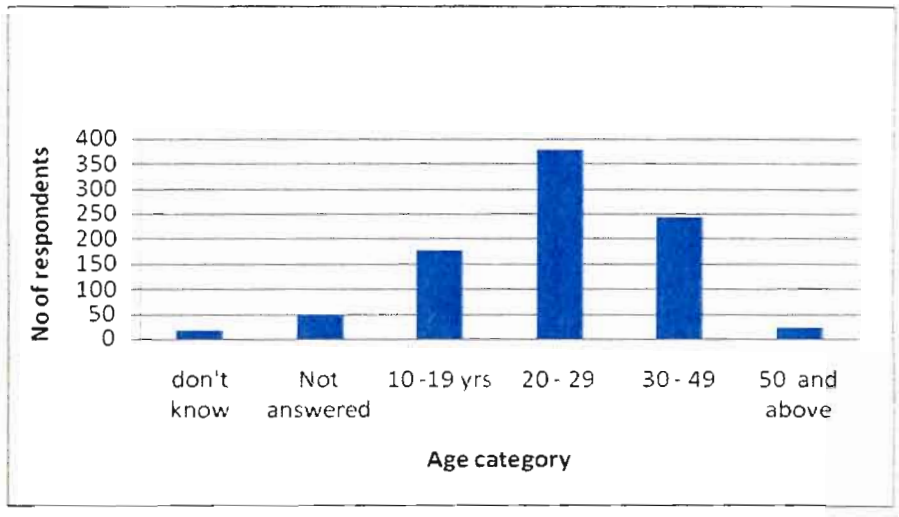
Social problems impact on the quality of life of the residents in many ways. Much as the findings do not represent the communities at large, it does show existence of such problems. This situation is explained in the context of alcohol consumption and how it can affect the drinker and the significant others.

6.3 Category of age at which respondents started drinking

It is indicated in Figure 3 below that some respondents started drinking alcohol at an early age of 10 years and the majority started to drink at the age between 20 and 29 years and 30 - 49 ages. It shows that many respondents started abusing alcohol before they reached adulthood. Those who started during adolescence are in the majority. It is evident that many people in selected areas of the study started taking alcohol from an early age and that binge drinking is prevalent amongst young people and adult population. It puts them in a risky situation

because addiction could set in because of extended periods of heavy drinking and the data below in Figure 3 indicates the age at which respondents started drinking.

Figure 3: Categories of age at which respondents started drinking



The significance of these results is that some people start drinking alcohol very early in life. It is acknowledged that if they continue to drink moderately, there is a possibility of not experiencing the negative effects of alcohol. However, if consumption is increased, there is a possibility of engaging in risky or binge drinking if there is no control. The situation as presented in the results makes young people in particular, (10-29 years, n=177 respondents and 20-29 years category, 377 respondents) vulnerable to risky drinking.

The results are consistent with the 1992 baseline health study of households in the Lesotho Highlands where 16.9 per cent of respondents who reported current drinking were 15-29 years (Jernigan, 2001:16). A study by Obot conducted in 1999 in Nigeria with 299 participants aged 11 to 20 years on their alcohol and drug use, indicated the average age of first consumption at 13.2 years (Obot *et al.*, 2003:59).

These studies show that alcohol is consumed from an early age. If a drinker does not stop chances are one would become an alcoholic. The Centre for Science in the Public interest (CSPI): Young people and Alcohol in MeadMadeComplicated: Alcohol and Culture (2008a:1) states that people who start drinking before they are 15 years have a four times higher risk to become alcoholics than those who start at 21years. The problems that are experienced are, amongst others, loss of

control over consumption, binge drinking and progression. According to Anderson and Baumberg as cited by Kuunders (2008b:1), heavy consumption during adolescence is a predictor of harmful consumption in early adulthood. Alcohol could affect their learning ability and contribute to failure to proceed with education. It could also present with negative effects in other areas of life such as marriage and family where others (children and family members) could be affected.

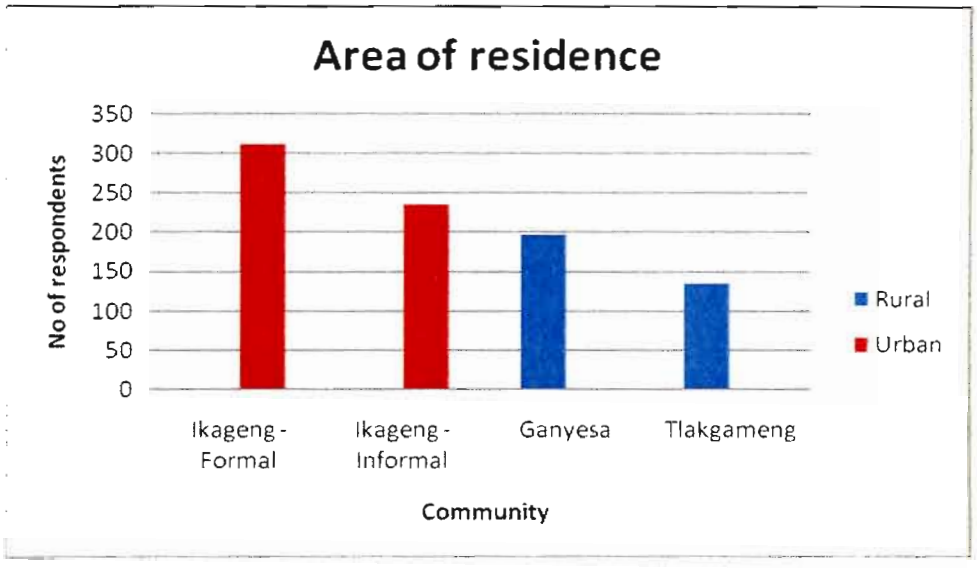
The results indicate that respondents started experimenting with alcohol at adolescence stage. It, therefore, means intervention strategies to prevent abuse should focus on young people because it is the age at which most people are exposed to alcohol use. If change is not realised, many would not reach adulthood or would end up being alcoholics and their lives would be destroyed, and this would affect them and their networks.

It is, therefore, concluded that adults in the selected areas of the study are prone to alcohol problems because, amongst other reasons, they started at a very early age to consume alcohol and the negative effects would affect them and other people in their social environment. The social, economic and health effects could be experienced due to prolonged drinking that started much earlier in their lives.

6.4 Area of residence

Alcohol consumption is used in all the selected areas and Figure 4 below indicates the spread of alcohol use in each area of residence and the number of people who consume alcohol.

Figure 4: Area of residence

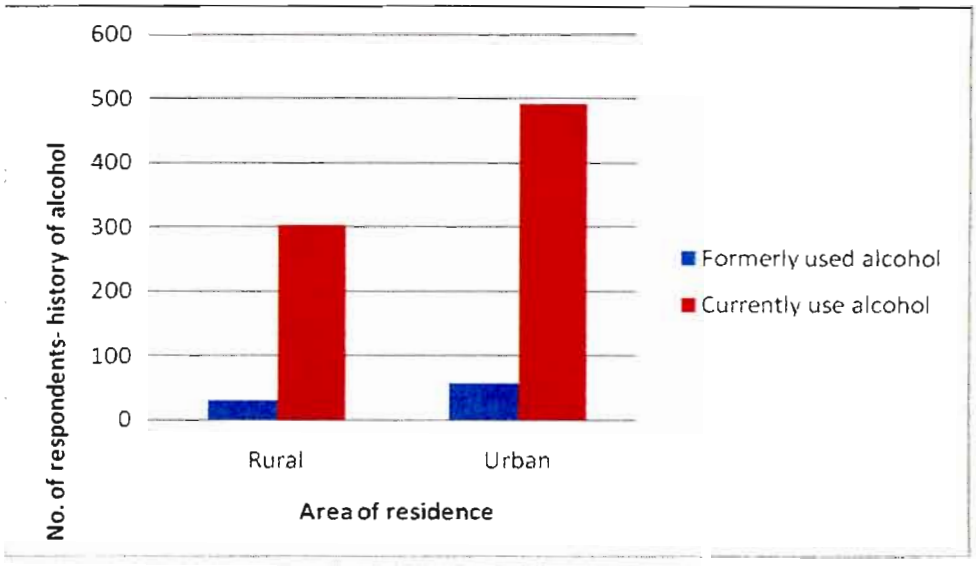


Both rural and urban communities use alcohol as shown in Figure 4. Of significance is that the number of respondents is higher in urban areas (n=549) than in rural areas (n=333). This could be attributed to employment opportunities or efforts to find a better life that attract more people to the urban areas. Peltzer and Ramlagan (2009:4) considered the alcohol consumption risk status in South Africa by geographic locality and provinces amongst others. Provinces with the highest levels of hazardous or harmful drinking in 2005 included Western Cape (13.8%), North West (10.6%), Northern Cape (8.9%) and Gauteng (7.3%).

6.5 Area of residence and history of alcohol use

The data indicates the number of people who used to take alcohol and those who were still using alcohol at the time the study was undertaken.

Figure 5: Area of residence and history of alcohol use



The results in Figure 5 show that many respondents in both rural and urban areas are currently using alcohol while very few are former users, meaning that they used to drink but have since stopped. The results indicate that there are many people who were using alcohol at the time data were collected. It is also indicated that users in the urban areas are more than in the rural areas, though the sample was not the same.

6.6 Frequency of alcohol use

In order to determine whether the respondents are social/moderate, binge or alcoholics, the frequency of their alcohol uses were analysed. The responses of those who were identified as binge drinkers are also discussed.

Figure 6: Frequency of alcohol use

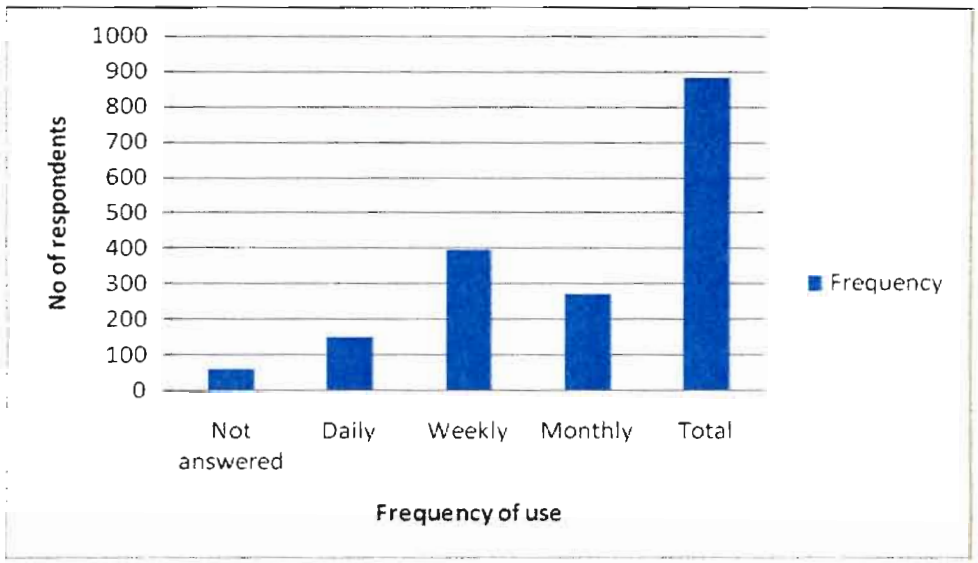


Figure 6 indicates that 17.1% (n=151) of respondents drink daily and could be classified as moderate, problem or high risk drinkers, depending on the quantity of alcohol. A critical question seeing that 79% of respondents in this study are unemployed is how they afford to drink daily. The contributory factors could be communal drinking, cheap home brew beverages that they can afford to buy, and easy accessibility because of many alcohol outlets in the communities.

The highest group is the weekly drinkers (45%) (n=397). Binge drinking has been identified with weekend drinking when drinkers indulge heavily, however, it cannot be concluded that weekly drinking is binge drinking unless it is described in terms of quantity and frequency of alcohol. The view is expressed by Parry *et al.* (2005:96) that both men and women consume large quantities of alcohol during weekends. The 1998 South African Demographic and Health Survey (Department of Health, 2002), a survey of 13826 persons, also showed that binge or risky drinking was rare on weekdays but increased significantly on weekends. Zawaira (2009:5) also indicates that 6.9% of South African women are classified as weekday risky drinkers and 32.3% are weekend risky drinkers. Communal and weekend drinking are linked in the sense that those who work and earn wages at the end of the week share with those who are unemployed. Those who receive pensions do the same when they have received their portion at the end of the month.

The third group is 30.8% (n=272) of those who drink monthly, which can be attributed to the period when they have received pensions. It is consistent with the results of the Lesotho Highlands Water Project (1996) that the majority of respondents indicated they drank alcohol monthly while others reported daily use (Jernigan, 2001:16).

MeadMadeComplicated (2003b:2) presented a study by Marques-Vidal *et al.* that investigated whether binge drinking is more dangerous than a regular consumption of alcohol. The results indicated that in Northern Ireland heart attacks are more frequent on Monday than any other day. A comparison of alcohol consumption and blood pressure was done between the French and Northern Irish to ascertain whether this was due to intake during the weekends. The results have shown that the Irish drank mostly on Fridays and Saturdays and blood pressure was high on Mondays, compared to French whose alcohol intake is fairly constant across the week. The indication is that alcohol that is consumed excessively in a single session has concerning negative social, economic and health effects.

6.7 Consumption of more than five drinks per session

The result of consumption of more than five drinks per day is presented focusing on the number of those who responded positively to the question. Furthermore, consumption of more than five drinks is cross tabulated with gender, average drinks and number of times alcohol is consumed.

The variable is linked to the definition of binge drinking as heavy, excessive and immoderate drinking of more than four or five drinks by women and men in one session (Plant & Plant, 2006:X). The findings in Table 2 indicate the number of those who drank more than five drinks and the gender differences. However, the question did not differentiate in quantities for men and women but just five or more drinks.

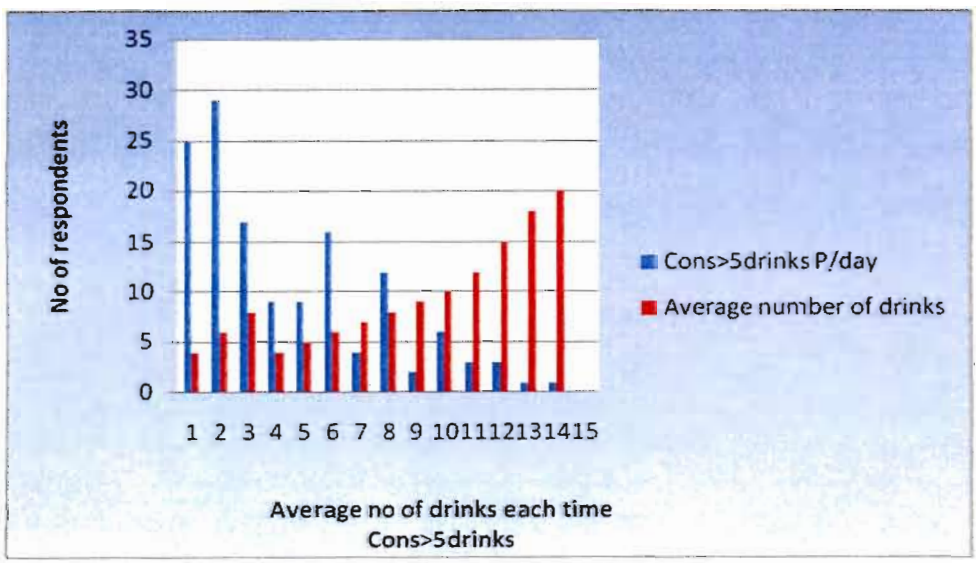
Table 2: Cross tabulation of Consumption of more than five drinks per day and gender

		Con>5/day			
		Not answered	Yes	No	Total
Gender:	Male	158	85	250	493
	Female	134	58	197	389
	Total	292	143	447	882

Those who drank more than five drinks per day were (n=143), that is 16.2% of the sample of 882. Of this group n= 28 responded that they drink more than five drinks daily, the weekly respondents n=59 and (n=54) drink more than five drinks monthly (Table 2). The other findings indicated 33% (n=292) of those who did not respond. There could be varied reasons for not responding such as not being able to quantify because of low level of education. Fifty one percent (n=447) gave a negative response which could be classified as moderate drinking.

The alcohol consumption is based on self-reports of the usual number of occasions on which respondents drank in a day, week or month and the usual number of drinks they consumed per occasion as indicated in Figure 7 below.

Figure 7: Consumption of more than five drinks per day and Average number of drinks



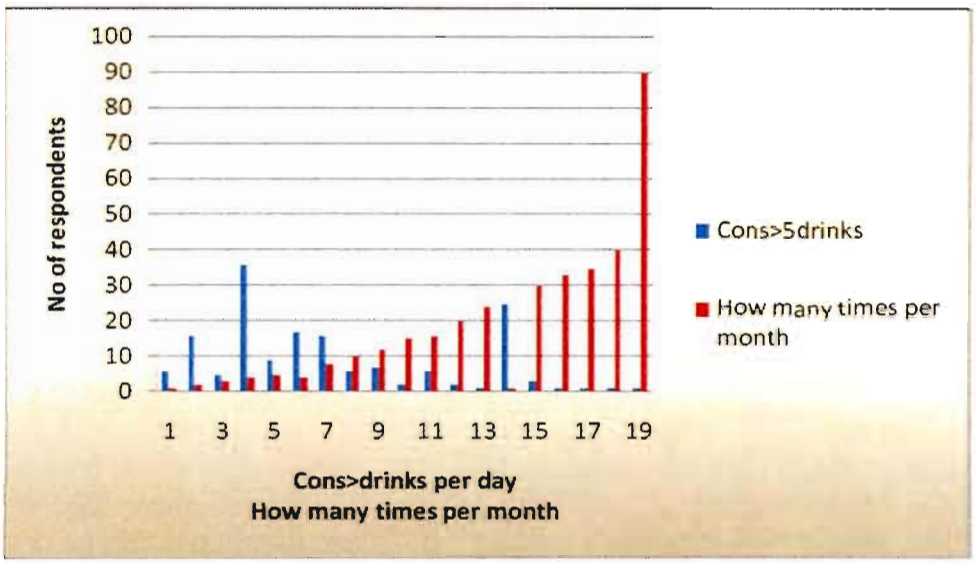
It is indicated that respondents do drink more than five drinks each time they consume alcohol. However, the types of the five drinks were not included in the analysis. Much as consumption of five drinks is used for identifying binge drinking, it should be noted that the alcohol content, ethanol, is dependent on the type of drink one consumes.

People drink different types of alcohol that contains pure ethanol. Pisa (2008:101) estimated the average grams of alcohol intake of pure alcohol (ethanol) by the amount of alcohol consumed per day. Beer, homemade brews, spirits and wine were considered to contain 3.6g, 3g, 36g and 9.4 g of pure alcohol per 100g of beverage respectively. The ethanol concentration for common types of alcoholic drinks is classified as one quart of beer is four units – 24 oz, one can of beer is two units – 12 oz or 350 ml, malt alcohol contains 5-8% of ethanol concentration and grain alcohol contains 95-97% (Soul City, 2007:16). The total number of drinks is then calculated from these estimates of quantity and frequency (Murray *et al.*, 2002:243). A point needs to be made that the home made brews might have different alcohol content because of the manner in which they are prepared.

Patel (2007:87) states that hazardous drinkers consume large amounts of alcohol and do so in high-risk patterns, such as binging. The volume of consumption is associated primarily with long-term consequences, and risky patterns of drinking are associated with acute consequences. All people consuming alcohol can become dependent on alcohol, even moderate drinkers if they do not control their drinking. People are classified as problem drinkers when their use has negative effects that can be mild to severe, on any aspect of their lives including their families, relationships, work or school. In order to determine whether a person has an alcohol problem, one would have to consider the type of alcohol a person drinks, the quantity, and period he or she has been drinking and the level of abuse at which a person can be classified based on his alcohol consumption. This study has identified different alcohol consumption patterns, namely, moderate, problem or high risk drinking and binge drinking.

Consumption of more than five drinks is cross tabulated with the number of times respondents drink per month as shown in Figure 8 below.

Figure 8: Consumption of more than five drinks per day and how many times per month



It is shown that respondents do binge drink because they drink more than five drinks each time they consume alcohol. The consumption rate ranges between 1-90 times a month with the majority (n=36) drinking four times a month, followed by respondents (n=17) who drink 6 times. It is not clear whether that is weekend or any day.

The weekly and monthly heavy drinking indicates a pattern of binge drinking in the two areas of study and the majority (76%) of respondents engage in binge drinking. This pattern of alcohol abuse is dangerous and has the potential of affecting the drinker, his or her family and society (WHO, 2004:60).

The point is that heavy drinking is noticed. Having considered consumption of more than five drinks, average alcohol per day and number of drinks consumed, a conclusion is reached that the respondents in the demarcated areas of the study do engage in binge drinking.

6.8 Description of binge drinking episodes

Focus groups and in-depth interviews were used to obtain a more in-depth understanding of the binge drinking phenomena. Participants were asked to describe their binge drinking episodes in terms of frequency, volume, type of alcohol, where and why they consume.

The responses varied in rural and urban areas. In the rural areas homebrewed alcohol is used because it is cheap and easily available as many women are selling it and one can get it at any time because there are many outlets/shebeens in the community. Clausen *et al.* (2005:2) state that homemade beers have been consumed in many African countries for centuries. This situation makes it possible to drink heavily because they get alcohol on credit. They consume up to 8 litres a day and most of the time they drink until they are intoxicated. The area of residence could be used as a determinant of the type of alcohol consumed and frequency as well. Patel (2007:S89) refers to a pattern of alcohol where distilled alcohol is consumed more in the urban areas by affluent people while traditional alcohol is consumed more in rural areas by poorer people. A rural male stated:

> *"We cannot afford beer or other hot stuff because we are not employed. African beer is prepared by women and it is cheap. It is fun to drink with other men and talk about life in general. At times we do piece jobs and we buy beer. We drink a lot on Fridays and Saturdays because some of our friends who are working are at home but at times, we do drink during the week as well. At times we drink the whole day and drink many litres because we all buy and share".*

Participants who reside in the township (urban area) stated that they consume beer especially during weekends, though they are not affluent. They acknowledge that beer is more expensive but they manage because they prefer communal drinking. They do drink alcohol during the week but not as much as over the weekends.

Many did not understand how the alcohol beverage they consumed is prepared and did not seem to bother or have interest to know as long as they have alcohol. Low level of education also plays a role in that members use concoctions without any understanding of the dangers involved. A rural male reported:

> *"Women prepare drinks but I never bother about how they ferment it but there are others who are quick in brewing and we all love that".*

The binge drinkers use home brewed alcohol which can be classified as unrecorded alcohol (WHO, 2004:15). This argument stems from the many unlicensed shebeens that sell alcohol. Their production is not known neither are the methods of production evaluated for suitability for consumption. The WHO (2004:18) mentions that there are many countries where there are beverages that are traditionally produced in the villages and in homes, especially in Africa. These traditional forms of alcohol are usually poorly monitored for quality and strength. Jernigan (2004:3) is of the view that traditional drinking patterns are often dominated by episodes of intoxication. This could be caused by the long hours the drinkers spend at the drinking venues which lead to the consumption of high volumes of alcohol. Some traditional home brew alcohols are referred to as concoctions because the way of preparing home brew alcohol changed when it was commercialised (see Chapter 2).

The cheapness of the home brew is a contributory factor that maintains drinking in the communities. The WHO (2004:18) states that cheap home brewed beer found an easy market among the low-income and no-income consumers. This point is in line with the situation in the selected areas of study. Some of the reasons that lead to high consumption could be that it is easy to buy beer, wine and other alcoholic drinks at supermarkets and bottle stores, shebeens, bars and at sports events (Soul City, 2007:2).

The binge drinkers were asked about their choice of drinking places and the kind of support they get from the drinking networks. Their view is that communal drinking is a good thing because they share costs and enjoy the company of others because alcohol is enjoyable when you drink it with friends. It also provides them with emotional support because they do not spend time alone thinking about their challenges like lack of food, or being unemployed. A rural male stated:

> *"It is nice to drink at a shebeen because we chat about many things, share advices and relieve stress of not working. People also buy drinks for you when you do not have money. You forget about your problems. The women who sell homebrewed beer also give us alcohol on credit and we pay when we have money".*

When asked about the reason or reasons why they use alcohol, the women in particular responded that they find it helpful in relieving stress. They find it difficult to provide for their children because they depend on Child Support Grant and other types of pensions. Some of them are single parents; one in particular has six children to take care of. The reasons for drinking are similar to conclusions drawn in a study of drinking motives, behaviour and problems by Peltzer (2003:1) that the most predominant drinking motive was social, followed by enhancement and coping. Social and enhancement drinking motives were predictors for current alcohol use, heavy and risky drinking, while coping drinking motives were predictors for drinking problems. An urban woman said:

> *"Life is stressful, and alcohol helps us to cope because we forget about our problems when we are under the influence of alcohol. We spend time with friends because we share the same frustrations of not having money to care for our families, which is why we go to shebeens".*

Social Issues Research Centre (2009:7) states that drinking does not, in any society, take place just anywhere and most cultures have specific, designated environments for communal drinking and may be seen as an extension or even a physical expression or embodiment of the role of drinking itself.

It is concluded that the volume of alcohol consumed in the selected areas is high considering that there is more that is unrecorded and respondents with their level of education could not provide the correct estimates. Those who drink heavily are prone to alcoholism.

The fact that the current users are more than non-users is an indication that many people use alcohol in the selected areas. Amongst the current users there are binge drinkers which indicate that there are males and females who consume more than five drinks in a day.

7. DISCUSSION AND CONCLUSION

The results of the quantitative and qualitative study indicate that the rate of alcohol abuse is high in both rural and urban areas of the demarcated areas of the North West Province and many people are currently consuming alcohol excessively

daily, weekly and monthly. This is consistent with study by Parry (2005:426) and the review of alcohol studies by Peltzer and Ramlagan (2009:10).

Alcohol is consumed by both males and females, and majority are unemployed and present with low education. The current drinkers are more than those who used to consume alcohol. It is also evident that the current drinkers started consuming alcohol at a young age; hence they are dependent on alcohol. The point is elaborated by Anderson and Baumberg (2006) that heavy consumption during adolescence is a predictor of harmful consumption in early adulthood. The frequency of drinking and consumption of more than five drinks in a day fits with the definition of binge drinking. Therefore, binge drinking is one pattern of drinking that was identified in the demarcated areas of study. The average drinks and the number of times alcohol is consumed have shown that there is binge drinking in the areas of study. It is in line with the explanation by the WHO (2004:5) that heavy episodic or binge drinking is drinking occasionally at a level where there is a high risk of intoxication and acute consequences. The problem is compounded by the fact that their socio-economic position is low as indicated in the biographical data and contributes to use of home brewed concoctions, especially in rural areas. This is consistent with the WHO (2004:18) that the poorer segments of the society consume local beverages and these drinks are poorly monitored, if at all, for quality and strength. The use of concoctions has its challenges as expressed in some studies. It means the volume of pure alcohol and the dangerous substances expose the drinkers to more danger.

Heavy alcohol consumption is also a major social and economic and health concern in South Africa. This view is supported by Morojele *et al.* (2006:217) and Wechsberg *et al.* (2008:131) that risky high levels of alcohol consumption has led to people engaging in unprotected sex, or engaging in sex work which could lead to HIV/AIDS. The social problems that are experienced in the areas of study presented negative effects that could be worsened by the low socio-econornic position. The effects of these socio-economic problems are felt by drinkers and their families as social support networks. The use of concoctions could lead to negative health consequences. The challenge could be faced by support networks because they have to care for the sick and at times breadwinners,

partners and carers die leaving others without emotional, material and instrumental support.

A conclusion is, therefore, drawn that binge drinking is a problem in the demarcated areas of study. The respondents continue to abuse alcohol irrespective of social and economic consequences on themselves and those who are part of their social environment. Jernigan (2004:3) asserts that a hazardous pattern of drinking presents with problems associated with intoxication episodes, including injuries and interpersonal violence causing harm to the drinker and to others, as well as adverse impacts on family. This view justifies the need to identify the social and economic effects of binge drinking on social support networks to be able to develop and implement a comprehensive intervention strategy to address the identified problem of alcohol misuse and abuse.

8. SUMMARY

Alcohol consumption in rural and urban communities is excessive, risky and has the potential of destroying the quality of life of individuals, families, and societies in general. Moderate, risky, binge drinking and alcoholism are identified as patterns of alcohol consumption in the selected areas. The socio-economic conditions are poor which exposes communities to more hardships. The drinkers are at risk of developing alcohol problems and their social support networks would further experience the negative effects. This justifies a relevant, integrated approach to address the socio-economic challenges and curb the abuse of alcohol.

9. REFERENCES

ANDERSON, P. & BAUMBERG, B. 2006. Alcohol in Europe: A Public Health Perspective. Institute of Alcohol Studies, United Kingdom.

BABBIE, E. R. 2009. The Practice of Social Research. Belmont, CA:Wadsworth.

BABBIE, E. R. & MOUTON, J. The Practice of Social Research. Oxford University Press: Cape Town.

BALETA, A. 1998. South Africa takes steps to restrict smoking and alcohol consumption. Policy and People. *The Lancet,* 352.

CLAUSEN, T., ROMOREN, T. I., ROSSOW, I., INGSTAD, B., MOLEBATSI, R. M. & HOLMBOE-OTTESEN, G. 2005. Patterns of alcohol consumption among older persons in Botswana. *Contemporary Drug Problems*, 1-6. Date of access: 26 March 2009.

CORDEN, A. & HIRST, M. 2008.Irnplementing a Mixed Methods Approach to Explore the Financial Implications of Death of a Life Partner. *Journal of Mixed Methods Research,* 2(3): 208-220.

DENSCOMBE, M. Communities in Practice: A Research Paradigm for the Mixed Methods Approach. *Journal of Mixed Methods Research*, 2 (3) 270- 283.

DEPARTMENT OF HEALTH AND COUNCIL FOR SCIENCE AND INDUSTRIAL RESEARCH. 2003. Analysis of Homebrewed "Concoctions". Pretoria.

DEPARTMENT OF HEALTH. 2002. South African Demographic and Heath Survey, 1998. www.doh.gov.za/facts/index.html. Date of access: 2 April 2008.

JERNIGAN, D. H. 2001. Global status report – Alcohol and Young people. World Health Organization, Geneva, Switzerland. Date of access: 10 September 2009.

JERNIGAN, D. H., 2004. Alcohol in Developing Societies: A Public Health approach, Summary. Finland, World Health Organisation.

JUKKALA, T., MÄKINEN, H., KISLITSYNA, O., FERLANDER, S. & VÅGERÖ, D. 2008. Economic strain, social relations, gender and binge drinking in Moscow. *Social Science & Medicine,* 66: 663-674.

INSERM COLLECTIVE EXPERT REPORT. 2003. Alcohol: Social Damage, Abuse and Dependence. http://ist.inserm.fr/basispresse/DP/DPanglais/25/february2003.pdf. Date of access: 8 July 2008

IVANKOVA, N. V., CRESWELL, J. W. & PLANO CLARK, V. L. 2007 Foundations and approaches to mixed methods research. (*In* Maree, K. (ed). Creswell, J. W., Ebersöhn, I., Eloff, R., Ferreira, N. V., Jansen, J. D., Nieuwenhuis, J., Pietersen, J., Plano Clark, V. L. & van der Westhuizen, C. 2007. First Steps in research. Pretoria: van Schaik, 254 – 282).

KERR-CORRÊA, F., IGAMI, T.Z., HIROCE, V. & TUCCI, A.M. 2007. Patterns of alcohol use between genders: A cross-cultural evaluation. *Journal of Affective Disorders*, 102: 265-267.

KUUNDERS, M. 2008a. Alcohol use: Consequences for individuals and society.

www.euphix.org/object_document/05203n27408.html. Date of access: 8 July 2008.

KUUNDERS, M. 2008b. Alcohol use: Causes and risk factors.

www.euphix.org/object_document/05209n27408.html. Date of access: 8 July 2008

LONDON, L. 2000. Alcohol consumption amongst South African farm workers: a challenge for post-apartheid health sector transformation. *Drug and Alcohol Dependence,* 59: 199-206.

LYNCH, J. & KAPLAN, G. 2000. Socio-economic Position, (*In* Berkman, L. F. & Kawachi, I. (eds) Social Epidemiology. New York: Oxford University Press, 13 -35)

MEAD MADE COMPLICATED: 2003a. Alcohol consumption patterns.

www.meadmadecomplicated.org/society/consumptionpatterns.html. Date of access: 8 July 2008.

MEAD MADE COMPLICATED: 2003b. Alcohol and Culture.

www.meadmadecomplicated.org/society/culturepatterns.html. Date of access: 15 August 2008.

MOROJELE, N. K., KACHIENG'A, M. A., MOKOKO, E., NKOKO, M. A., PARRY, C. D. M. & NKOWANE 2006. Alcohol use and sexual behaviour among risky drinkers and bar and shebeen patrons in Gauteng province, South Africa. *Social Science and Medicine,* 62: 217-227.

MSENGANA-NDLELA, M. 2006. Preview on Bophirima District Municipality, by the Director-General: Department of Provincial and Local Government (the dplg). http://www.thedplg.gov.za. Date of access: 15 August 2008.

MURRAY, R. P., CONNETT, J. E., TYAS, S. L. BOND, R., EKUMA, O., SILVERSIDES, C. K. & BARNES, G. E. 2002. Alcohol volume, drinking pattern,

and cardiovascular disease morbidity and mortality: Is there a U-shaped function? *American Journal of Epidemiology,* 155(3): 242 – 248.

NIEUWENHUIS, J. 2007. Analysing qualitative data. (*In* Maree, K. (ed). Creswell, J. W., Ebersöhn, I., Eloff, R., Ferreira, N. V., Jansen, J. D., Nieuwenhuis, J., Pietersen, J., Plano Clark, V. L. & van der Westhuizen, C. 2007. First Steps in research. Pretoria: van Schaik, 99 – 117).

NORTH WEST PROVINCIAL GOVERNMENT: 2004. North West Provincial Growth and Development Strategy: 2004 -2014.

http://www.environment.gov.za/soer/reports/northwest/01%20contents.pdf. Date of access: 15 August 2008.

OBOT, I. S., KARURI, G. S. & IBANGA, A. J. 2003. Substance use and other risky behaviours of secondary school students in a Nigerian urban area. *African Journal of Drug and Alcohol Studies,* 2 (1 & 2), 57 - 65.

PARRY. C. D.M., BHANA, A., MYERS, B., PLUDDEMANN, A., FLISHER, A. J., PEDEN, M. M. & MOROJELE, N. K. 2002. Alcohol use in South Africa: findings from the South African community epidemiology network on drug use (SACENDU) project. *Journal of studies on alcohol*, 63: 430-435.

PARRY, C. D. M., MYERS, B., MOROJELE, N. K., FLISHER, A. J., BHANA, A., DONSON, H. & PLŰDDEMANN, A. 2004. Trends in adolescent alcohol and other drug use: findings from three sentinel sites in South Africa (1997-2001). *Journal of Adolescence*, 27: 429-440.

PARRY, C. D. M. 2005. South Africa: Alcohol today. *Addiction*, 100: 426-429.

PARRY, C. D. H., PLŰDDEMAN, A., STEYN, K., BRADSHAW, B., NORMAN, R. & LAUBSHER, R. 2005. Alcohol use in South Africa: Findings from the first demographic and health survey. *Journal of Studies in Alcohol,* 66: 91-97

PATEL, V. 2007. Alcohol use and mental health in developing countries. *AEP*17: S87-S92.

PELTZER, K. 2003. Drinking motives, behaviour and problems among Black South African University students. *African Journal of Drug & Alcohol Studies,* 2 (1 & 2), 1 - 10.

PELTZER, K. & RAMLAGAN, S. 2009. Alcohol Use Trends in South Africa. *Journal of Social Sciences*, 18(1): 1-12.

PLANT, M. & PLANT, M. 2006. Binge Britain – Alcohol and National response. London: Oxford University Press.

PISA, P. T. 2008. Association between biological alcohol consumption markers, reported alcohol intakes, and biological health outcomes in an African population in transition. *Thesis,* North West University, Potchefstroom Campus.

RATAEMANE, S. & RATAEMANE, L. 2006. Alcohol consumption in South Africa. *International Journal of Drug Policy*, 17: 373-375.

REDDY, S. P., PANDAY, S., SWART, D. JINABHAI, C. C., AMOSUN, S. L., JAMES, S., MONYEKI, K. D. STEVENS, MOROJELE, N. K., KAMBARAN, N.S., OMARDIEN, R.G. & VAN DEN BORNE, H. W. 2003. Umthenthe uhlaba usamila – The South African Youth Risk Behaviour Survey (2002), Cape Town: Medical Research Council.

REHM, J., REHN, N., ROOM. R., MONTEIRO, M., GMEL, G., JERNIGAN, D. & FRICK, U. 2003. The global distribution of average volume of alcohol consumption and patterns of drinking. *European Addiction Research,* 9, 147-156.

SANCA National Annual Report. 2004/2005. Johannesburg: NLDT printers.

SKWEYIYA, Z., 2007. Statement by the Minister of Social Development, Dr Zola Skweyiya, Substance Abuse Media Briefing, Pretoria, 20 August 2007. http://www.dsd.gov.za. Date of access: 4 Oct. 2007.

SKWEYIYA, Z. 2008. Statement by the Minister of Social Development, Substance Abuse Media Briefing, Pretoria, 29 May 2008. http://www.dsd.gov.za. Date of access: 30 May 2008.

SOCIAL ISSUES RESEARCH CENTRE 2009. SOCIAL AND CULTURAL ASPECTS OF DRINKING – Culture Chemistry and Consequences, 2009. www.sirc.org/publik/drinking6.html Date of Access: 17 April 2009.

SOUL CITY INSTITUTE. Health & Development Communication. 2007. Alcohol and You. South African Broadcasting Corporation. Johannesburg: Jacana Media Publishers.

SOUTH AFRICAN BROADCASTING CORPORATION (SABC) 3 February 2009. Homebrew: Mbamba, Special Assignment Programme.

TEDDLIE, C. & TASHAKKORI, A. 2009. Foundations of Mixed Methods Research: Integrating Quantitative and Qualitative Approaches in the Social and Behavioral Sciences. Thousand Oaks, CA.:Sage Publications.

VAN AS, S. 2004. The taxing of alcohol abuse – Establishing an alcohol injury fund. *Science in Africa*. http://www.scienceinafrica.co.za/2004/january/injuryfund.htm.

VORSTER, H.H. 2007. Alcohol study: Application to NRF. Unpublished.

WALMSLEY, D. & WALMSLEY, D. 2002. North West Province State of the environment report: Overview. www.environment.gov.za/soer/reports/northwest/01%20contents.pdf.

WECHSBERG, W. M., LUSENO, W. K., KARG, R. S., YOUNG, S., RODMAN, N., MYERS, B. & PARRY, C. D. H. 2008. Alcohol, cannabis, and methamphetamine use and other risk behaviours among Black and Coloured South African women: A small randomized trial in the Western Cape. *International Journal of Drug Policy,* 19: 130-139.

WORLD HEALTH ORGANIZATION REPORT (WHO) 2000. Health Systems: Improving performance. Geneva, Switzerland.

WORLD HEALTH ORGANIZATION REPORT. 2002. Reducing risks, promoting healthy life. Geneva, Switzerland.

WORLD HEALTH ORGANIZATION. 2004. Global status report on alcohol. Geneva, Switzerland.

ZAWAIRA, F. 2009. The burden of alcohol consumption in the African Region. World Health Organisation. Date of access: 12July 2009.

CHAPTER 5

Article 4

THE SOCIO-ECONOMIC EFFECTS OF BINGE DRINKING ON SOCIAL SUPPORT NETWORKS IN SELECTED AREAS OF THE NORTH WEST PROVINCE, SOUTH AFRICA

B.M.P. Setlalentoa – PhD student - School of Psychosocial Behavioural Sciences (Social Work), North-West University, Potchefstroom Campus

E.H. Ryke – Senior Lecturer – School of Psychosocial Behavioural Sciences (Social Work), North-West University, Potchefstroom Campus

H. Strydom – Professor – School of Psychosocial Behavioural Sciences (Social Work), North-West University, Potchefstroom Campus

ABSTRACT

***Objective**: The article seeks to identify social support networks of binge drinkers in the selected areas of North West Province, which are Ganyesa, Tlakgameng Villages and Ikageng Township, and explore the socio-economic effects binge drinking has on these networks.*

***Method**: The qualitative approach was used, and data was collected using semi-structured interviews and focus groups with binge drinker and, their family members.*

***Results**: Parents, spouses, siblings and children were identified as social support networks that are affected by binge drinking. Role performance is compromised by binge drinkers and in return, support systems are affected. The low socio-economic situation of the communities contributes to the problem. Many social effects are experienced in the areas of study, such as rape, violent crimes, financial stress, women and child abuse, amongst others.*

***Conclusion**: The family members were identified as support network representatives. Binge drinking contributes to failure to provide social support. The situation presents with negative social, emotional and economic effects that are detrimental to the drinker, their significant others and the community in*

general. There is a need for a comprehensive intervention strategy that will focus on drinkers, families and the society to address the problem of alcohol abuse.

Keywords: Binge drinking; Social support; Socio-economic effects

Social support networks; Social network analysis

1. INTRODUCTION

Alcohol abuse has been reported as a major concern and is a source of social and economic problems in the North West Province (Peltzer & Ramlagan, 2009:4). Therefore, the Alcohol Study Project was launched to gain a better understanding of alcohol consumption patterns and the causes and consequences of binge drinking (Vorster,, 2007:25). This sub-study of the Alcohol Study Project seeks to examine the socio-economic effects of binge drinking on the support networks of Ganyesa, Tlakgameng Villages and Ikageng Township in the North West Province.

2. PROBLEM STATEMENT

According to Van As (2004:1), alcohol abuse is estimated to cost South Africa in excess of R9 billion per year and the social costs of alcohol-related trauma and accidents far exceeds those of most other countries. The former Minister of Social Development, Dr. Z. Skweyiya in the media briefing on substance abuse, 29th, May 2008 stated that alcohol is the substance of first choice in South Africa and is used by 31% of the total population. He further stated that substance abuse is a major contributor to crime, poverty, reduced productivity, unemployment, dysfunctional family life, the escalation of chronic diseases such as HIV/AIDS, as well as injury and premature death.

The negative effects of excessive consumption are also linked to many harmful consequences for the individual drinker, his or her immediate environment and society as a whole (WHO, 2004:59). In the United Kingdom, for example, up to 1.3 million children are affected by parental alcohol problems, 22 000 deaths each year are caused by alcohol and one third of all domestic violence incidents are linked to alcohol abuse, (Alcohol Harm Reduction Strategy, 2004:4). The Addiction Recovery Basics on "How alcohol abuse affects family", (2008:1) clearly states that when someone experiences alcohol problems, the negative effects of drinking affect the drinker in question, a partner and other family members.

It has been identified in the quantitative sub-study (see Chapter 4) that in the selected areas of this study, alcohol is used frequently especially during weekends, alcohol consumption is high, and it is consumed by men, women and youth. The predominant alcohol consumption pattern of the alcohol users fits the definition of binge drinking. It is for this reason that social support networks of the identified binge drinkers are further examined in this qualitative study to identify how they are affected by binge drinking with specific reference to socio-economic effects. Provision of social support is pursued to identify the type of support expected and provided, how support is perceived, whether there is reciprocal support and the intention or behaviour of those who are supposed to provide support. This article answers the research questions: who are the social support networks of binge drinkers and what are the socio-economic effects experienced by these networks due to binge drinking?

3. OBJECTIVE OF THE STUDY

The objective of the article is to identify the social support networks of binge drinkers and to explore the socio-economic effects of binge drinking on social support networks.

4. RESEARCH METHODOLOGY

The study adopted a qualitative approach to identify and explore the socio-economic effects of binge drinking on social support networks.

4.1 Design

The collective case study was used as a type of design in qualitative research. Creswell (2007:73) states that it is an appropriate approach when the researcher has clearly identifiable cases with boundaries and seeks to provide an in-depth understanding of the cases. The binge drinkers were selected from those identified (see Chapter 4) to provide more information about drinking episodes and social support. Their support networks were selected to provide more information about binge drinking and how it affects them as far as support is concerned.

The participants were recruited from the 143 identified binge drinkers from the sample of 882 alcohol users (see Chapter 4). The field workers were provided with a list of names of the identified participants and proceeded to invite them to

participate in the focus groups and in-depth interviews. The eligibility criterion for participation in the focus group and in-depth interviews was based on those who matched the description of binge drinking of four or five drinks for women and men respectively in one drinking session. The rationale for selecting a sample of fourteen was based on the fact that qualitative research provides an in-depth understanding of the issue and a small sample size of about 5 -25 participants is sufficient, because one need not generalise the findings to the population (Creswell, 2007:125).

The selection criterion for the two focus groups was those people who are currently experiencing episodes of binge drinking and each group consisted of seven members, one from a rural and one from an urban area. Each group consisted of three women and four men, age ranging from 37– 61 years. The rationale for using gender as a selection criterion was to verify the issue that women are now drinking alcohol, whereas in the olden days this was not practised (see Chapter 2). The male participants were more than females because their number was higher in the PURE dataset.

4.2 Data collection

The binge drinkers described their drinking episodes and their role in providing social support. The support networks provided information describing how they have experienced life with a person who abuses alcohol and how it has affected them. Creswell (2007:58) says that the inquirer collects data from persons who have experienced the phenomenon, and develops a composite description of the essence of the experience for all of the individuals. The interviews provided an understanding of the participants' perspective, their meanings, and their subjective views about alcohol abuse as informed by a constructivist perspective (see Chapter 3).

Data were collected from two types of sources, that is, the binge drinkers and their family members. The rationale for including the binge drinkers was to hear their views about provision of social support and to identify their major support system. The family as a social support network was identified and family members of the binge drinkers were interviewed to explore their experiences with a person who is binge drinking.

Semi-structured interviews using an interview schedule were conducted for participants to express their views on social support broadly and how it is affected by binge drinking (Addendum 11). The themes, namely, type of support, recipient perception, reciprocal support and behaviour or intention of provider as described by Hupcey (1998) were used to answer the research questions specifically to understand how binge drinking affects social support networks. For binge drinkers, data were collected in focus groups, one in each area of the study and followed by interviews. During interviews and focus groups notes were taken and responses were audio recorded and later translated from Setswana to English and then transcribed for coding and analysis.

4.3 Procedure

The researcher had meetings with the team from AUTHeR and visited the areas to meet the field workers and acquaint herself with the project and the site where research was conducted. Because Ganyesa and Tlakgameng are tribal land, the visit was announced at the tribal office because it is important as one has to follow protocol, and culture demands and that you show respect by making your presence known. The field workers were briefed on the process and roles were clarified pertaining to focus groups and in-depth interviews. Their role was to recruit participants who matched the description of binge drinking, arrange venues for groups and inform participants about the dates of meetings. They assisted the researcher to locate the homes of the participants, but did not participate in the in-depth interviews.

4.4 Ethical consideration

Ethics approval was granted to the PURE study by North-West University, ethical clearance 04M10 (Annexure 2a). This sub-study examined alcohol intake in the same population and was, therefore, covered by the PURE approval (Annexure 2b). Ethics approval was granted for the Alcohol Study subsidised by National Research Fund (NRF) (FA- 2006041100003).

The participants consented to participate in the in-depth interviews and focus groups and signed a consent form after a thorough explanation was provided in the Setswana language (Annexure 8). For under-aged children and young adults

who responded on behalf of the family as a social support network, the parents were requested to extend their consent to have interviews with children to hear their views about binge drinking and social support.

4.5 Data analysis

Content analysis was used to analyse responses from the in-depth interviews with binge drinkers and support networks and from focus group discussions. This type of analysis is used to analyse qualitative responses to open-ended questions in interviews or focus groups. It also assisted in looking at data from different angles with a view to identifying keys in the text that helped to understand and interpret data (Nieuwenhuis, 2007:101). It was used to understand the experiences of the binge drinkers and those of support networks who live with a binge drinker. Specific reference was on social support.

5. RESULTS

The results of the study are presented focusing on the profile of participants, social support and socio-economic problems.

5.1 Profile of participants

This study provided an opportunity for diverse groups of individuals; the binge drinkers and their identified support networks to share their experiences regarding binge drinking and its effects. The identified social support networks were all the family members, namely, spouses, minor and adult children and parents of binge drinkers as illustrated in Table 1 below.

Table 1: Profile of binge drinkers (B) and identified support networks (S)

Members (B)	Gender	Short background	Alcohol use	Support network (S)
A	Female 48 years	Unmarried, lives with six children, Unemployed, receives child support grant for three children. Live in a one-roomed mud house	Drinks home brew alcohol excessively especially when she has received the grant. She is a monthly drinker. She drinks home brewed beer.	Child female 21 years, scholar
B	Male 59 years	Married, lives with five children and four grandchildren, Three daughters, first with one child, second has two and last one has two children. Children are unemployed and all live in the same household. Unemployed and receives child support grant for all five grand children. The parents (B & C) do not have any source of income.	Drinks home brewed alcohol. Consumes during the weekends and during the week at times. The adult children also abuse alcohol.	Elder and second daughter 30 and 25 years. Both were unernployed
C	Female 56years	Wife of member B.	Takes home brewed alcohol, Consume during weekends.	As above
D	Male 45 years	Unmarried, unemployed, no children, receives disability grant. Lives at his mother house.	Takes home brewed alcohol and beer, especially after receiving grant. He is a monthly drinker.	Mother, 70years, pensioner

E	Female 61 years	Unmarried, unemployed, has three children. House belong to daughter, has no house of her own, and lives with daughter and her two grandchildren aged 5 and 7years old. Depends on the daughter's disability grant and maintenance money paid for grandchildren.	Take home brewed alcohol during weekends.	Daughter, 27years, unemployed, receives disability grant
F	Male 55 years	Married, unemployed, three children aged 9, 14 and 22 years. The 14 year old boy is truant and has dropped out of school. Both F and G receive disability grant.	Both parents F and G use home brewed alcohol. Drink whenever they receive grants, monthly.	Daughter, 22 years scholar
G	Male 48 years	Customary marriage, they have two children, one is school going and one is a young adult.	Take home brewed alcohol especially during weekends.	Son, 23 years, unemployed
H	Female 39 years	Living with partner, unemployed, One child, 10years old, receives child support grant	Both abuse alcohol (beer) during weekends.	Mother, 60years, unemployed
I	Male 63 years	Unmarried, living with a partner and have two young adults children– receives old age pension	Abuses alcohol (beer), monthly after receiving pension.	Sister, 35 years, unemployed
J	Male 37 years	Unmarried, no children, unemployed but do casual jobs	Use alcohol (beer) during weekends.	Mother, 63yrs, pensioner

K	Female 45 years	Unmarried, one child who has two daughters, one nephew in Std 7, participant receives foster grant for her nephew	Drinks alcohol (beer) during weekends	Daughter, 20years, scholar
L	Male 46 years	Unmarried, receives disability grant. One daughter, not attending school, has a child of her own.	Abuses alcohol, prefers beer and whisky during the week at times and weekends	Daughter, 22years, has a child, unemployed
M	Male 54years	Married, unemployed, five children, two are under 18 years and attend school	Abuses alcohol prefers beer during weekends.	Wife 54years unemployed
N	Female 49 years	Married, unemployed. Three children, one school going age.	Drinks alcohol, prefers beer during weekends	Son, 20 years Scholar

Data from Table 1 were considered and classified into different themes that describe the drinking behaviour and socio-economic situation of binge drinking participants and their social support network representatives. The identified themes are gender, age, marital status and household situation, employment and income, and support networks.

5.1.1 Gender

There were fourteen binge drinkers consisting of eight males and six females. The support networks were fourteen and consisted of twelve females and two males.

5.1.2 Age

The age range of the binge drinkers is 37 - 63 years. The majority of them are at an age that allows them to find work unless disability makes it impossible to work. However, they do not see it that way because others who do not receive pensions also try ways of accessing pensions rather than find employment. The school-going children who are cared for by parents or grandparents, who are binge drinkers, were also identified. The binge drinking problem puts them at risk because they still need care and support from parents. The age range of support

network representatives is 20 – 63, with the majority below 20 years. A point to be noted is that even though they are over 21 years, the young adults still live with the parents.

5.1.3 Marital status and household situation

It was also noted that eight members were unmarried and have children that they have to provide for. The socio-economic position indicates that the family is struggling to make ends meet. Some of those who are married with children, both partners abuse alcohol. These situations could expose children to neglect and abuse, especially those who still depend on parents for care and support. One participant stated that she cares for her nephew whose mother has died and she has two children of her own. It is indicated in Figure 1 that there are participants who care for the orphans. Lack of social support affects the social networks and present with social, economic and health negative effects.

5.1.4 Employment and income

The profile indicates that the families are living in poverty because the majority are unemployed; depend on pensions and grants and are cared for by support networks that live in the same household. It was noted that the majority of binge drinkers and their support networks are unemployed and depend on old age pension, disability and child support grants. Overdependence on pensions even those who are young to find employment was noticed. The participants are unemployed except one who indicated that he has a temporary job. It is an indication that social support is compromised because of lack of income. The young children who are economically dependent on parents are vulnerable because of binge drinking by parents. Parents, who are poor, spend pension money on alcohol which makes it more difficult to provide support. The profile of social challenges indicated that of the 882 questionnaires of the PURE study, 327 respondents reported unavailability of food (see Chapter 4) which could be attributed to poverty with abuse of money on alcohol being one contributory factor.

5.1.5 Weekend and monthly drinking

Table 1 indicates that males and females drink alcohol excessively especially during weekends and monthly when they have received pensions and grants.

5.1.6 Support networks

The support networks representatives included a one spouse, three mothers, ten children and one sibling.

The profile provided a picture of the situation in the selected areas of study, indicating the binge drinkers' families' composition, socio-economic position and support networks. In-depth interviews and focus groups to hear the voices about lived experiences and views about social support are hereunder explored.

5.2 Social support

Social support is defined as "support accessible to an individual through social ties, which are networks, to other individuals and it encompasses social networks, perceived support and supportive behaviours" (Hupcey, 1998:1232) (see Chapter 3). According to Tracy *et al.* (1994:481), social support refers to many different ways in which people provide assistance to one another: emotional encouragement, advice, information, guidance, tangible aid or concrete assistance. It can be provided spontaneously through the natural helping networks of family and friends, or can be mobilised through professional intervention. Tracy and Whittaker (1990:461) are of the view that people are rarely isolated; rather, they are surrounded by social networks that may support, weaken, substitute for, or supplement the helping efforts of professionals.

For the purpose of this study, Hupcey's (1998:1232) themes are used to understand the situation in the selected areas with regard to social support, namely, type of support, recipient perception, reciprocal support and behaviour and intentions of provider. The binge drinkers were asked about the role they play insofar as provision of support is concerned. The family members, as recipients of support also provided their views with regard to the support they receive.

5.2.1 Type of support

Type of support refers to emotional (love and care), instrumental (material, house work or child minding) and informational (giving advice, feedback) support that is provided, received and exchanged among support networks and behaviour of the provider (Hupcey, 1998:1232). They are functions performed for an individual by others. Tracy *et al.* (1994:482) refer to studies on social support that indicated differential impacts from various types and sources of support.

5.2.1.1 The perceptions of binge drinkers regarding the type of support they provide to their support networks

The binge drinkers were asked about the type of support they provide for their families. There was an agreement among them that they are responsible for material and emotional support, however, some members acknowledged that there are times when they cannot do so because they would be under the influence of alcohol. Some felt children understand that adults take alcohol and that they should take care of themselves.

> *"I buy food for my family, pay school fees and I have also built a house for us even though it is incomplete."* (Material support).
>
> *"I am not able to help my children with homework because I am not educated."* (Instrumental support).
>
> *"I love my children even though at times I spend time with my drinking pals. They know I love them. I know they do not approve of my drinking alcohol but there is nothing I can do because life is not easy on some of us."* (Emotional support).

The binge drinkers seem to justify the manner in which they provide support. Use of alcohol is used as an escape from the challenges that are experienced by families, however, the impact of the type of support provided on their support network is not given priority. Instead, the binge drinkers expect the support networks to accept the *status quo.* Lincoln (2000:233) states that this attitude by a

member of a social network causes distress such as sadness and resentment and affects social interactions negatively.

The providers were binge drinkers who were a spouse, child or parent. The group members (binge drinkers) were asked about their ability to provide emotional, instrumental and material support to family members. Most of the group members expressed their intention to take care of their families to ensure cohesion. However, it has not been easy to provide emotional and instrumental support because of not being at home at times. They do provide material support but at times it is not possible due to lack of resources. They do admit that alcohol does inhibit proper execution of their role as parents and providers. The participants were asked to elaborate on what they see as their role in their families. Their response was that they care, feed and clothe their children and spouses or partners but because they are not working, it is not always possible to provide. A male participant said:

> *"I am not working; depend on piece jobs and pension. If I do not have money to buy food, they (his family) go to bed without food. There is nothing I can do if I do not have money. They know I am not working."*

Some of the practices are presented as a normal, yet the effects thereof are detrimental because children are not receiving support as expected. Role performance is not given priority because children are expected to assume roles of parents when they are not present to take control. One male drinker justified his actions and said:

> *"My parents used to drink and I had to take care of my siblings, prepare food, wash them and clean the house."*

Of significance in the statement is that the socially constructed views take precedence because this participant experienced a situation where he had to take of care of his siblings as a child, and just assume that his children should also accept the role. Family members do not have a choice because others cannot provide for them. Support is provided when it is possible, if not, they are expected to understand irrespective of the support networks' age or circumstances. One

could deduce that the environment has a strong influence on peoples' thinking and way of doing things. They construct their own social reality because of the circumstances to which they were exposed. In turn, providers assume other generations are obliged to accept even though the situation is unbearable.

The danger of this situation is that children tend to imitate behaviour of parents. Children are socialised to accept no support as normal and this kind of behaviour deprives them of love and care which is critical for a developing child. They cannot challenge the behaviour of adults neither can they engage them on their rights to food, shelter and care. An exposure to such views could be replicated in the generations to come and this could be a vicious circle. Their upbringing in some instances constructed ideas that failure to support because of lack of resources is a way of life that their networks should accept. Most of them were exposed to the kind of life in their early years. Some responses were indicative of lack of understanding or simply ignorance.

Performance of roles by binge drinkers is compromised in most instances. Drinking is carried out primarily outside the family and home, thus denying members time needed to carryout family responsibilities. Drinking also costs money and can impact upon resources particularly of a poor family, leaving family members destitute. The other consequence could be loss of income or wages, premature death of a provider, home accidents, family violence and mental health problems (WHO, 2004:60). Participants have noticed that the effects of their drinking on support networks have affected their relationships. In the in-depth interview one binge drinker who is a parent mentioned that it is difficult to even discipline children when a parent is abusing alcohol. A female binge drinker reported as follows:

> *"He (her child) told me to leave him alone because I drink alcohol as well. He (the child) said: I do not ask you for money to buy alcohol."*

This is an indication that alcohol abuse makes parents not to be good role models because they have socialized their children that alcohol is a way of life.

5.2.1.2 The views of support networks regarding the type of support they get from binge drinkers

The children were asked about the type of support they receive from their binge drinking parent or parents. The responses covered all three types of support, that is, concrete assistance, emotional and information or advice. They responded that their parents do take care of them though not always, although not all parents provided all three types of support. Lack of emotional, material and instrumental support from the binge drinkers was expressed by other children. The parents provide food but at times children go to bed without having it. Parents are not able to assist them with school work and do not attend school meetings when they are called to do so. One child mentioned that the parents are not literate and, therefore, cannot help them with school work. Some children said that their parents do attempt to attend school meetings though not all the times. Parents are not motivating them to aspire to succeed because they have never experienced such support from their own parents. One school going child said:

> *"My younger brother has dropped out of school. My parents use alcohol, at times they do not notice that he is playing truancy because, either they are under the influence of alcohol or they are not at home. I have tried to motivate him to go back to school without success. They are not always there to provide leadership and support."*

When this particular family was visited at about 11H00 during the school holidays, the parents were home with friends, enjoying their home brewed alcohol and the child was in the house.

Some of the children stated that they receive love especially from their mothers but generally parents are never at home.

> *"My mother buys us food but at times we go to bed without food."*

Many families live in poverty. One child stated that they are really suffering because parents are not working and find it hard to provide for their basic needs. It was evident during the visits that most families are living below poverty datum line. It was not easy for the children to express their views about the behaviour of

parents because it is not acceptable to do so in their culture. The young adults did not express dissatisfaction with alcohol use and when the point was explored, it became evident that they are also using alcohol, hence the response. The spouse was also concerned about the non-availability of the partner to provide support to children or even her. Care, love and tangible assistance is not provided. The mother who is a pensioner stated that she provides support to her disabled son who should be supporting her as an old person. It is clear that support is comprised when one family member abuses alcohol.

5.2.2 Recipient perception

Hupcey (1998:1234) is of the view that the recipients' positive perception of the support provided, information and feedback would maximise positive effects. Social support is the extent to which an individual believes that his or her needs are fulfilled. The support expected and provided should match; otherwise it will serve no purpose as the needs remain unsatisfied. Tracy *et al.* (1994:484) assert that the perceived availability of social support and the nature and function of relationships within a network are critical. The support networks also expressed their views pertaining to effects that parental or spouse drinking have on the family members.

5.2.2.1 Perceptions of children

The majority of children expressed concern about their future and blamed abuse of alcohol as a major contributory factor. They find it unacceptable for parents to continue abusing alcohol when the families live in poverty. Provision of support such as emotional support do not require money, but parents' unavailability or excessive drinking makes it difficult to even provide it. Some acknowledged that the parents are trying to take care of them but it is not enough. This view is supported by Lincoln (2000:236) that individuals feel that although the correct person provides support, at times it is not done in a manner perceived as helpful. The children believe things would be better if parents were not abusing alcohol.

> *"My mother is not working, we struggle with food, and blankets, but she always tries to provide for us."*

"I left school because my mother and father failed to pay school fees. I am very unhappy because they drink alcohol."

"Ma cooks for us but at times we do not find her home after school because she visits her friends and most of the time when she comes back, she is under the influence of liquor. I really hate it when she does this because it is embarrassing."

Inability to provide support to children could be classified as neglect and abuse because the significance of parents in the development of children cannot be overemphasised. Unavailable parents fail to socialise the children to know the importance of love and care which could make it difficult for children to care for their own children later in life. Possible negative effects that could be seen are withdrawal, delinquency, and sadness because of excessive alcohol intake by parents. This view is supported by Velleman and Templeton (2003:103) that the majority of children who have parents with drinking problems are exposed to such problems at home, continuously, throughout most years of childhood and adolescence. Fatout (1990:76) goes further to state that severely abused and neglected children suffer from the psychological outcomes of their abuse throughout their lives. Child abuse was identified in the PURE study with 224 positive responses (see Chapter 4). Absence of parents who frequent shebeens is one indication of abuse because children are left alone and anything negative could happen to them.

According to the WHO (2004:60), parental drinking is correlated with child abuse and impacts a child's environment in many social, psychological and economic ways. Children in the homes of a drinker suffer from a variety of physical, emotional problems at a greater rate than children from other homes. These children often demonstrate behavioural problems. Turning Point (2006:2) reports that children were more likely to experiment with drugs and alcohol at an early age; they missed school and had poor experiences and low aspirations to succeed. For instance, one support network, a teenage girl expressed concern about the behaviour of her 14 years brother who left school in the middle of the year because he was playing truancy and her parents did not realise this because

they are not vigilant. This situation has caused her distress. In one family the unmarried, three unmarried young adults found at home, were unemployed, have babies, depend on child support grant and also abuse alcohol just like their parents. It would not be easy for parents to discredit using alcohol because both parents abuse it. They are not good role models.

Children have experienced negative effects such as unavailable parents, which creates a problem because children are forced to assume the roles of parents and this may negatively affect family functioning. The children are not supported in educational matters and do not receive love and attention because of abuse of alcohol by parents. According to Tracy *et al.* (1994:482), concrete assistance with child-rearing and housing tasks has been associated with increased responsiveness of parents to their children.

Alcohol misuse is generally damaging to families, impacting on parents' ability to care for their children. Some of the problems caused by binge drinking are conflict and disharmony between the parents and cause harm to children.

Some of the adolescents in the households who were interviewed had very little to say about the negative effects of alcohol or social support they receive from the binge drinkers. When further probing was done, it emerged that they are also abusing alcohol; hence they could not elaborate on the effects they experience as a result of binge drinking. The perception of recipients indicates that social support is not provided in an acceptable manner and is therefore, negatively affected by binge drinking. The impact thereof is child neglect, poor relationships, stress in homes and general breakdown.

5.2.2.2 Perceptions of spouse

The spouse who is a support network of a husband who is binge drinking expressed her unhappiness about alcohol drinking behaviour of her partner. The wife stated that her husband is always away from home and not available to provide guidance and leadership in the family. It becomes more difficult because both wife and husband are not working, have no source of income and the husband spent his pension money on alcohol. It is alleged that the husband spent time at drinking venues but when he is sick, the wife is expected to take care of

him. The wife further explained that most women whose partners abuse alcohol suffer because the husbands fail to provide social support:

> *"I am the only one who is providing for children because my husband is hardly home, always out with friends, drinking at shebeens. I find it difficult to understand why he prefers to be with his drinking friends all the time. When he is home, he does not want to chat with us or even check whether children are managing at school."*

Failure to provide support is viewed by a wife whose husband abuses alcohol as one form of women abuse. Women abuse was identified as one of the social problems experienced in the selected areas of study (see Chapter 4).

According to Velleman and Templeton (2003:106), marital cohesion incorporates ideas of affection, participation in household tasks, how the wife viewed the husband when he was sober and the degree of optimism held about the future of the marriage. The participant who is a wife of a binge drinker indicated that the absence of the husband, his drunken stupor, and inability to show affection has affected the cohesion in their relationship. Because they are unemployed and depend on the husband to provide them with their pension, they stay to get assistance. She would have left the marriage if she had means to provide for the children.

5.2.2.3 Perceptions of parents and sibling as support networks

In one family, the parent was experiencing problems with the son who is abusing alcohol. He is always under the influence of alcohol and this has affected the elderly parent because the son is not able to care for himself. The same feelings were expressed by a sibling whose brother abuses alcohol.

5.2.3 Reciprocal support

Reciprocal support is an exchange of resources between recipient and provider. The actual giving, receiving and exchange of support is referred to as the function of social support (Hupcey, 1998:1232). Tracy and Whittaker (1990:464) refer to it as proportion of network relationships in which "help goes both ways".

The participants, both binge drinkers and support networks, were asked the question to ascertain whether support is reciprocated: Is support reciprocated in your family where each member performs a role or roles to enhance social functioning? The responses from the male participant binge drinkers were that they expect their partners and children to perform their roles in the family. A male participant said:

> *"In my culture women are expected to cook, clean and generally take care of the household. The women should be home with the children to provide love and care. The husbands have the responsibility to provide food, housing and money for education of children. We all have to perform what is expected of us."*

The male participants felt that these responsibilities are not affected by drinking of alcohol except in situations where women are also abusing alcohol. The women participants responded that it is not always easy to take care of children alone. They need assistance from men but they are not helpful. The wife participant said:

> *"My husband never bothers about the needs of children. I also want to be assisted but help is not forthcoming."*

The support networks responded that the parent and partners were not performing their roles as expected because of alcohol abuse. This situation created unpleasantness among networks because support is not reciprocated.

5.2.4 The behaviour and intentions of the binge drinker as a provider

The behaviour of the provider of support determines the satisfaction or dissatisfaction, or survival, functioning or dysfunctioning of a system (Hupcey, 1998: 1234).

The behaviour of binge drinkers has led to many problems that brought dissatisfaction and dysfunctioning in families. One problem that was experienced in many families is domestic violence and this was confirmed by children and a spouse, as well as by the female binge drinkers with partners. They further stated

that children and partners live in fear especially on the days they know that the drinker is out drinking. A woman participant said:

> *"The violence is sparked by either not responding quickly to his knock at the door, not having food or anything that can trigger violence. At times we have to run away from home because of violence. On many occasions, especially during weekends, we end up calling the police or going to the police station to seek refuge."*

This experience is consistent with the view by Turning Point (2006:1) that in the United Kingdom, about one third of all domestic violence incidents are linked to alcohol misuse. The view is also expressed in the WHO (2004: 63) that excessive alcohol use is a strong and consistent correlate of marital violence. The consequences of domestic violence could be detrimental for the entire family. One support network said:

> *"My mother always becomes violent when she is under the influence of alcohol. She chases us out of the house, breaks utensils and really behaves in an unacceptable manner."*

The association of violence and alcohol abuse has been identified by the Medical Research Council in a study conducted in 2000 in Cape Town, Durban and Johannesburg that revealed that about one-third to half of arrestees who were charged with offences categorised as "family violence" reported being under the influence of alcohol at the time of alleged offences. Family relationships are destroyed and many negative effects such as divorce, death or injuries could be experienced. Children could learn violence and aggression because of exposure to such behaviours when parents are under the influence of alcohol.

Other problems that are experienced in the selected areas are rape and assaults and 417 respondents in the PURE study have shown existence of such problems (see Chapter 4). The participants reported that women have being raped or assaulted while under the influence of alcohol and this is what was said:

> *"We know of incidents were women were assaulted and raped after drinking alcohol. Most of the time, it is men*

they meet on the way home, or their drinking pals. At times men buy drinks for women and then demand sex."

Abbey *et al.* (2001:7), in their article on alcohol and sexual assault, conclude that heavy drinkers, both perpetrators and victims, spend time in bars and in parties and the former use drinking as an excuse for socially unacceptable behaviour and the latter's alcohol intoxication reduces ability to evaluate risk or to resist effectively. None of the participants revealed whether they have experienced this kind of problem, but the fact that they frequent shebeens exposes them to such incidences.

Alcohol plays a significant role when men and women engage in arguments especially at shebeens, that lead to fights and at times people get injured. Other types of crimes like theft and housebreaking have been experienced in the communities. They all agreed that alcohol put them at risk of experiencing any of the problems mentioned above. The binge drinkers had also experienced arrests when police raided the shebeens.

The children felt that they are negatively affected by behaviour of their parents. The children have to assume roles that interfere with their studies. One child said:

"It is difficult for me to study after doing all the chores because of exhaustion. I do not have a choice because my parents are always out drinking with friends."

The behaviour of drinking parents has led to some of the children experimenting with alcohol at an earlier age when parents were not at home. They have also stayed away from home because of the violence and aggression in their households where arguments and conflict are common, especially when parents are under the influence of alcohol.

They stated that parents depend on pension money for survival, yet they abuse it on alcohol. One child in particular, felt strongly that her parents would have built a house if they were not abusing alcohol. They struggle to buy food and are not able to assist her with school work because they are always under the influence of alcohol. The problem is compounded by their low level of education. This particular participant (female aged 21 years) was eager to finish school so that she

can start working and improve their lives. Financial stress is experienced by many participants as was presented in Chapter 4.

6. DISCUSSION AND CONCLUSION

The Victorian Health Foundation, (2005) cites Berkman and Glass that social networks can provide social support, social influence, opportunities for social engagement and meaningful social roles, as well as access to resources and intimate one-on-one contact. Social support also strengthens mental health. According to Tracy *et al.* (1994:482), the stress buffering effects of emotional support, especially from close relationships, has been related to emotional well-being. Social support also contributes to psychological well-being because positive interactions have a beneficial impact on well-being (Lincoln, 2000:237). This study indicated that binge drinking denies social networks, especially families that support, which means that it affects their mental health. Poor social networks, that is, social ties, social connectedness, social integration and social activity have detrimental effects on members of families.

The study has highlighted the negative socio-economic effects that are experienced by drinkers and their support networks. These negative effects include economic insecurity and poor financial decisions because money is used on alcohol instead on provision of material support. This has led to financial difficulties, marital conflict, child abuse and neglect, unhappiness, loss of relationships and a general poor quality of life.

The focus groups and interviews revealed the pattern of drinking but also identified the socio-economic consequences that have been experienced by binge drinkers and support networks as a result of binge drinking. The data from the profiles indicated that in one way or the other social support is compromised because of alcohol abuse. The rationale for seeking responses on social support was to understand what binge drinkers perceive to be their role in their families and whether they perform as expected.

The views of support networks in relation to support they expect, exchange and receive from the providers was obtained. The investigation was guided by an understanding of the causes and consequences of alcohol misuse (Chapter 2) and social support as discussed in Chapter 3. The quantitative data (Chapter 4)

provided a situational analysis with regard to alcohol abuse and binge drinking in the selected areas and prompted a qualitative enquiry to hear the views and experiences of binge drinkers and their social support networks. The network representatives that were identified by the binge drinkers are children, partners, parents and a sibling.

6.1 Children

The children were identified as the most vulnerable because of their dependence on parents to provide social support. They expressed concern regarding their parents' abuse of alcohol. They perceive it as a contributory factor to their low socio-economic situation because money is wasted on alcohol, depriving them of material support. Their unavailability also deprives them of emotional and instrumental support. The situation is worse where both parents abuse alcohol.

Fatout (1990:76) is of the view that alcohol abuse results in the child being unable to develop and sustain relationships with others during childhood and adulthood as well. The negative effects that are experienced when parents fail to provide a predictable, safe, secure environment for their children could lead to inability to develop. It is compounded by failure to value children as individuals with personal rights, feelings, and interests, but is seen as an extension of the parents and could lead to lack of separation in the child. Alcohol abuse by parents makes children preoccupied with the behaviour of parents which leaves little time or energy for exploring and enjoying the world or relationships with others. Exposure to domestic violence and aggression could be learned behaviour arising from living in a disruptive household, where arguments and parental conflict are common. Absent parents who abuse alcohol make children more vulnerable to negative consequences such as the daughters and a son who abuse alcohol.

6.2 Wife

The wife as a support network was also negatively affected socially, economically and emotionally as well. Partners have to carry the responsibility of socialisation on their own because alcohol makes partners absent most of the time. The responsibility of providing social support is left to one partner and it becomes more difficult when there is financial stress in the family. The situation is worsened by

violence, conflict, and contributes to lack of cohesion in the family. They support the binge drinker by performing chores yet the support is not reciprocated. Marriages are likely to end in divorce where there are alcohol problems. It is stated that the effects of men's drinking on the members of the family is often particularly on women in their roles as mothers or wives of drinkers. The risks include violence, infections and an increased burden in their role as economic providers, (WHO, 2004:61). Some of the female binge drinkers alleged that they use alcohol to escape the social and economic challenges. However, it does not address the problem, instead it affects them because they fail to provide support when needed and this affects the children negatively.

6.3 Parents and siblings

The elderly parents and siblings face the same challenges because their children and other siblings abuse alcohol and are not supportive. The children are not reciprocating support they receive from parents. Even those parents who are able to provide for themselves are worried about their children who are facing a bleak future because of alcohol abuse. Behaviour of the binge drinker causes distress and harm to the individual and their support networks.

Conclusively, provision of social support cannot be overemphasised because emotional support, companionship and opportunities for meaningful social engagement have an influence on self-esteem, coping effectiveness, and sense of well-being. People who have less or no social and emotional support are more likely to experience depression, poor health, distress and isolation. The impact of alcohol abuse on family life is that the drinking and its consequences can result in substantial mental health problems of family members (WHO, 2004: 61). This as well, contributes to a poor quality of life.

The negative effects of alcohol affect the drinker and they automatically affect others in the social environment. This is in line with the ecological perspective that demonstrates the relationship and connection between people and their environments. It is for that reason that the social support networks are negatively affected by alcohol abuse.

A conclusion can be drawn that the selected areas of study are exposed to excessive alcohol consumption that has negative effects for the drinker and

significant others. Poverty, unemployment, child neglect and domestic violence are some of the identified socio-economic effects. Intervention strategy to motivate high-risk drinkers to moderate their alcohol consumption would be helping the drinker and the support networks as well. Support networks need to be included in primary, secondary and tertiary treatment so that they are able to cope. The intervention to address socio-economic challenges requires attention to deal with the causes and effects of alcohol abuse and improve quality of life. It, therefore, demands that attention be given to develop relevant alcohol reduction/intervention strategies to address alcohol abuse and misuse in South Africa.

7. SUMMARY

The study has verified that alcohol abuse is apparent and is done so frequently, especially when drinkers have received their pensions. It is evident that the selected communities occupy a low socio-economic class and provision of social support is compromised in many instances. The social support networks are undoubtedly affected by this heavy episodic drinking that presents with socio-economic effects that are detrimental for the drinker, spouses, children, parents and the society in general as integrated and interdependent systems.

Many consequences as stated in Chapter 2 are experienced in the selected areas of study. Family disruption is caused by failure to provide shelter, emotional, economic and psychological support. Development of coherent intervention strategies is critical to address the problem of binge drinking and other related problems.

8. REFERENCES

ABBEY, A., ZAWACKI, T., BUCK, P. O., CLINTON, A. M. & McAUSLAN, P. 2001. Alcohol and Sexual Assault. National Institute on Alcohol Abuse and Alcoholism, *Alcohol Health and Research World,* 25, (1).

ADDICTION RECOVERY BASICS – How alcohol abuse affects Family. 23 July 2008. http://addictionrecoverybasics.com. Date of access 13 October 2008.

ALCOHOL HARM REDUCTION STRATEGY FOR ENGLAND. 2004. www.cabinetoffice.gov.uk/media. Date of access: 12 May 2009.

CRESWELL, J. W. 2007. Qualitative inquiry & research design: Choosing among five approaches. 2nd Ed. London: Sage Publications.

CRESWELL, J. W. 2009. Research design: Qualitative, Quantitative, and Mixed Methods Approaches. 3rd ed. Los Angeles: Sage Publications.

FATOUT, M. 1990. Consequences of abuse on the relationships of children. *Families in Society: The Journal of Contemporary Human Services,* 76 – 81. Date of access: 30 October 2009.

GREEF, M. 2005. Information collection: Interviewing. (*In* de Vos, A. S., Fouché, C. B., Delport, C. S. L. & Strydom, H. 3rd *ed.*, Research at grass roots: for the Social Sciences and Human Services Professions. Pretoria: Van Schaik Academic, 286 – 313).

HUPCEY, J. E. 1998. Clarifying the social support theory - research linkage. *Journal of Advanced Nursing*, 27: 1231- 1241.

LINCOLN, K. D. 2000. Social support, negative social interactions, and psychological well-being. *Social Service Review*, 6: 231- 252. Date of access: 2 September 2009.

MEDICAL RESEARCH COUNCIL. 2000. Fact sheet – alcohol use in South Africa. Prepared by Alcohol and Drug Research Group, www.sahealthinfo.org/admodule/alcohol.htm. Date of access: 13 April 2009.

NIEUWENHUIS, J. 2007. Analysing qualitative data. (*In* Maree, K. (ed). Creswell, J. W., Ebersöhn, I., Eloff, R., Ferreira, N. V., Jansen, J. D., Nieuwenhuis, J., Pietersen, J., Plano Clark, V. L. & van der Westhuizen, C. 2007. First Steps in research. Pretoria: Van Schaik Academic, 99 -117).

PELTZER, K. 2003. Drinking motives, behaviours and problems among black South African university students. *African Journal of Drug & Alcohol Studies, 2 (1 & 2):1 -10.* Date of Access 12 July 2008.

PELTZER, K. & RAMLAGAN, S. 2009. Alcohol Use Trends in South Africa. *Journal of Social Sciences*, 18(1): 1-12.

SKWEYIYA, Z. 2008. Statement by the Minister of Social Development, Substance Abuse Media Briefing, Pretoria, 29 May 2008. http://www.dsd.gov.za. Date of access: 30 May 2008

TRACY, E. M. & WHITTAKER, J. K. 1990. The social network map: Assessing social support in clinical practice. *Families in society: The Journal of Contemporary Human Services*, 461 – 470. Date of access: 18 August 2009.

TRACY, E. M., WHITTAKER, J. K., PUGH, A., KAPP, S. N. & OVERSTREET, E. J. 1994. Support networks of primary caregivers receiving family preservation services: An exploratory study. Families *in Society: The Journal of Contemporary Human Services*, 481-489. Date of access: 2 September 2009.

TURNING POINT. 2006. Bottling it up: The effects of alcohol misuse on children, parents and families. Turning point, London. www.turning point.co.uk. Date of access: 13 April 2008.

VAN AS, S. 2004. The taxing issue of alcohol abuse: Establishing an alcohol injury fund. *Science in Africa.* Date of access: 13 April 2008.

VELLEMAN, R. & TEMPLETON, L. 2003. Alcohol, Drugs and the Family: Results from a long-running research programme within the UK. *European Addiction Research*, 9, (3).

VICTORIAN HEALTH PROMOTION FOUNDATION – RESEARCH SUMMARY. 2005: Social inclusion as a determinant of mental health and wellbeing. www.vichealth.vic.gov.au/MHWU/. Date of Access: April 2009.

VORSTER, 2007. National Research Fund Alcohol Project: Application for Focus Areas – Sustainable Livelihoods: The Eradication of Poverty. North West University – Potchefstroom Campus.

WECHSBERG, W. M., LUCENO, W. K., KARG, R. S., YOUNG, S., RODMAN, N. MYERS, B. & PARRY, C. D. M. 2008. Alcohol, cannabis, and methamphetamine use and other risk behaviours among Black and Coloured South African women: A small randomized trial in the Western Cape. *International Journal of Drug Policy,* 19: 130 -139.

WORLD HEALTH ORGANIZATION (WHO). 2004. Global status report on alcohol. Geneva, Switzerland.

CHAPTER 6

Article 5

INTERVENTION STRATEGIES TO COMBAT THE EFFECTS OF BINGE DRINKING: A COMMUNITY SUPPORT NETWORKS' PERSPECTIVE

B.M.P. Setlalentoa – PhD student - School of Psychosocial Behavioural Sciences (Social Work), North-West University, Potchefstroom Campus

E.H. Ryke – Senior Lecturer – School of Psychosocial Behavioural Sciences (Social Work), North-West University, Potchefstroom Campus

H. Strydom – Professor – School of Psychosocial Behavioural Sciences (Social Work), North-West University, Potchefstroom Campus

Abstract

Objective: *The purpose of the study was to identify the effects of binge drinking in selected areas in the North West Province from the perspective of community support networks and to analyse the intervention strategies employed to address the problem.*

Method: *A qualitative approach was used, using open-ended interviews with community support networks as key informants. An analysis was done based on assessment of risk and risk environment, targeted interventions, levels of intervention with emphasis on structural arrangements, the vulnerable, community and individuals.*

Results: *Alcohol consumption is high in the selected areas, and is abused by men, women and youth. The low socio-economic status contributes to failure to respond positively to efforts aimed at addressing the problem of binge drinking. There are intervention efforts to address alcohol abuse by government and non-governmental organisations to a certain extent. Through concerted effort more can be done taking into consideration the communities' involvement.*

Conclusion: *There is a need for development of an appropriate intervention strategy that takes cognisance of the nature of the community for which*

intervention efforts are intended. In order to provide a holistic intervention, implementation of legislation needs to be contextualised in line with specific challenges experienced by communities in question. For the strategy to succeed, the implementers need to ensure that resources are available.

Keywords: Alcohol harm reduction; binge drinking; community support networks; intervention strategies

1. INTRODUCTION

Alcohol abuse has been reported as a major concern and is a source of social and economic problems in many developing countries like South Africa (Monteiro, 2001:98; WHO, 2004:1). The former Minister of Social Development, Dr. Z. Skweyiya in the media briefing on substance abuse on the 29th May, 2008 identified binge drinking as a major problem that affects drinkers, families and society. It places a burden on social, economic and health well-being of not only binge drinkers, but also their social support networks such as (family and friends) and community (social services), and causes harm that needs to be reduced or eliminated. Community support networks, in particular, with multi-sectoral skills have the responsibility to intervene to reduce harm in partnership with community members.

Community support networks provide support or services for helping residents to meet their own social-emotional needs, as well as general welfare concerns. They consist of resources within any given community that can be potentially tapped by individuals in meeting their needs. It could be an alcohol rehabilitation centre or a welfare organisation that provides services to a particular community. The community or formal support networks use different approaches or strategies that are aligned in different policies and programmes to address the problem of alcohol abuse. Their focus is on reducing the harm that is caused by alcohol abuse by pointing the way to precise targeting of services (Robson & Marlatt, 2006:255).

2. PROBLEM STATEMENT

Alcohol remains the primary drug of abuse in South Africa (NDMP, 2006-2011:7). The Alcohol study detected from the PURE study data that the selected areas of study are no exception. Binge drinking was identified as one of the patterns of alcohol consumption abused by adult males, females and young people (see

Chapter 4). According to Rataemane (2004:13), alcohol is available everyday to the old as well as the young. He further identified binge drinking, amongst others, as a pattern of alcohol use in Africa. According to the former Minister of Social development Dr Z. Skweyiya (2005:1), the high rate of binge drinking is a cause for concern given the significant association between alcohol abuse and academic failure as well as the link between binge drinking and high-risk sexual behaviour. It is also a concern because of its association with poverty; unemployment and low level of education (see Chapter 4). He further stated that interventions are required to address the problem of binge drinking.

The selected communities present with low socio-economic position and are ravaged by a binge drinking pattern. Many people are poor, unemployed and depend on social grants and pensions, yet alcohol abuse is high (see Chapter 5). This is consistent with the views of Zawaira (2009:4) that poverty is one of the problems experienced by people who abuse alcohol in Africa. According to Lynch and Kaplan (2000:20), the level of education and income are important markers of socio-economic position. Income in particular is a useful measure because it relates directly to the material conditions that may influence well-being (Lynch & Kaplan, 2000:20). Parry and Bennets (1998:7) are of the view that the prevalence of alcohol misuse is high among residents of disadvantaged communities where there is easy access to alcohol. Morojele *et al.* (2009:2) also states that structural factors such as poverty and unemployment make substance abuse problems devastating and difficult to solve in poorer and marginalised communities. Of concern are the negative socio-economic effects that are experienced by the drinkers, families and society (WHO, 2004:60).

Service providers as community support networks are addressing the socio-economic problems, amongst them, alcohol abuse. Rataemane (2004:13) mentions some of interventions used such as providing information on alcohol, positive engagements of youth in and out of school, promotion of responsible use, treatment and rehabilitation. However, implementation seems to be difficult.

The government of South Africa has introduced legislation to deal with the problem to reduce harm, demand and supply. According to Rataemane and Rataemane (2006:373), alcohol harm reduction refers to the reduction of problems due to alcohol abuse, such as violence, road accidents, loss of productivity and spread of

sexually transmitted diseases resulting from unsafe sex. The community support networks are responsible for implementing policies, programmes and plans to address alcohol abuse. The challenge is that the problem persists irrespective of the efforts by government, non-governmental organisations and industry. The harm that is caused by alcohol abuse has far reaching negative effects that affect the drinker; those who are part of his immediate environment and the society as a whole including those who provide services that are meant to reduce or eradicate the problem.

This article seeks to answer the following research questions:

- What are socio-economic effects of binge drinking from the perspective of community support networks and how are they affected?
- Which roles community support networks play in combating the alcohol abuse problem?
- How can the networks reduce alcohol abuse and harm caused by it?

3. OBJECTIVES

- To explore the socio-economic effects of binge drinking in the selected areas from the community support networks point of view
- To identify the roles played by community support in combating the alcohol abuse problem
- To analyse the intervention strategies used by community support networks to combat the problem of binge drinking and make recommendations.

4. RESEARCH METHODOLOGY

The study followed a qualitative approach to obtain the views of community support networks as key informants. Interviews were conducted using open-ended questions (Annexure 12) to obtain as much information as possible pertaining to alcohol use in the communities they serve. Emphasis was placed on the strategies used to address the alcohol problem. Documents, in the form of legislation and national plans, were used to provide a base to analyse intervention strategies that are developed and implemented by community support networks. The analysis provided information that led to the formulation of recommendations on reducing harm that is caused by alcohol abuse. These recommendations are outlined focusing on the themes such as assessment of risk and risk environment,

targeted interventions, multi-level synergistic intervention and multi-sectoral responsibility and partnerships as proposed by Stimson (2006:9).

4.1 Participants

The purposive sampling strategy was used to select key informants. The identified key informants were direct service providers involved in events and activities pertaining to alcohol harm reduction in the selected communities of study. These key informants were from the Department of Social Development as workplace service providers and responsible for substance abuse programmes, the South African Police Service and Huhudi and Tlokwe High Schools as service providers. The rationale for selecting these key informants was to understand the context or settings in which they address the alcohol abuse problem. See Table 1 for a profile of the key informants.

TABLE 1: Profile of participants/key informants

Key informant	Area	Field of practice/operation	Qualifications
Social worker	Ganyesa and Tlakgameng	Substance abuse programme	B (SW)
Social worker	Ikageng	Generic	B (SW)
Police- Station commander and Superintendent	Ganyesa and Tlakgameng	General - Safety and Security	Matric – Police training
Police officer	Ikageng	General - Safety and Security	Matric- Police training
2 Principals and 2 educators	Ganyesa and Ikageng (Huhudi and Tlokwe High Schools)	Teaching and Management	B A in Education

4.2 Procedure

Welfare organisations as community support networks that employ social workers to provide psychosocial services to communities were selected and contacted to request permission to conduct the study (Annexure 4). The management of the Provincial Department of Social Development provided names of social workers who are responsible for substance abuse programmes in Ganyesa and Ikageng. The Department of Social Development was identified as the main structure in

combating the alcohol abuse problem as the Minister also stated that it is the lead department working closely with other role players such as Health, Public Works, South African Police, Education and Home Affairs and non-governmental organisations.

The North West - South African Police Services - Social work Unit Manager provided names of station commanders who are based in the selected areas of study. The police service is responsible for safety and security and was selected to provide their view on the use of alcohol and how it affects them and the community they serve, because they deal with problems such as crime, domestic violence, enforcement of laws, to mention a few.

The Superintendent-General of the Department of Education allowed the researcher to contact schools as service providers responsible for teaching of learners who reside in the selected areas of study. The objective was to understand how binge drinking affects learning and how the school as a community support system deals with alcohol abuse of learners.

4.3 Ethical consideration

Permission was sought and granted to conduct the study from the North-West University Ethics Committee (Annexure 2a and b). Permission was also sought and granted by the North West Departments of Social Development, Education, and Police Services to conduct interviews and the relevant officials were identified by the key informants (Annexure 4).

4.4 Data analysis

Content analysis was used as a data analysis method. Data from the interviews were recorded and categorised according to identified themes. This type of analysis is used to analyse qualitative responses to open-ended questions in interviews or focus groups. Data were considered from different angles with a view to identify keys in the text that helped to understand and interpret data (Nieuwenhuis, 2007:101). It was used to understand the experiences of the key informants and intervention strategies employed to combat the alcohol abuse problems in the demarcated areas of the study.

5. RESULTS

The results of the interviews with key informants as community support networks are discussed hereunder. Focus is on the socio-economic effects of binge drinking, challenges, current intervention strategies employed by community support networks and interventions. This highlighted the situation in the demarcated areas of study and suggestions for intervention are proposed.

5.1 The socio-economic effects of binge drinking in the selected areas

The key informants are of the opinion that binge drinking has detrimental effects on the workplace, individuals, families and the community. It affects quality of life and exposes the support networks to abuse, neglect, hunger, premature death, poverty, injury, to mention a few.

5.1.1 Interview with the social workers

One of the major problems that are experienced in the two demarcated areas is substance abuse, specifically alcohol. The social workers also expressed that many adverse effects are noticed such as family disruption, child abuse and neglect, violence, crime and general social breakdown. The social workers reported that in the two selected areas of study, high alcohol consumption is noticed amongst youth and adults. These social workers carry a high caseload ranging from marital problems and family conflicts, lack of parental care that lead to child neglect, high rate of teenage pregnancy, uncontrollable children, and some of these psychosocial problems are alcohol related. In their view there is a general social breakdown. The social workers confirmed that binge drinking is experienced during the week but more during the weekends. The majority of drinkers use homebrewed alcohol. Beer and ciders are used but not much because they are expensive. The social workers from both selected areas of the study stated that many social problems are experienced because of alcohol abuse by parents. Young people use alcohol excessively as well. One social worker noted:

> *"We have noticed a high number of children who are neglected because their parents abuse alcohol and spend most of the time away from home. They are always*

visiting shebeens. The patrons of the drinking venues are exposed to fighting, injuries and at times, death due to alcohol abuse. The frequent patrons of shebeens are men, women and young people and this is a cause for concern. Many people are not employed; they depend on pensions and casual jobs but opt to use the money for alcohol. People indulge in binge drinking on pay days and they do so excessively."

The social workers reported that there are many drinking venues (shebeens and taverns) in the community that contribute to the social problems of these communities. Parents spend most of the time away from home leaving young children without proper care and support. The neglect and abuse of children are part of the costs of alcohol consumption because it leads to emotional, physical and educational problems (Zawaira, 2009:10). There is a need to improve the situation because in some families, both parents abuse alcohol. Family disruption is rife and has led to other related problems such as juvenile delinquency, teenage pregnancy and HIV/AIDS. Parents are not good role models. The key informants reported that the youth, as young as 18 years of age, are at risk because they abuse alcohol. They leave school before Grade 10 to do seasonal work in farms. On their return, they drink excessively until the money is finished. One social worker said the following:

"It is a practice that the young ones go to farms for seasonal work. They would leave school or a job when the time comes to go to the farms. The learners would leave school to make money in this kind of employment. The money they receive is spent on alcohol."

For the youth in particular, the situation in the selected areas is similar to what Meel (2006:1) found when she conducted a study in the Transkei that highlighted that binge drinking among youth, especially males, is high.

The social workers reported that there have been people who needed rehabilitation in a treatment centre. In a period of eighteen months prior to the interview, these social workers referred five people to SANPARK Centre in

Klerksdorp which is the nearest place that offers in-patient services. However, it has not been very successful because all five relapsed, some left treatment before completion and they were not motivated to stop drinking. The social workers are also not able to form after care groups because the patients come from scattered communities and have no resources to meet at one point.

The social worker who is responsible for probation services stated that many crimes committed by young people are alcohol related. The crimes that have been recorded in both areas of study include murder, rape, and assault with grievous bodily harm. For young people, substance abuse is often associated with serious and often devastating social problems such as crime and violence (Morojele *et al*, 2009:1). One social worker went on to say incest has also occurred but the challenge is that the family would engage in victim-offender mediation and then avoid laying a charge. In her view, this perpetuates the problem because the perpetrator could continue to abuse children knowing that the family would not lay a charge against him.

To reduce poverty and unemployment the Expanded Public Works Programme (EPWP) was established (Nzimakwe, 2008:208). The Department of Social Development in particular contributed by employing people through non-governmental (NGOs) and community and faith-based organisations to work on projects such as home-based care, Early Childhood Development and Community Development. The job opportunities were open for youth, women and men and disabled people. Skills development training opportunities were created by various other government departments to develop various skills such as bricklaying, carpentry and plumbing.

Efforts to involve the participants from the communities of this study in EPWP development projects have not yielded good results because the community members were not interested. The social workers explained:

> *"The community members are not motivated to engage in community projects. They are not self-reliant but at the same time they want money. They always come to social work offices to demand pensions."*

The reasons stated for not participating in projects are that community members want to receive money in a short period and they are not prepared to wait for profit that takes long to be realised. At the same time, they are not doing much to find employment even though some of them do not qualify for pension. The social workers explained that the community members receive pensions and grants which tend to make them dependent on the state. Many families are beneficiaries of pensions and grants as their only source of income. The beneficiaries use it for alcohol and very little goes for maintenance of the family, and this worsens poverty.

5.1.2 Interview with South African Police Service (SAPS) participants

The SAPS were identified as one of the community support networks who provide public safety and security services. In both areas they reported that there are many cases of alcohol related crimes especially over the weekends, though they could not provide statistics. The problem of alcohol abuse is seen among youth and adults, both women and men. Domestic violence is rife and most of the time it is alcohol related. Assaults take place at drinking places and at times the patrons die due to fights and injuries sustained. According to Meel (2006:2), in South Africa, 76% of all deaths after interpersonal violence have been shown to be alcohol related. The Women's Rural Advocacy Programs (2007:1) has indicated that data on the concurrence of domestic violence and alcohol abuse vary widely, from as low as 25% to as high as 80% of cases. Alcohol is also associated with high trauma rates on South Africa's roads. A police officer said:

> *"To show that young people visit shebeens and abuse alcohol: A 20 year old was stabbed this past weekend at the shebeen and there was a fight. He was stabbed to death by a 21 year old. He is in the cells at the moment. A young life was lost prematurely. We are experiencing many challenges in this community."*

Efforts to fight crime are hindered by challenges such as alcohol and drug abuse that continue to be generators of crime (Nqakula, 2006) and interpersonal violence which places a huge burden on communities and individuals (WHO, 2005:1). A

police officer referred to cases of rape where women were at or from a drinking place.

> *"Women also frequent drinking places. There have been cases of rape, older and young women are victims because they all drink and try to walk home alone. In some cases, men buy alcohol for women with an intention to have sex with them when they are under the influence of alcohol".*

The WHO (2008:2) states that young women who visit bars frequently are at greatest risk of being victims of sexual aggression in nightlife environments, whereas men are more likely to initiate acts of sexual violence. The impact of sexual violence on both physical and psychological health can be devastating, long lasting and even fatal. The latter could be due to HIV/AIDS infection that could lead to death and the support network experiences loss of a loved one or a breadwinner.

One of the main challenges is to cope with many shebeens in the communities. They are risk environments that are a danger to communities but also put a strain on police services because the unpleasant deeds are unpredictable as is evident from this statement by a police officer:

> *"The problem is that there are many shebeens in the community that sell homebrewed beer and other intoxicating beverages. The police officers often raid them but they continue to sell. The situation is worse during weekends."*

The situation has not changed even though the Apartheid laws were removed. The Apartheid system has contributed to the alcohol problem in South Africa. In response to resisting oppression, alcohol was used. One such indication is the growth of shebeens or illegal outlets that served as a form of resistance. However, the Apartheid policies were changed but the alcohol problem continued and has now reached a high level (Parry, 2005:426).

It has been noticed that most of the drinking is done at shebeens, which are notorious where foul and dangerous concoctions are brewed and sold to the public

and cause health problems. Alcohol consumption at the shebeens very often leads to violence, assaults, stabbings, rapes and murder, to mention a few. The police officer also reported that many of alcohol-related problems are experienced mostly during the weekends, at homes and shebeens. This is consistent with the study conducted in Russia by Pridemore (2006:1034) that has shown that there is a link between alcohol consumption and violence due to high rate of binge drinking on weekends.

5.1.3 Interview with the educators

The school as a community support network is also experiencing a problem of alcohol abuse by learners. It was reported that this maladaptive behaviour makes teaching and learning very difficult. The culture of learning is affected by an unresponsive environment where the majority of the population is uneducated and unemployed. The use of alcohol is a major problem even on school premises. A teacher observed:

> *"Alcohol abuse is a real problem in schools. The learners stay away from school because they drink alcohol during weekends. They leave school during the day to drink alcohol. Even though parents are poor, government has no-fee school, therefore, they are provided with an opportunity to learn."*

Many parents are not helpful because they also abuse alcohol and most of them are not educated. The parents do not participate in facilitating learning or other activities related to schools.

> *"We are struggling because parents abuse alcohol as well. A teacher cannot also get support from home because parents are not literate and some still do not understand their role in helping children with learning".*

The teacher also expressed the point that learners leave school before they reach matriculation to work on the farms.

5.2 Current intervention strategies used by community support networks

There are 12 social workers operating in Ikageng and none is dedicated to deal with substance abuse programmes. The social worker who was interviewed stated that she was involved at some stage but not anymore and there is no one who is responsible for the substance abuse programme. The cases are dealt with as and when they are reported. There are 18 social workers operating in Ganyesa and Tlakgameng and one is specifically responsible for the substance abuse programme. She is involved in prevention, protection, promotion and rehabilitation services. The South African Police could not provide the number of members operating at the local police stations. There are six high schools in Ikageng and two in Ganyesa and two in Tlakgameng. The following intervention strategies were highlighted:

5.2.1 Teenagers Against Drug Abuse (TADA) Programme

It was discovered that one of the high schools in Ganyesa has a serious problem with alcohol abuse. The social workers established the programme called Teenagers Against Drug Abuse to address the problem in this specific school and it is the only one where the programme is established. The activities included drama, presentations on life skills as a prevention measure and peer groups discussions. The young people responded very well. However, they have not been able to formally evaluate whether there is a positive change in the school as a whole. The programme is not established in Ikageng.

5.2.2 Young Adults Against Drug Abuse Programme (YAADA)

This programme was established by the social workers for youth who are out of school. The youth are encouraged to develop programmes that would be funded by government. In Ganyesa, the programme is not well attended because the group members are more concerned about money and normally leave to work on farms. They are not motivated to address the problem of alcohol abuse. In Ikageng, the social worker stated that this programme is not established yet.

5.2.3 Implementation of the National Drug Master Plan

The Central Drug Authority is established in terms of the Prevention and Treatment of Drug Dependency Act, of 2008 and one of its functions is to give effect to the National Drug Master Plan. The Department of Social Development is the coordinating body that facilitates and oversees the implementation of the National Drug Master Plan (2006-2011).

The plan is a strategy to combat substance abuse focusing on health and socio-economic consequences of substance abuse and guidelines on priorities and a framework for action in combat substance abuse are provided. The key integrated strategies are supply, demand and harm reduction.

The government departments are expected to implement the plan to prevent and combat substance abuse by forming forums and establishing Local Drug Action Committees. The social worker outlined the activities undertaken to implement the National Drug Master Plan.

5.2.4 Anti-Drug Week

The social workers are responsible to observe the Anti–drug week during June which is Youth month. It is done to educate and make people aware of the dangers of substances. The campaign involved a door to door awareness programme for individuals and families, visits to shebeens and taverns and presentations at schools. During the 2009 campaigns, it was realised that many families have one or both parents and children abusing alcohol, the drinking venues are always full of people drinking alcohol, and the owners of these places offer alcohol on credit and are not concerned about the young people who are under the age of 18 years who frequent the places. They are not even aware of the age restrictions.

5.2.5 Local Drug Action Committee (LDAC)

The members of the committee are representatives from the Departments of Social Development, South African Police Service, Agriculture, Home Affairs, South African Social Security Agency, Public works and some non-governmental organisations. The LDAC in Ikageng is inclusive of Health and the North-West

University. In both selected areas, this committee is active and each representative is responsible for a substance abuse programme such as prevention services, information dissemination sessions, presentations on how to deal with stress, the dangers of alcohol abuse and participation in health awareness campaigns in their respective departments and organisations. They join hands on specific projects that are meant to address the substance abuse problem in the community. Otherwise, they have regular meetings to give feedback on different programmes they have been involved in. The social workers in Ganyesa reported that the Departments of Health, Education and the Tribal office are not involved in the committee yet they are critical partners.

5.3 Challenges that are experienced in the selected areas

The key informants agreed that binge drinking is a huge problem in the communities. Individual and family intervention is given priority in the communities though the number of social workers is not enough to manage the alcohol related problems. The situation is even worse in the area where there is no social worker who is responsible for substance abuse.

It has not been possible to practice group work because people are not motivated to stop drinking and to participate in groups. Long distances between villages, poverty and shortage of staff are also contributory factors to failure to use this method for rehabilitation.

Binge drinking remains a problem because parents are not good role models. They abuse alcohol and fail to perform their roles due to excessive drinking. There is a general breakdown of morals in the communities. It is not easy to break the vicious circle of alcohol abuse.

Absence of the Tribal authorities in alcohol reduction programmes also creates a vacuum. The social workers and other role players take an initiative to establish poverty reduction programmes and projects for the community to take control to improve the quality of their lives. However, community members are not responding well and not motivated to get involved in community development that could lead to empowerment. According to their assessment, the community members are dependent, not self-reliant, and want short term relief. The social workers are of the view that the government has created many opportunities for

communities but the communities are not willing to take responsibility to get what is needed for survival and development. They did emphasise that there are situations where help has been accepted and improvement was noticed, but not significantly.

The interviews with the key informants have highlighted that intervention plans often fail because of organisational or community shortcomings. Partnerships for intervention are also not yielding the expected results for a varied number of reasons. For instance, it was noticed that efforts were employed but a proper assessment of the extent of the problem was not done. The Prevention of and Treatment for Substance Abuse Act of 2008 outlined a comprehensive national response for the combating of substance abuse and mechanisms aimed at demand and harm reduction in relation to substance abuse through early intervention, treatment and re-integration programmes amongst others. Analysis of implementation of the new policy is not possible at this stage because it was adopted in 2008 and is only now being implemented. However, plans and programmes were put in place to address the problem.

Some guidelines of the National Drug Master Plan were followed such as the establishment of the Local Drug Action Committee, but there is no vigorous intervention by role players except celebrating commemorative days and holding meetings. The other critical role players like the Tribal authority and the Departments of Education and Health are not involved in the committee.

5.4 Suggested intervention strategies

In this section current interventions are commented on and intervention strategies suggested. Awareness of alcohol and related problems and the need for action is widely accepted. However; more emphasis needs to be given to reviewing intervention efforts and facilitating policy implementation in an integrated manner. Attention needs to be given to internal and external environments to be able to win the war against alcohol abuse. Emphasis is on actions aimed to reduce supply and demand. For the binge drinking problem to be addressed, there should be a well developed alcohol reduction harm strategy that is relevant and appropriate for the community. In order to achieve this aim, Medina-Mora (2005:26) states that risk factors should be identified at all levels such as individual, family, school,

among peers and in the community. Intervention strategies are proposed based on Stimson's (2006:9) themes that focus on assessment of risk and risk environment, targeted interventions, multi-level synergistic interventions and multi-sectoral responsibility and partnership.

5.4.1 Assessment of risk and risk environment

Stimson (2006:9) is of the view that evidence-based interventions and evidence-informed policy are likely to be effective in addressing alcohol problems. His argument is that effective interventions should be identified as well as the costs. It is also critical to identify those interventions that are likely to be relevant, feasible and appropriate. There is a need to develop capacity to assess the risk environment, especially at local level.

Alcohol harm reduction strategies should be informed by a proper assessment of risk and risk environment that is performed by all role players such as social workers, police, health workers, educationists, traditional leaders and policymakers. The risk assessment calls for a change in prevention of alcohol abuse to prevention of risk factors. Evidence from the environment would provide relevant information that guides in developing a strategy that focuses on interventions that are likely to be effective (Stimson, 2006:9). A proper assessment of the environment, taking into consideration culture, human, financial and infrastructural resources, and socio-economic status of the community is important. It would determine the kind of intervention that is appropriate to reduce harm. In order to reduce the harm caused by alcohol, the individuals, families, community, organisations and government need to accept that the problem exists and take action to address it.

The key informants reported that there was no study or assessment done to determine the extent of the alcohol problem and risks in their communities. Intervention strategies were developed at national level and applied in all areas. It would seem that there is intervention in some areas but no assessment was done to determine the appropriate intervention suitable for the locality, particularly those who present with the kind of socio-economic situation such as the two selected areas of study (low level of education, poverty, and unemployment) (see Chapter 4). Medina-Mora (2005:26) says contextual factors such as poverty,

neighbourhood disorganisation, lack of health and social services and availability of substances are important determinants of the level of use and problems. Evidence based interventions are informed and are likely to target the identified risks. Policy should be checked for local transferability and feasibility of implementation.

Poverty, low level of education, unemployment and dependence on pensions and any effort to address alcohol abuse are thwarted because problems are multifaceted. According to Stimson (2006:9), a proper assessment of risk and the risk environment should consider effective interventions that are likely to be effective, but of course, the cost should be determined. Budgetary allocations should cater for alcohol programmes and the police and social workers alluded to a shortage of funds that affects service delivery.

Stimson further states that "off-the-shelf solutions" in tackling alcohol issues are not effective, relevant, feasible and appropriate for everyone. The point is emphasised by Parry (1998:130) that interventions should be designed for the particular communities they are meant to reach. Generic programmes may not be effective for tackling the alcohol problem in some areas.

An assessment is meant to provide a holistic ecosystems' view of the community such as their strengths and socio-economic position amongst others, which could be used to develop intervention strategies, instead of developing a policy that should fit all irrespective of their shortcomings or resources. Mokdad *et al.* (2007:304) support this view that evidence-based prevention strategies such as enforcing age restriction and reducing alcohol outlets can help change social norms regarding acceptable drinking behaviour and thereby reduce excessive alcohol consumption and related harms. Research should be done in order to obtain relevant and appropriate information that would assist in planning and intervention. The National Drug Master Plan (2006-2011) was developed for all the provinces in South Africa and no specific interventions were proposed for different areas, irrespective of the fact that the population is diverse and unequal in terms of resources and education, amongst others. These areas have not developed their Mini-Drug Master Plan as proposed.

For a proper assessment to be done there should be capacity to assess the risk environment, especially at local level. The numbers of professionals in the selected areas of study are inadequate. It would not be possible to do a proper assessment that would assist in designing strategies and policy makers to make informed decisions. Capacity to assess the risk environment is needed and one social worker would not be able to do a proper assessment. There is a need to increase the number of social workers and also to consider employment of other categories of social service occupations such as social auxiliary workers and community development officers to provide assistance to social workers.

The departments and organisations that are involved in the Local Drug Committee are not experts in the field of alcohol abuse. As much as social workers study specialised fields of practice during their graduate training, it would be advisable to pursue studies specifically on alcohol abuse to gain specialised knowledge and practice for effective interventions. It would be part of continued professional development or of post-graduate studies.

Capacity is also needed in other structures such as schools to be able to assess risk. Teachers reported that they are at times faced with psychosocial challenges that they are not able to address because they are not trained to do so. Employment of social workers in school would provide capacity to assess the risk environment and take appropriate action.

Community members need to be capacitated in prevention and early identification and intervention in alcohol abuse related problems. This intervention would require people with basic education to understand what they are suppose to do. The challenge is the low level of education in the community. However, attention needs to be given to identify community members who are willing to participate and should be assisted to build capacity by training assessment. Mabandla (2007:1) states that people should have an interest in the success of the country and their society. It calls for all being prepared to unite in action for change. Ownership of intervention programmes could assist in treatment and contribute to reducing the harm that is caused by alcohol. This view is supported by Rataemane (2004: 7) that "treatment works with the support of family and community", therefore, empowering the community to mobilise around alcohol and related issues can be a powerful strategy. The social workers could use their

knowledge and skills in promoting social change, such as community work to educate, share knowledge and train community members to develop the relevant skills in addressing alcohol abuse problems.

The Local Drug Action Committees should be involved at all levels of assessment and ensure that their areas of operation also involve people with capacity to assess risk and risk environment. The knowledge about alcohol abuse and intervention strategies is needed to be able to address the problems. The Local Drug Action Committee members are identified by their departments and the majority of them are administration officers who act as Employee Assistance officers. They do not have people who are qualified in the psychosocial fields. For instance, the community support networks such as the police have appointed social workers to address the psychosocial needs of police officers but they are based far from Ganyesa. While the situation still prevails, the members of the Local Drug Action Committee representing different departments and organisations should be trained to assess risk.

The rationale for doing proper assessment is to facilitate identification, assessment and treatment of alcohol problems. The end result is to come up with intervention strategies that are relevant for the context and not try to apply one generic strategy for the whole country that does not provide for the different environmental conditions. Parry (2000:219) states that a single policy formula is not good, instead a mix of strategies is needed that will work to determine appropriate ones taking into account factors such as capacity to respond, political feasibility in different cultural contexts, public acceptance and likelihood of impact.

5.4.2 Targeted interventions

According to Stimson (2006:9), targeted interventions should focus on contexts such as drinking venues, specific groups such as vulnerable young people, the elderly and behaviours such as extreme drinking, alcohol and sex. Targeted interventions reported by the key informants included drinking venues, schools and homes.

5.4.2.1 Drinking venues

Intervention was targeted at drinking venues but it seems that it was done as a once off occasion during the anti-drug week. The police visit the drinking venues randomly but can only do so if they know about existence of such a venue. They stated that the number of drinking venues in the villages and township is not known because they operate illegally.

Many of the shebeens in the communities are not registered and, therefore, fail to adhere to the law pertaining to production and selling of alcohol. According to Parry and Bennets (1998:10), there are between 150 000 and 200 000 unlicensed alcohol outlets in South Africa and this weakens the influence of any measure aimed at reducing underage drinking. The young people are especially vulnerable because of lack of enforcement of age restriction laws in the bars, supermarkets that sell alcohol and alcohol stores. Easy availability of alcohol at the shebeens in the community contributes to easy access.

Efforts to change the situation should be directed at owners of the drinking venues by involving them in education programmes that focus on responsible drinking. They could also be motivated to participate in other income-generating projects rather than use illegal ways of generating income. Enforcement of the laws that monitor licensing needs to be given priority so that easy availability is dealt with.

5.4.2.2 Specific groups

There are specific groups that require attention because they are vulnerable, for example school going children, young people, women and the elderly. Martinic (2006:11) states that those individuals at particular risk for harm can be specifically addressed. The key informants registered concern regarding all these groups.

School going children should be targeted to prevent them from the use of alcohol. Prevention is still better than cure. It is any activity designed to avoid substance abuse and reduce its health and social consequences (Medina-Mora, 2005:25). School children are vulnerable and, therefore, require prevention programmes such as life skills to protect them from harm that is caused by alcohol. According to Ebersöhn and Eloff (2006:57), life skills are all kinds of skills and capacities that an individual needs to be able to enrich his life in a meaningful

way. The aim is to develop their core life skills such as problem solving, decision making, creative and critical thinking and self concept (Couch *et al.,* 1997:16-32). It was noted that the TADA programme was introduced in one school in Ganyesa which is a good effort. It would be beneficial to evaluate implementation and impact. It should then be extended to other schools to facilitate these skills.

Therefore, schools should consider employing social workers who will be dealing specifically with psycho-social issues of school children. The social workers would serve as a link between schools and homes of the children, who will at the same time work with families that need assistance in order to provide a conducive environment for learning and development. The teachers as well would be capacitated by the social worker and other specialists that could be invited to school to share knowledge and skills such as early identification of behavioural problems.

Provision of information on alcohol and its effects on the human body is relevant for young children as a preventive measure. Children have been identified by social workers as vulnerable because they are neglected by parents who are abusing alcohol (see Chapter 5). They are exposed to negative psycho-social effects such as delinquency, home accidents, or physical or sexual abuse.

The youth are vulnerable and should be assisted to deal with peer pressure to be able to stay away from alcohol use. This view is supported by Parry (1998:13) that life skills programmes should be designed to address the attitudes of young persons towards binge drinking and should also take into account the influence of normative factors and self-identity on the intentions of males to engage in binge drinking. Involvement of role models who recovered from substance use could motivate youth to participate in programmes. YAADA programme was introduced without success even though it is an intervention strategy to address the problem faced by youth. An evaluation of the situation that involves youth would assist because they have other needs such as unemployment, as expressed by the social worker. A holistic approach could yield better results.

In order to get the youth to participate in the programmes it is suggested that these programmes should be run by youth themselves, especially those who are recovering from substance abuse. They could run workshops, seminars and also

focus on other issues of interest such as employment and educational opportunities. Use of role models such as musicians who play their kind of music could assist in changing behaviours. Participation of a youth representative in the LDAC is also recommended.

Parents and families need to be targeted for change, growth and development of the individuals and their families. The significance of the family in the development of children cannot be overemphasised. There is a need for services such as screening and early identification of families who need support and prevention programmes. Effective parenting skills could be introduced to capacitate parents to deal with parenting difficulties, maintaining a home, setting rules and boundaries and developing support networks. Parents who abuse alcohol are not good role models because young adults who are exposed to families where alcohol is misused, are more likely to model this behaviour or to consider it as acceptable. Focus should be on building healthy families where good values are instilled to ensure that children grow in a supportive, caring environment. Cultural practices that curbed alcohol abuse in the past could be reintroduced with the Tribal authority leading the process.

A door-to-door campaign was used where family members were provided with information on alcohol use and abuse. Much as it is commendable, it was done once during the Anti-Drug week. Information was provided but considering the level of education of the majority of community members, it is not possible for them to grasp and do something about the binge drinking problem. Motivating drinkers to stop abusing alcohol cannot be done in one session.

Unemployed community members. The key informants confirmed that there are high unemployment, poverty and illiteracy rates as contributory factors to alcohol abuse. The social workers were of the view that participation in community development programmes could ease the problem. There is a need for vigorous drives by structures such as the Department of Labour to facilitate skills development in different trades. Other departments such as Agriculture, Health and Education could focus on other skills and adult education.

One shortcoming that was identified was a lack of recreational facilities. Shebeens are used for meeting friends and entertainment, yet they were

established as resistance to Apartheid policies (Parry, 2005:426). Freeman (undated) states that poverty and Apartheid have an effect on the use of alcohol in that people drank because the government did not supply other recreation facilities. This situation remains a challenge for the present government to provide recreational facilities to keep people away from alcohol.

Community involvement ensures that the community takes control of their lives and is self-reliant. The vision of the White Paper for Developmental Social Welfare (1997:14) was to facilitate the development of human capacity and self-reliance within a caring and enabling socio-economic environment. This notion of self-reliance is expressed with caution considering Hochfeld's (2007:84) view that the discourse of self-reliance is problematic in terms of expectation of economic self-sufficiency of families in the context of high levels of unemployment and extreme poverty. In this instance, self-reliance is emphasised for change of behaviour in as far as alcohol abuse is concerned. Members of society have to take responsibility to change behaviour and refrain from using poverty as a reason for abusing alcohol, because the damage caused by alcohol is huge and if not curtailed, damage could lead to death. In some instances it leads to more poverty and becomes a vicious circle.

Parents should be involved in helping the young people not to abuse alcohol. The authorities in the Italian city of Milan want parents to take responsibility to address the problem. They have warned that "parents of children under the age of 16 years who consume, buy or even possess alcohol will face a fine of €450 (just more than R5000) from 20 July 2009", (Sunday Times, 2009: 2),. It is stated in the article that the Mayor, Letizia Moratti says it was necessary to protect young people because children as young as 11 years have already experimented with alcohol and one-sixth of hospital admissions for alcohol abuse involves youngsters less than 14 years of age. It might not be possible to enforce this kind of intervention in South Africa because of high levels of poverty and unemployment; however, it could serve as a deterrent for those who can afford it. Though those who cannot afford it could get an option of detention, it might not change the behaviour. Programmes such as effective parenting skills and implementation of legislation to protect children should be monitored.

Focus on moral regeneration could assist in changing the unacceptable behaviours but for success to be realised, a coordinated intervention is needed. Planning and implementation with clear monitoring and evaluation mechanisms as a team is critical. The community needs to take responsibility to address the problem. Use of assets of the wider social system such as community associations and local institutions could be used. Ebersöhn and Eloff (2006:25) refer to the theoretical framework for the eco-systemic perspective that would include the whole social system, wider community and local community including families and individuals.

Focus should be on continuous education in all spheres such as families, schools, social clubs, churches and professionals such as social workers, priests, nurses or teachers should take the lead and share knowledge such as recommendations from the WHO. The WHO Africa (2008:4) encourages public education on the negative consequences of drinking alcohol that it can be effective in increasing recognition of alcohol-related harm in the community and providing active participation in policy measures. Education should be extended to community, schools, mass media and social marketing campaigns and passive measures such as warning labels. The challenge is to continue motivating the community to change the mindset and make themselves self-reliant. There is a need to increase community action and support.

Community development encourages people to take control of their development and this can be a solution in terms of dissemination of information, training and education. Identification and involvement of community leaders, experts and role models would add value to efforts to address the alcohol problem. Mkhize (2006:4) states that alcohol reduction harm strategy needs ambassadors, champions and role models. The structures such as government departments, civil society, business and Tribal authority could identify people in their respective areas to facilitate change.

5.4.2.3 Behaviours

Behaviour change should be encouraged and maladaptive behaviours such as heavy episodic drinking at parties, customary events and weddings should be discouraged. Zawaira (2009:7) identified risk factors such as weak cultural

controls as contributing to alcohol abuse. Cultural teachings could be re-introduced to change behaviours. Interventions should be targeted to change behaviours by using life skills, enforcement of laws, spot checks at schools and general education on responsible drinking. The social workers should assist clients to unlearn maladaptive behaviour. Therefore, behaviour modification as an intervention approach could be used to change maladaptive behaviour and also change the environment to make it responsive to peoples' needs. Alcohol use is learned and, therefore, can be unlearned. The social environment influences behaviour by shaping norms, enforcing patterns of social control and providing or not providing environmental opportunities (Berkman & Kawachi, 2000:7). Incorporating the social context in behavioural interventions would include communities, different helping professions, and work places to achieve behavioural change.

5.4.3 Multi-level synergistic interventions

According to Stimson (2006:9), multi-level synergistic interventions to separating drinking from risky activities should be developed at various levels. He identified three aspects namely, structural arrangements, for example laws and policies, communities which include drinking environments, drinking norms and lastly, individuals which could cover awareness, choices and responsibility.

5.4.3.1 Structural arrangements

There are laws and a national plan in South Africa that focus on alcohol use such the Liquor Act No 59 of 2003 which covers aspects such as production, distribution and consumption of alcohol. The information from the key informants indicated that enforcement of this law is weak. Because home brew beverages are unrecorded, production is not controlled and it is sold in unregistered outlets, it becomes very difficult to control its consumption. The unregistered outlets also sell beer and distillers. According to the WHO (2008:2), alcohol use in African countries includes home-brewed and industrial beverages, thus increasing the total amount of alcohol intake. This consumption poses challenges regarding quantities consumed and safety issues related to unregulated production of alcohol.

However, it requires a concerted effort from all role players. The synergy between all role players would certainly reduce the harm caused by alcohol if all are focusing on addressing the problem. It would require better coordination and enforcement of the laws. Teamwork is one way of ensuring that all subordinate their efforts to the whole.

Enforcement of this Act requires more police who are well resourced if they are to manage the problem. It would require those who sell alcohol to be involved in information dissemination and programmes that educate people on the dangers of alcohol. They should not be concerned with commercial gain at the expense of the well being of people, but rather be involved in helping them to control their alcohol use. Restriction of selling alcohol to under age people needs to be enforced even if it means investing more money for better control and enforcement systems. In order to regulate availability of alcohol, some controls are needed. The WHO (2008:5) states that control has shown to be an effective strategy in a variety of socio-cultural circumstances.

One example of stricter control is the Western Cape Province that has developed a law to address alcohol abuse. The Western Cape Liquor Act No 4 of 2008 was introduced in an effort to exert greater control over the liquor industry. The aim is to enforce stricter criteria for successful licences, reduce the number of available liquor outlets by prohibiting shebeens from operating in residential areas and control of trading hours. It is reported that there are 3200 legal sellers and about 30 000 illegal outlets in the Western Cape, and it is estimated that implementation of the Act could result in between 60 000 and 100 000 jobs losses. It was reported in the Mail and Guardian online, 27 January 2009 that the Minister of Finance, Economic Development and Tourism expressed his concern about the effect that these illegal outlets has on communities, especially those who live in close proximity to liquor outlets associated with crime and gangsterism. The members of communities support the Act because of the negative effect the outlets have on them.

It is acknowledged that these recommendations would lead to loss of income for those who sell alcohol from their homes; however, the shebeens have long-term social implications for the safety and wellbeing of communities. Because of probable loss of income, there were about 600 shebeen owners and workers who

marched to the Western Cape legislature in protest against new legislation that was passed in November 2008. However, The Western Cape government is more concerned about the harm than the money lost. It is critical that community information, mobilisation and support mechanisms for alternative means to generate income are put in place to assist those who are in need.

The Prevention of and Treatment of Substance Abuse Act, No 70 of 2008 was developed to deal with the prevention of and treatment for substance abuse such as alcohol and the harm associated therewith, the rehabilitation of service users in the various institutions and the reintegration of service users in their communities. The prevention programmes need to be ongoing and not once- off, and treatment should be more intensive and in order to do so, more people (professional and auxiliary workers) are needed. There is a need for rehabilitation centres specifically addressing substance abuse problems. However, hospitals could establish a ward for admission for alcohol abuse patients and a multi–disciplinary team could then give proper attention to patients to reduce harm to individuals. There is a need for employment of more social workers who should deal specifically with substance abuse programmes.

The Act, Chapter 2, p.14 states that organs of state must adopt a multifaceted and integrated approach to enhance coordination and cooperation in the management of substance abuse and ensure the effective implementation of the National Drug Master Plan.

There is a need to include more social workers in the field who would liaise with families and community structures that could assist with aftercare services. Provision of aftercare services that has been emphasised in the Prevention of and treatment of Substance Act, that aftercare services provide ongoing professional support after a formal treatment episode to maintain sobriety, abstinence, personal growth and to enhance self-reliance and proper social functioning. The partners such as social workers and health practitioners could consider using the local hospital for admission and more field workers are needed to monitor progress. There is a need to train community care workers who would work with the social workers because there is a shortage of social workers in the country.

5.4.3.2 Drinking Culture of Communities

The key informants were concerned about the culture of drinking and drinking environments in the two areas. It is very difficult to change culture especially when it has gone out of hand and there is very little understanding by the people who abuse alcohol. However, shebeen owners need to be included in efforts to teach people about the dangers of alcohol abuse. Education should be extended to all areas including the drinking environments. For example, the Liquor Boards could go on road shows to educate people about the Liquor Act and emphasise the importance of for instance, licensing and production of alcohol. Enforcement should be preceded by education. Stimson (2006:9) refers to responsible hosts that would extend their role to ensuring that patrons are assisted to be responsible drinkers. Changing drinking norms from bad to good ones could reduce harm caused by alcohol abuse.

5.4.3.3 Individual responsibility

Individuals remain responsible for rehabilitation if positive changes are to be realised. Robson and Marlat (2006:257) state that harm reduction can include working with individual drinkers, helping them to manage their problems with more insight. Awareness programmes such as information dissemination are methods of intervention that capacitate people to be able to make informed choices. Life skills as a preventive measure could help children from an early age to be aware of dangers of alcohol, make the right choices and take responsibility for their lives. Drinking responsibly should be emphasised for individuals to take control of their lives. Heavy episodic drinking in particular is dangerous and individuals need to be aware of its negative effects.

5.4.4 Multi-sectoral responsibility and partnership

Stimson (2006:9) states that multi-sectoral responsibility and partnerships are essential to manage the problem of alcohol abuse. Community support networks have different roles and responsibilities to perform that would ensure that alcohol harm is reduced. There is a need for a balanced approach that focuses on all aspects pertaining to addressing alcohol and related problems. For instance, enforcement of opening and closing times of alcohol outlets, ensuring that health

standards are met, streets have sufficient light and social order is maintained, to mention a few. These could facilitate alcohol harm reduction or elimination. This would require involvement of all stakeholders to execute their roles and responsibilities and can be realised if all subordinate their efforts to addressing the problem. Performance of roles as individual entities and as a collective is crucial in addressing socio-economic and behavioural problems. Different roles bring particular skills, knowledge and experience that could yield good results. The positive changes are possible if strong partnerships are formed, with clear mandates, responsibilities and focus on alcohol harm reduction strategies. The National Drug Master Plan (2006-2011) calls for shared responsibility and strong partnerships to address the problem that will certainly reduce the harm on individuals and others in their social environment. Partnerships should be established to share costs, but most importantly, to address the problem focusing on all aspects.

The plan outlined strategies for prevention, early intervention, treatment, after-care and reintegration. In addition, the policies also include community-based intervention, capacity building, management of treatment practices and information management. This comprehensive action plan is meant to facilitate contributions and clarify responsibilities of the various sectors, partners and stakeholders. Much as the teams in Ganyesa and Ikageng are trying to implement the National Drug Master Plan and the Prevention of and Treatment of Substance abuse of 2008, there are still many challenges. Gaps in the implementation and monitoring of these policies and programmes have been evident. There is a need for a coherent, consistent and strong action with relevant actors for the plan to succeed. The former Minister of Social Development, in a media statement in May 2008, stated that the Department of Social Development is the leader in reducing the abuse of legal and illegal drugs, however, other government departments and non-governmental organisations need to be involved to ensure that they mitigate the impact of the problem through the provision of prevention and treatment services.

For intervention to succeed there should be financial, human and infrastructure resources for proper implementation. Social workers identified office and staff as some of the challenges to be addressed. This situation was also highlighted by Zawaira (2009:13) that there are low budgetary allocations for addressing alcohol-

related problems in Africa. This result in failure to implement policies aimed at addressing the problem.

6. DISCUSSION AND CONCLUSION

For effective intervention strategies to curb the alcohol abuse problem in the selected areas, community support networks need to recognise that they are not dealing with alcohol abuse only, but problems such as poverty, unemployment and education/ skills development because socio-economic problems are multi-faceted. It is also important to consider building stronger family units that can provide proper guidance and support to ensure that generations are built on a solid base. Therefore, a holistic, multi-level, multi-sectoral intervention is required for all role players such as government departments, non-governmental organisations and community and faith-based organisations. Focusing on their scope of practice with a view to contribute to reduction of harm caused by alcohol should be a priority for all. The civil society and community members need to be involved in efforts to address the alcohol abuse and other related problems. Research to understand particular situations of different areas is needed. Ongoing evaluation of current policies and intervention strategies should be conducted with a view to determine the impact on targeted problems. The results of research and evaluation would then inform practice and policy development.

There is a need to develop and increase access to affordable and effective treatment and rehabilitation, especially in public hospitals. Restriction to control alcohol consumption by controlling the availability of alcohol is a responsibility of all role players but the critical ones are the police and Tribal authority. Families need to be informed to prevent problems from arising. Control of numbers of drinking or selling outlets especially unregistered ones, is necessary and would include modifying the public drinking environment. The harm reduction includes working with individual binge drinkers to help them manage their drinking problem with insight. Abstinence should be encouraged to all, but more to those who have not started taking alcohol.

7. SUMMARY

For community support networks to manage alcohol and related problems, proper assessment is needed. Interventions should be targeted for specific targeted

groups taking into consideration their socio-economic position. Multi-level and multi-sectoral collaboration and interventions should be considered and enhanced at all times. Continuous evaluation of policies and intervention strategies are critical to ensure that the challenges are addressed.

8. REFERENCES

BERKMAN, L. F. & KAWACHI, I. 2000. Social Epidemiology. New York: Oxford University Press.

CITY OF MILAN PLACES ALCOHOL BAN ON KIDS UNDER 16 (2009, July 19). *The Sunday Times*, p 2.

COUCH, S., FELSTEHAUSEN, G. & HALLMAN, P. 1997. Skills for life. New York: West Publishing.

EBERSÖHN, L. & ELOFF, I. 2006. Life skills and Assets (2nd ed). Pretoria: Van Schaik Academic.

FREEMAN, J. (undated) Services Seta Employee Assistance Programme Toolkit: Addiction – managing Substance abuse in the workplace.

HOCHFELD, T. 2007. Missed opportunities: Conservative discourses in the draft National Family Policy of South Africa. *International Social Work*, 50(1): 79-91. Date of Access: 11 August 2009.

LYNCH, J. & KAPLAN, G. 2000 Socio-economic Position. (*In* Berkman, L. F. & Kawachi, I. (Eds) Social Epidemiology. New York: Oxford University Press, 13 - 35).

MABANDLA, B. 2007. Conference presentation by the former Minister of Justice and Constitutional Development, 28 May.

MARTINIC, M. 2006. Patterns of drinking and the need for targeted interventions.

(*In* Conference Report - Buning, E., ed. Paper presented at the 3rd International Conference on Alcohol and harm reduction – Creating realistic and concrete solutions, 22 – 25 October 2006, Cape Town: South Africa. 1-73). Date of access: 2 August 2009.

MEDINA-MORA, M. E. 2005. Prevention of substance abuse: a brief overview.

World Psychiatry 4 (1):25 – 30.

MEEL, B. L. 2006. Alcohol-Related Traumatic Deaths in Transkei, South Africa. *Internet Journal of Medical Update,* 1, (1) Jan –June.

MKHIZE, B. 2006. Need for ambassadors, champions and role models to tell the message (*In* Conference Report - Buning, E., ed. Paper presented at the 3rd International Conference on Alcohol and harm reduction – Creating realistic and concrete solutions, 22 – 25 October 2006, Cape Town: South Africa. 1-73).

MOKDAD, A.H., BREWER, R.D. & WARNER, L. 2007. Binge drinking is a problem that cannot be ignored. *Preventive Medicine* 44: 303-304.

MONTEIRO, M. 2001. A World Health Organization Perspective on Alcohol and Illicit drug Use and Health. *European Addiction Research*, 7 (3): 98-103.

MOROJELE, N. K., PARRY, C. D. H. & BROOK. 2009. Substance abuse and the young: Taking Action. *Medical Research Council Research Brief:* June

NIEUWENHUIS, J. 2007. Analysing qualitative data (*In* Maree, K. (ed). Creswell, J. W., Ebersöhn, I., Eloff, R., Ferreira, N. V., Jansen, J. D., Nieuwenhuis, J., Pietersen, J., Plano Clark, V. L. & van der Westhuizen, C. 2007. First Steps in research. Pretoria: Van Schaik Academic, 99-117).

NQAKULA, C. 2006. Crime Prevention and Combating (Monitoring and evaluation media briefing. www.info.gov.za/speeches/2006/06092810451001.htm.

NZIMAKWE, T. I. 2008. Addressing unemployment and poverty through public works programmes in South Africa. *International NGO Journal*, 3 (12) 207-212.

PARRY, C. D. H. 1998. Substance abuse in South Africa: Country Report focusing on young persons. WHO/UNDCP Regional Consultation, 24-26 February, Zimbabwe

PARRY C, & BENNETS A. 1998. Alcohol Policy and Public Health in South Africa. United Kingdom: Oxford University Press,

PARRY, C. D. H. 2000. Alcohol problem in developing counties: Challenges for the new millennium. Alcohol in developing countries, *Suchtmed* 2 (4):216-220. Date of Access: 11 August 2009.

PARRY, C. D. H. 2005. South Africa: Alcohol today. *Addiction*, 100: 426-429.

PRIDEMORE, W. A. 2006. Weekend effects on binge drinking and homicide: the connection between alcohol and violence in Russia. *Addiction,* 99(8): 1034-1041.

RATAEMANE, S. 2004. Central Drug Authority Report. www.dsd.gov.za/docs_guidelines/2005/docs/cda2004.doc

RATAEMANE, S. & RATAEMANE, L. 2006. Alcohol consumption in South Africa. *International Journal of Drug Policy,* 17: 373 – 375. Date of Access: 10 August 2008.

ROBSON, G. & MARLATT, G. A. 2006. Harm reduction and alcohol policy. *International Journal of Drug Policy*, 255 -257. Date of access: 2 October 2009.

SHEBEEN OWNERS PROTEST W CAPE LIQUOR ACT. *Mail & Guardianonline* (2009, January, 27th). Date of Access: 2 August 2009.

SKWEYIYA, Z. 2005. Speech by the former Minister of Social Development for the Ke Moja Rollout, 11th, March.

SOUTH AFRICA: LIQUOR ACT, No 59 of 2003. Gazette No. 26294. Cape Town: Government Gazette

SOUTH AFRICA: NATIONAL DRUG MASTER PLAN 2006 – 2011. www.welfare.gov.za/Documents/2007. Date of Access: & July 2009.

SOUTH AFRICA: PREVENTION OF AND TREATMENT OF SUBSTANCE ABUSE ACT No 70 of 2008. Gazette No. 32150 CapeTown: Government Gazette.

SOUTH AFRICA: WESTERN CAPE LIQUOR ACT No 4 of 2008. 6582 – 27 November 2008.Cape Town: Provincial Gazette Extraordinary.

SOUTH AFRICA: WHITE PAPER FOR DEVELOPMENTAL SOCIAL WELFARE, February 1997.

STIMSON, G. 2006. Reducing alcohol related harm- what are the options and what can we do.(*In* Conference Report - Buning, E., ed. Paper presented at the 3rd International Conference on Alcohol and harm reduction – Creating realistic and concrete solutions, 22 – 25 October 2006, Cape Town: South Africa, 1-73).

WOMEN'S RURAL ADVOCACY PROGRAMS. 2007. Alcohol abuse and Domestic violence. www.letswrap.com/dvinfo/alchol.htm.

WORLD HEALTH ORGANIZATION. 2004. Global status report on alcohol. Geneva, Switzerland.

WORLD HEALTH ORGANIZATION – Europe. 2005 Policy Briefing – Alcohol and Interpersonal violence

WORLD HEALTH ORGANIZATION – Africa. 2008. Actions to reduce the harmful use of alcohol. Regional Committee for Africa.

WORLD HEALTH ORGANIZATION – 2008. Global Campaign for violence prevention. Youth violence, alcohol and nightlife. Fact sheet 4 –Preventing sexual violence in nightlife environments.

ZAWAIRA, F. 2009. The Burden of alcohol consumption in the African Region. World Health Organization.

CHAPTER 7

SUMMARY, EVALUATION, CONCLUSIONS, IMPLICATIONS AND RECOMMENDATIONS

1. INTRODUCTION

This chapter provides a summary, draws conclusions and makes recommendations regarding theory, practice as well as future research.

2. SUMMARY

This study is part of the Alcohol study that is conducted by the Africa Unit for Trans-disciplinary Health Research (AUTHer), in the Faculty of Health Sciences at the North-West University, South Africa. The data is drawn from the Prospective Urban and Rural Epidemiology (PURE) which is an international twelve year cohort study that tracks changing lifestyles, risk factors and chronic disease in urban and rural areas of sixteen countries in transition, namely, Argentina, Brazil, Chile, UAE, China, Columbia, India, Kenya, Zimbabwe, Sweden, Poland, Turkey, Iran, Tanzania, Russia and South Africa. The PURE, South Africa has started a five year Alcohol study to gain a better understanding of alcohol consumption patterns and the causes and consequences amongst South Africans.

The rationale to undertake the Alcohol study is that the South African population is experiencing health transition due to rapid urbanization. The problem is that this population in transition experiences high levels of alcohol misuse and abuse that has adversely affected, directly or indirectly, the quality of life of many South Africans. There is a need to find a holistic approach to examine the phenomenon of binge drinking and how it affects support networks. This study, therefore, focused on identifying the socio-economic effects of binge drinking on social support networks in Ganyesa, Tlakgameng Villages and Ikageng Township, in the North West Province. This study contributes to a better understanding of causes, consequences of binge drinking on support networks and contributes to suggestions for developing a holistic, intervention strategy to combat the effect of binge drinking in the selected areas of the study.

3. EVALUATION

The study focused on identifying binge drinkers, their social support networks which included informal (family members) and formal (service providers) in the selected areas with an intention to understand how they are affected by binge drinking. The intervention strategies that are used in South Africa were identified, and an analysis of how these are implemented in the selected areas of the study was done and proposals were presented. The quantitative and qualitative approaches were used and triangulated to verify that binge drinking is a problem and it affects social support networks adversely.

Three theoretical perspectives were discussed to justify the argument that people are interrelated and interdependent and when one system is affected, negatively and positively, the others get affected too. Therefore, people cannot be separated from their environment. It means any attempt to study the effects of binge drinking cannot exclude others who are part of the social environment.

It is further explained that as people interact and transact, human needs and problems emanate and they all get affected. It is expected that by being in the same environment demands that people perform certain roles to enhance their social functioning. The role in this instance is linked with provision of support. The argument is from a premise that failure to perform the role destabilizes systems. Social constructivism was used to identify the views that binge drinkers have about their behaviour and the support they are expected to provide to networks and in turn, how the support network views the situation and how they are affected by binge drinking. The information is important and would contribute to development of relevant and integrated strategies.

3.1 The strengths of the study

- The researcher is Setswana-speaking, a language used by the participants in the study, thus addressing the barrier that could have been created by interpretation.
- The study was also inclusive in terms of:
    - Gender: both male and female participants qualified for inclusion and provided alcohol consumption patterns for each group.

- These were used for comparison and cross tabulation, which enriched the findings.
- The use of triangulation of quantitative and qualitative approaches contributed to understand the phenomenon of binge drinking and also enhanced the question of validity and reliability.

3.2 The limitations of the study

- **Non-participation in the PURE study quantitative data collection**

The researcher was not part of the team when data were collected, hence relying on secondary data devoid of human interaction.

- **Lack of generalisability**

The study focused on two selected areas in the North West Province and can, therefore, not be generalised to the whole province because the sample size was small and not representative of all the areas in the province. However, quantitative data provided a picture for the selected areas and the qualitative data pursued the views of participants and formed unique interpretations.

Nonetheless, the strengths of the study outweigh its limitations.

4. CONCLUSIONS

Conclusions regarding objectives, aim, and basic theoretical statement are presented next.

4.1 The objectives of the study

4.1.1 The social aspects of alcohol abuse/misuse in South Africa

The first objective was to review literature to understand the social causes of alcohol abuse/misuse in South Africa. The historical background of how alcohol was introduced in South Africa was discussed and the subsequent challenges to Apartheid laws to understand the context of alcohol use. The socio-economic effects were highlighted. Therefore, this objective was achieved. Having identified the causes and effects, it was critical to also understand binge drinking in relation to social support networks.

4.1.2 Social support networks in relation to binge drinking from various theoretical perspectives

The meaning of social support was unpacked and emphasis was placed on how binge drinking affects support networks. This discussion was supported by theoretical frameworks that focused on the relationships between people and their environments, the importance of performance of their roles in providing, receiving or exchanging support and also on how socially constructed views contribute to alcohol abuse and failure to provide social support.

The study has shown that person-in-environment paradigm does provide a base to understanding that binge drinking is detrimental for the drinker as a person, the family and community that are part of the drinker's environment. The objective was thus reached.

4.1.3 Alcohol consumption patterns in selected areas in the North West Province

Binge drinking as one of the alcohol consumption pattern in the selected areas of the study was pursued. The study indicated that there are a significant number of binge drinkers in the community. Poverty, low levels of income and education were used as markers of socio-economic position and were identified as some of the socio-economic challenges in the demarcated areas of study. The alcohol consumption patterns were identified; therefore, the objective was achieved.

4.1.4 The profiles of the binge drinkers and their support networks.

The profiles of the binge drinkers were highlighted that included amongst others, their drinking behaviour, family members with school going children who are still dependent on parents, employment status and type of drinks they consume. Their support networks were identified and provided information on how they are affected by binge drinking.

4.1.5 Socio-economic effects of binge drinking on support networks.

The profiles of identified binge drinkers and the social problems in the areas were highlighted. The negative effects of alcohol include failure to provide support (emotional, instrumental, and informational) and lead to abuse and neglect. Some of the effects of this prolonged high intake are, therefore, accentuated by the conditions of living.

The objectives were achieved through application of a mixed methods approach using the quantitative and qualitative methodologies. The two research approaches provided rich data that supported the view that quality of life is adversely affected, directly or indirectly by alcohol abuse. A conclusion is drawn that the family as a support network is affected by binge drinking because the drinker is not able to provide support, be it emotional, material, instrumental or informational or perform the role that is expected from the drinker.

The study also indicated that community support networks are affected in that:

- Poverty, unemployment and low level of education are contributory factors to abuse of alcohol, thus impeding efforts to address the problems.
- Community members are not responsive to efforts to improve their socio-economic position due to abuse of alcohol and due to low education, and not motivated to take control for changing the situation.
- Community members depend on social grants and are not motivated to find employment.
- Available resources to improve the community are not optimally used by community members.
- Many alcohol outlets defeat their efforts to address alcohol problems in the communities.

It was, therefore, concluded that binge drinking has negative effects on the support networks. The objective was thus reached.

4.1.6 Intervention strategies to combat the effects of binge drinking: a community support networks' perspective

The key informants provided information on the strategies they use to address the problem of alcohol abuse.

The environment is not conducive for providing services in that:

- Lack of human and infrastructure is a barrier to good service.
- Interdisciplinary team approach is attempted but is not functioning optimally to yield good results.

Suggested intervention strategies focused on assessment of risk and risk environment, targeted interventions, multi-synergistic interventions and roles and partnerships. A conclusion is drawn that in order to address the alcohol abuse problem, social epidemiology should be considered as it emphasizes the social determinants of well being. Therefore, appropriate strategies should be developed for specific areas.

4.2 The aim of the study

The aim of the study was achieved in that the study identified the socio-economic effects of binge drinking on support networks. The findings of the study would contribute towards the development of a holistic, integrated and coherent strategy to address alcohol use, abuse and misuse in South Africa, has been achieved.

4.3 The basic theoretical statement

The theoretical statement has been confirmed in that the study managed to identify that binge drinking adversely affects the social support networks in rural and urban areas and the findings would contribute to development of the strategy for the selected areas of the study.

5. IMPLICATIONS

Having achieved the objectives of the study and drawn conclusions as stated above, the implications with regard to theory, practice and education and training are highlighted.

5.1 Theory

- The ecological perspective, role theory and social constructivism as a post-modern perspective are critical for understanding interactions and transactions between people and environments.

5.2 Practice

- Interventions should take cognizance of the fact that the effects of the socio-political challenges still linger on and efforts to address them take cognizance of the past and opt for a holistic approach.
- Interventions should be directed at both people and environments if change in alcohol abuse is to be realized. It also relates to true partnerships where each system uses its strengths to address the problem. The interdisciplinary approach should be maximized and clear contributions of each participant should be identifiable.
- Proper assessment of risk and risk environment creates the framework for intervention and, therefore, should be done to initiate change.
- Community development as an approach should be used on an ongoing basis. Much as it is important to observe days or weeks set aside for anti-drug campaigns, continuous intervention is required. Communities need to be engaged throughout the year. Dissemination of information and skills transfer should be given priority where members of the community receive accredited training that would assist them to run groups or manage projects. This would encourage them to take control of their change and rehabilitation.
- Community leaders should be consulted to identify members who can be capacitated in community involvement in alcohol treatment. It is a strategy that could help with acceptance and involvement in programmes such as education in life skills, empowerment and workshops in understanding alcohol and its effects on a person and others in his immediate environment.

- Social support networks such as the family need to be strengthened and capacitated to understand how to live with a person who abuses alcohol. Group work with families of binge drinkers like the AL-ANON are encouraged for them to support the drinker and also be encouraged to support them to develop coping strategies.
- Social planning as a model of community work is helpful but the community needs to be encouraged to participate to ensure that change takes place and is reinforced. Community education and self-help groups should be used to encourage them to take control of their lives. Social constructivism says that the people have views about their lives. This requires service providers to understand their own world and develop strategies from within the community and not try to fit off-the-shelf strategies.
- Social work services and infrastructure should be coordinated and shared with other role players to ensure that a comprehensive strategy is used to maximize interventions.
- Employment of more social workers and social auxiliary workers attached to the substance abuse unit should be given priority. Continued professional development in the area of alcohol abuse would yield better results for professionals and consumers of service. It is advisable to specialize in the particular field.
- Implementation of plans and policies should be structured and community members should be involved from assessment, identification, priotisation, planning to implementation. This study was part of a trans-disciplinary study and as such it promises rich data that would contribute to an integrated approach that would be used to tackle the alcohol-related problems in South Africa broadly.
- Chapter 2 as an article is submitted for peer review and for publication in the South African Journal of Clinical Nutrition.
- The researcher is Setswana-speaking, a language used by the participants in the study, thus addressing the barrier that could have been created by interpretation.

- The study was also inclusive in terms of:

5.3 Education and Training

- Education of social work should emphasise studies in alcohol treatment. It could be developed as a postgraduate specialty focusing on individuals, groups and communities. This would ensure that social workers who are working in the field are experts.
- The ecological perspective provides a base for understanding the synergy between people and environments and it is important as a point of departure. In the study of the situation the role set needs to be understood with the views people hold about their lives.
- Accredited training of social auxiliary workers as assistants in alcohol treatment is essential to provide assistance to social workers and address skills shortage in the country. They could be identified in the community and encouraged to access training at Further Education and Training institutions.
- Social workers should continue with professional development to ensure that they are familiar with contemporary intervention approaches. The interventions should be based on changing structural forces that impede development.

6. RECOMMENDATIONS

It is recommended that the following actions be undertaken regarding future research:

- Social support networks should be further analysed to determine their role in addressing alcohol abuse problem.
- Further research to develop speciality in alcohol intervention strategies is critical.
- There is need for advanced intervention approaches in social work to use in alcohol harm reduction programmes. Further research to develop a specialization in substance use and abuse should be pursued.

- Possibility of developing contextualized area specific interventions especially those who are poor, unemployed and less educated should be explored.
- A study that focuses on social epidemiology as an approach for multi-disciplinary intervention is necessary in order to broaden understanding of health in the sense of well-being and not necessarily sickness or illness. A study of social determinants should be pursued to develop an integrated strategy that could be used by the multi-disciplinary team.
- There is a need to conduct further research to understand the abuse of alcohol by women in particular which has been noticed as a changed cultural pattern.

7. SUMMARY STATEMENT

In summary the importance of social support, social networks and network analysis provided a base for understanding the socio-economic effects of binge drinking. The theoretical perspectives supported the notion that people cannot be separated from their environments in which they perform different roles. In order to identify the problems caused by binge drinking, one needs to understand the environment which includes those who are affected and those who provide services meant to curb the problem. The social epidemiology promises a broad understanding of the social, economic and health effects with a view to developing a comprehensive strategy to address the alcohol abuse problem in South Africa.

ANNEXURE 1: ETHICS APPLICATION LETTER

P O Box 50242
Mafikeng South
2791

The Ethics Committee
North-West University
Potchefstroom

ETHICAL CLEARANCE

I am a PhD student in the Department of Social Work, Potchefstroom Campus. I would like to submit the attached proposal for ethical clearance. It is a sub-study of the Alcohol Project that will use existing data of the Prospective Urban and Rural Epidemiology (PURE) which is a twelve-year project that will track changing lifestyles, risk factors and chronic diseases using periodic standardized data collections in urban and rural areas of sixteen countries in transition, of which South Africa is one.

The aim of the Alcohol study is to gain a better understanding of the alcohol consumption patterns and of causes and consequences of binge drinking among South Africans. This sub-study in particular seeks to identify the socio-economic effects of binge drinking on support networks in the selected areas of the North West Province.

The PURE ethical clearance number is 04M10.

Yours faithfully

BMP Setlalentoa

ANNEXURE 2a: GOEDKEURING VIR EKSPERIMENTERING MET MENSE

YUNIBESITI YA BOKONE-BOPHIRIMA
NORTH WEST UNIVERSITY
NOORDWES UNIVERSITEIT

Etiekkomitee
Tel (018) 299 2558
Faks (018) 297 5308
E-Pos dnvealr@puk.ac.za

Dr A Kruger
Bussie 594
Noordwes-Universiteit
(Potchefstroomkampus)

2 September 2004

Geagte dr Kruger

GOEDKEURING VIR EKSPERIMENTERING MET MENSE

Hiermee wens ek u in kennis te stel dat u projek getiteld *"PURE study (Prospective Urban and Rural Epidemiology study)"* deur die Etiekkomitee goedgekeur is met nommer 04M10.

Gebruik asseblief die nommer genoem in paragraaf 1 in alle korrespondensie rakende bogenoemde projek en let daarop dat daar van projekleiers verwag word om jaarliks in Junie aan die Etiekkomitee verslag te doen insake etiese aspekte van hulle projekte asook van publikasies wat daaruit voortgespruit het. U sal in Mei 2005 die dokumentasie hieroor ontvang.

Goedkeuring van die Etiekkomitee is vir 'n termyn van hoogstens 5 jaar geldig (volgens Senaatsbesluit van 4 November 1992, art 9.13.2). Vir die voortsetting van projekte na verstryking van hierdie tydperk moet opnuut goedkeuring verkry word.

Die Etiekkomitee wens u alle voorspoed met u werk toe.

Vriendelike groete

N.T. Malan

PROF. NT MALAN
VOORSITTER: ETIEKKOMITEE

ANNEXURE 2b: ETHICS CLEARANCE

NORTH-WEST UNIVERSITY
YUNIBESITI YA BOKONE-BOPHIRIMA
NOORDWES-UNIVERSITEIT
POTCHEFSTROOM CAMPUS

Private Bag X6001, Potchefstroom
South Africa 2520

Tel: (018) 299-1111/2222
Web: http://www.nwu.ac.za

AUTHeR
Tel: (018) 299-4237
Fax (018) 299-2464
EMail Este.Vorster@nwu.ac.za

Chair
Ethics Committee
NWU

18 June 2008

Combined Summary and Recommendation

APPLICATION LETTER FROM MS. B.M.P. SETLALENTOA

The application (letter) from Ms. Setlalentoa indicates that her proposed study is part of the PURE Study, which already received ethics approval, also to examine alcohol intake in this population. Since she will not be using new or different methods from those already approved, I hereby recommend that her proposed sub-study is covered by the PURE approval.

Kind regards

Este' (H.H.) Vorster

Chair
Sub-committee

ESTE.VORSTER@NWU.AC.ZA c:\documents and settings\administrator\my documents\ellek\2008 ethics\application letter from ms.doc

ANNEXURE 3: LIST OF THE RESEARCH TEAM AND THEIR CONTRIBUTIONS TO THIS STUDY

NAME	ROLE IN THE STUDY
Ms B. M. P. Setlalentoa (PhD candidate)	Writing and compilation of this thesis, which include the collection and analysis of data, presentation of findings, and writing of articles (chapters). First author of 5 articles (Articles 3, 4, 5, & 6) and first author of co-authored article 1– Chapter 2.
Ms N. G. Phetlho-Thekisho (PhD candidate)	Co-author of an article in this thesis – Article 2 (1 & 3)
Dr P. Pisa	Co-author of an article in this thesis – Article 2 (7)
Dr D. T. Loots	Co-author of an article in this thesis – Article 2 (7)
Dr E. H. Ryke	Promoted the entire thesis and co-authored an article in this thesis – Chapter 2 (6 & 7)
Prof H. Strydom	Co-promoted the entire thesis

ANNEXURE 4: LETTER TO KEY INFORMANTS

P O Box 50242
Mafikeng South
2791
23 April 2009

The Head of Department
.....
.....

Dear Sir/Madam

REQUEST FOR PERMISSION TO CONDUCT RESEARCH

I am a PhD student registered at North-West University, Potchefstroom Campus, and the title of my study is "The socio-economic effects of binge drinking on support networks: A social perspective". It is a sub-study of the Alcohol project that aims to gain an understanding of alcohol consumption patterns and of causes and consequences of binge drinking in the North West Province. The ultimate aim is to develop an integrated intervention strategy that could be used in the Province.

I would therefore like to conduct interviews with officials in your department who are responsible for substance abuse programmes, specifically related to alcohol. The selected areas of the study are Ganyesa, Tlakgameng and Ikageng. Social workers are identified as one support network that provide services in the communities where problems of alcohol abuse are experienced. The responses will be based on the following open-ended questions:

What are the social and/or economic effects of binge drinking?
What are the intervention strategies used to combat the problem?
If yes, explain what you do to address alcohol and related problems

If not, what should be done to address the problem?

Permission to conduct the study was granted by the North-West University Ethics Committee, (Please find letter attached).

Your assistance will be highly appreciated.

Yours sincerely

.....

Ms B.M.P. Setlalentoa

ANNEXURE 5: SOUTH AFRICAN JOURNAL OF CLINICAL NUTRITION

AUTHOR INSTRUCTIONS

All manuscripts and correspondence to:

The Editor
African Journal of Clinical Nutrition
Private Bag X 1
Pinelands 7430 (CT)

COPYRIGHT

Material submitted for publication in the South African Journal of Clinical Nutrition (SAJCN) is accepted provided it has not been published elsewhere. Copyright forms will be sent with acknowledgement of receipt and the SAJCN reserves copyright of the material published. The SAJCN does not hold itself responsible for statements made by authors.

AUTHORSHIP

All named authors must give consent to publication. Authorship should be based only on substantial contribution to: (i) conception, design, analysis, and interpretation of data; (ii) drafting the article or revising it critically for important intellectual content; (iii) final approval of the version to be published. All three of these conditions must be met (Uniform requirements for manuscripts submitted to biomedical journals; www.icmje.org/index.html).

CONFLICT OF INTEREST

Authors must declare all sources of support for the research and any association with the product or subject that may constitute conflict of interest

PROTECTION OF PATIET'S RIGHTS TO PRIVACY

Identifying information should not be published in written descriptions, photographs, and pedigrees unless the information is essential for scientific purposes and the patient (or parent or guardian) gives informed written consent for publication. Informed consent for this purpose requires that the patient be shown the manuscript to be published. (www.icmje.org)

ETHNIC CLASSIFICATION

Work that is based on or contains reference to ethnic classification must indicate the rationale for this.

MANUSCRIPTS

*Short items are more likely to appeal to our readers and therefore to ba accepted for publication. **Please provide a word count for all submissions.***

***Original articles** of 4 000 words or less, with up to 6 tables or illustrations, should normally report observations or research of relevance to the field of nutrition. Reference should preferably be limited to no more than 15.*

***Short reports or scientific letters,** which include case reports, side effects of nutrient supplements/drugs and brief or negative research findings should be 1000 words or less, with 1 table or illustration and no more than 6 references.*

***Editorials, Opinions, Issues in the field** of nutrition, should be about 800 words and are welcome, but unless invited, will be subjected to the SAJCN peer review process.*

***Review articles** are rarely accepted unless invited.*

***Letters to the editor,** if intended for the correspondence column, should be marked "for publication", signed by all authors and presented in triple spacing. Letters should be no longer than 400 words with only one illustration or table.*

***Obituaries** should not exceed 400 words and may be accompanied by a photograph.*

MANUSCRIPT PREPARATION

Please send your manuscript on disc accompanied by three printouts, in triple spacing, with wide margins and paginated.

Research articles should have a structured abstract not exceeding 250 words (50 for short reports) comprising: Objectives, Design, Setting, Subjects, Outcome measures, Results and Conclusions.

Refer to articles in recent issues for guidance on the presentation of headings and subheadings.

Abbreviations should be spelt out when first used in the text and thereafter used consistently.

Scientific measurements should be expressed in SI units except: blood pressure should be given in mmHg and haemoglobin values in g/d1. If in doubt, refer to www.icmje.org/index.html

ILLUSTRATIONS

Figures consist of all material that cannot be set in type, such as photographs and line drawings.
Tables and legends for illustrations should appear on separate sheets and should be clearly identified.
Line drawings should be arranged to conserve vertical space. Note that reduction to 80 mm for a single column or 170 mm for double columns should not render lettering illegible. Explanations should be included in the legend and not on the figure itself.
Figure numbers should be clearly marked on the back of prints and the top of illustrations should be indicated.
In any tables or illustrations submitted have been published elsewhere, written consent to republication should be obtained by the author from the copyright holder and the author (s).
A limited number of illustrations are free at the discretion of the editor. Colour illustrations are encouraged but are charged to the author. A quote will be provided on request. Consider sponsorship.

REFERENCES

References should be inserted in the text as superior numbers and should be listed at the end of the article in numerical and not in alphabetical order. Authors are responsible for verification of reference from the original sources.
Reference should be set out in the Vancouver style and approved abbreviations of journal titles used, consult the list of Journals in Index Medicus for these details.
Names and initials of all authors should be given unless there are more than six, in which case the first three names should be given followed by et al. First and last page numbers should be given.
***Journal references** should appear thus:*
*Price NC. Importance of asking about glaucoma. BMJ 1983; **286**: 349-350.*

***Book reference** should be set out as follows:*
Jeffcoate N. Principles of Gynaecology. 4th ed. London: Butterworth, 1975: 96-101.

Weinstein L, Swartz MN. Pathogenic properties of invading microorganisms. In: Sodeman WA jun, Sodeman WA, eds. Pathogenic Physiology: Mechanisms of Disease. Philadelphia: WB Saunders, 1974: 457-472.

***Manuscripts accepted but not yet published** can be included as references followed by (in press)*
***Unpublished observations and personal communications** may be cited in the text, but not in the reference list.*

MANUSCRIPT REVISIONS

In the event of a manuscript needing revision following the peer review process, all revision changes to the original manuscript should be made using the "track changes" function in Microsoft Word, or in any other such similar format so as to facilitate the speedy completion of the review process. In the event of an "author-reviewer" difference of opinion, the author (s) should state their opinion in writing in the text, which should be bracketed. Revised manuscripts which do not conform to this revision format will be returned to the authors for editing.
Revised manuscripts should be returned to the editorial office within 3 weeks of receipt thereof.

GALLERY PROOFS

*Gallery proofs will be forwarded to the author before publications and if not returned **within 2 weeks** will be regarded as approved. Please note that alterations to typeset articles are costly and will be charged to the authors.*

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An order form for reprints, with a price list, will be sent to the author as soon as an article has been placed.

CPD POINTS

*Authors can earn up to 15 CPD points for publishing **articles**. Certificates will be provided on request after the articles has been published.*

ANNEXURE 6: AUTHOR GUIDELINES FOR SOCIAL SCIENCE & MEDICINE

Two types of contribution are welcomed:

Full papers. *These are original research reports or critical reviews of a field, and may be up to 8000 words including abstract, tables, and references as well as the main text. Papers below this limit are preferred. The editors are prepared to consider longer papers in exceptional cases, though justification for this must be made at submission by the author.*

Short items. *These are reports of research findings, commentaries on topical issues of between 2000 and 4000 words.*

Submission will be considered on the understanding that:

the article comprises original, unpublished material (except in the form of a conference abstract or as part of a published lecture or a thesis submitted for an academic qualification).

- *the studies on which it is based have been subject to appropriate ethical review.*
- *It is not under consideration for publication elsewhere.*

Its publication is approved by all authors and tacitly or explicitly by the responsible authorities where the work was carried out.

If accepted, it will not be published elsewhere in the same form, in English or in any other language, without the written consent of the Publisher.

Authors are required to confirm the above points during submission.

Manuscript Preparation

General: *We accept most word processing formats, but MSWord files are preferred, with all author-identifying text removed. They are acceptable in US or UK English, but the use of either must be consistent throughout the manuscript. Submissions should be double spaced and use between 10 and 12pt font, and any track changes should be removed. The editors reserve the right to adjust style to certain standards of uniformity. Authors should retain an electronic copy of their manuscript*

Abstract: *An abstract must be included in the submitted manuscript. An abstract is often presented separately from the article, so it must be able to stand alone. It should state briefly and clearly the purpose and setting of the research, the principal findings and major conclusions. Please note that excessive statistical details should be avoided, abbreviations/acronyms used only if essential or firmly established, and that the abstract should not be structured into subsections.*

Keywords: *Up to 8 keywords are entered separately into the online editorial system (EES) during submission, and should accurately reflect the content of the article. Again abbreviations/acronyms should be used only if essential or firmly established.*

Author details: *This information is entered into the online editorial system (EES) during submission and should not be included in the manuscript itself*

Text: *In the main body of the submitted manuscript this order should be followed: abstract, main text, reference, and appendix. Please use a concise and informative title (avoiding abbreviations where possible), as these are often used in information-retrieval systems. During submission authors are asked to provide a word count; this should include all text, including that in the tables, figures, references etc. The use of endnotes and footnotes should be avoided if possible, though if necessary they should be listed separately at the end of the text and not at the bottom of each page. All pages must be numbered in the bottom right-hand.*

References: *Social Science & Medicine uses the APA referencing system, details of which can be found at http://owl.english.purdue.edu/owl/resource/560/05/ and http://www.apastyle.org/. All publications cited in the text should be presented in the list of references following the text of the manuscript. In the text refer to the author's name (without initials) and year of publication e.g. "Since Peterson (1993) has shown that ..." For 2-6 authors all authors are to be listed at first citation, with "&" separating the last two authors, for more than six authors, use the first six authors, followed by et al. The list of references should be arranged alphabetically by authors' names. The manuscript should be carefully checked to ensure*

that the spelling of authors' names and dates are exactly the same in the text as in the reference list. Responsibility for the accuracy of bibliographic citations lies entirely with the author(s).

Tables: *Tables should be numbered consecutively and given a suitable caption and if possible provided at the end of the same file as the main text.*

Copyright: *Upon acceptance of an article, authors will be asked to sign a "Journal Publishing Agreement" (for more information on this and copyright see http://www.elsevier.com/copyright).*

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ANNEXURE 7: AUTHOR GUIDELINES FOR SOCIAL WORK/MAATSKAPLIKE WERK JOURNAL

The journal publishes articles, short communications, book reviews and commentary on articles already published from any field of social work. Contributions relevant to social work from other disciplines will also be considered. Contributions may be written in English or Afrikaans. All contributions will be critically reviewed by at least two referees on whose advice contributions will be accepted or rejected by the editorial committee. All refereeing is strictly confidential. Manuscripts may be returned to the author if extensive revision is required or if the style or presentation does not conform to the Journal practice. Commentary on articles already published in the Journal must be submitted with appropriate captions, the name(s) and addressees of the author(s) and preferably not to exceed 5 pages. The whole manuscript plus one clear copy as well as a diskette with all the text, preferably in MS Windows (Word or WordPerfect) or ASC11 must be submitted. Manuscripts must be typed double spaced on one side of A4 paper only. Use the Harvard system for references. Short references in the text: When word-for-word quotations, facts or arguments from other sources are cited, the surname(s) of the author(s), year of publication and page number(s) must appear in parenthesis in the text, e.g. "..." (Berger 1967: 12).More details about sources referred to in the text should appear at the end of the manuscript under the caption "References". The sources must be arranged alphabetically according to the surname of the authors. Note the use capitals and punctuation marks in the following examples:

TWO AUTHORS: ABELS, P & MURPHY, MJ 1981. **Administration in the human services.** Englewood Cliffs, New Jersey: Prentice-Hall, Inc.

COLLECTION: CONNORS, TD (ed) 1980. **The nonprofit Organization Handbook.** New York: McGraw-Hill Book Company.

ARTICLES IN COLLECTION: ALEXANDER, CA 1977. Management of Human Service Organizations. In: TURNER, JB (ed). **Encyclopedia of Social Work.** (17th ed) Washington: NASW Inc., 844-849.

DOCTORAL THESIS: PIETERSE, JE 1985. **Aangehoudendes in werkkolonies: 'n sosiologiese ondersoek.** Pretoria: University of Pretoria. (D.Phil.thesis).

UNPUBLISHED MANUSCRIPT: STEYN, AF. **Die uitdagings en geleenthede vir gunstige lewensomstandighede in Suid-Afrika.** Paper read at Manpower 2000 conference. (2-4 October 1980).

NEWSPAPER REPORT: The future of social work. **Sunday Times**, Johannesburg, 17 Oct. 1982: 11.
PERSONAL COMMUNICATION: VAN DER MERWE, PJ 1982. Director General. Department of Manpower. Pretoria.

The South African journal for social work "Social Work/Maatskaplike Werk" (ISSN – 0037-8054) provides the following guidelines to authors:

ANNEXURE 8: CONSENT FORMS

1.1 Focus group interviews/ Interviews

I ..... hereby consent to participate in the focus group discussions conducted by Ms Setlalentoa, for research purposes.
She explained that I am free to terminate the interview if I feel uncomfortable.

I ..... hereby consent to participate in the interviews and extend such consent to include my family members as well in.
She explained that we are free to terminate the interview if we feel uncomfortable.

Signatures/Thumbprint:
Participant .....
Researcher .....

1.2 Key-informants

I..... hereby consent to participate in this research on "Socio-economic effects of binge drinking on social support network", conducted by Ms BMP Setlalentoa. I have seen letters from the Head of Department and North West University Ethics Committee that indicate that she has been given permission to conduct the study. She explained that I am free to terminate the interview if I feel uncomfortable.

Signatures:
Participant .....
Researcher.....

Consent form for Focus group interviews/In-depth interviews in the Setswana language

Foromo ya tumelo ya ba ba botsolotswang ka tsenelelo/ya dipotsotherisano tsa setlhopha se se tsepameng

Nna,..... ke dumela gotsaya karolo ka go ithaopa mo dipuisanong tsa setlhopha se se tsepameng/ se se botsolotswang ka tsenelelo, se tsamaisiwa ke Mme Setlalentoa.

Ke dumetse gore a buisane le ba legae ja me go tsweletsa dipatlisiso ka tiriso ya nno tagi le tlhokomelo ya legae.

Go dirisiwa ga segatisamantswe.

Go khutlisa ditherisano ka gangwe fela fa ke simolola go sa nnisege kgotsa go tlhobaela.

Tshaeno/Kgatisamonwana:

Motsayakarolo .....

Mmatlisisi.....

ANNEXURE 9:(Extracted from the PURE adult questionnaire for analysis)

PURE/SOUTH AFRICA - ADULT QUESTIONNAIRE

1. Name----------
2. Date of birth----------
3. Sex----------

4. Marital status

☐ Never Married ☐ Common law/living with partner ☐ Currently married

☐ Widowed ☐ Divorced ☐ Separated

5. What level of formal education have you completed

- None
- Primary
- Secondary/high school/higher secondary
- Trade school
- College/University
- Unknown
- Occupation
- Legislators, senior officials and managers
- Professionals
- Technicians and associate professionals
- Clerks
- Service workers and shop market sales workers
- Skilled agricultural and fishery workers
- Craft and related trade workers
- Plant and machine operators and assemblers
- Elementary occupations

- Armed forces
- Homemaker
- Main source of income
- Are you currently employed?

28a Alcoholic beverages

- Which best describes your history of alcohol use
- Formerly used alcohol products
- Currently use alcohol products
- Never used alcohol products
- At what age did you start?
- What forms of alcohol have you regularly used
- Frequency (Daily, weekly, monthly)
- At least once a month do you consume>5 alcoholic drinks/day
- How many times per month do you consume >5 alcoholic drinks in a day?
- What is the average number of drinks that you consume each time?

34. Have you experienced any of the following events during the last 12 months?

i) Major stress

ii) Unavailability of food/food security

36. What level of financial stress have you felt in the last 12 months?

38 a) Has your household been a victim of the following crime(s) in the last 12 months?

- Rape
- Women abuse
- Child abuse
- Other

38a)(ii) Do you think that crime in your area has increased in the past 5 years?

38c) Do you care for any orphans in your family? No..... Yes.....

ANNEXURE 10: SOCIAL NETWORK GRID

ID_____ Respondent _____ Name	#	Area of life 1. Household 2. Other family 3. Work/school 4. Organizations 5. Other friends 6. Neighbors 7. Professionals 8. Other	Concrete support 1. Hardly ever 2. Sometimes 3. Almost always	Emotional support 1. Hardly ever 2. Sometimes 3. Almost always	Information/ advice 1. Hardly ever 2. Sometimes 3. Almost always	Critical 1. Hardly ever 2. Sometimes 3. Almost always	Direction of help 1. Goes both ways 2. You to them 3. They to you	Closeness 1. Not very close 2. Sort of close 3. Very close	How often seen 0. Does not see 1. Few times/yr. 2. Monthly 3. Weekly 4. Daily	How long known 1. Less than 1 yr. 2. 1–5 yrs. 3. More than 5 yrs.
	01									
	02									
	03									
	04									
	05									
	06									
	07									
	08									
	09									
	10									
	11									
	12									
	13									
	14									
	15									
1–6		7	8	9	10	11	12	13	14	15

Fig. 3. *Family support project social network grid.*

ANNEXURE 11: INTERVIEW SCHEDULE FOR BINGE DRINKERS AND FAMILY SUPPORT NETWORK REPRESENTATIVES

Social support	
1.1 Types of support Emotional support Material or concrete support Information or advice	
Binge drinker	Support networks
What impact do you consider alcohol use has on your family? Which types of support do you provide to your families?	Which type of support do you receive from your parents, spouse, child or sibling?
1.2 Recipient perception	
How is availability and provision of social support perceived by the support networks, in particular children, spouse and parent?	What is your perception regarding support you get from parents, spouse, child or sibling?
1.3 Reciprocal support (direction of help)	
Do you help the support networks as much as they help you? Do you receive support from your support networks?	Do you help the support networks as much as they help you? Do you receive support from your support networks?
1.4 Behaviour of the provider	
What is the impact of your behaviour as a provider on your family?	How do you feel about the drinking behavior of your parent, spouse, child or sibling?
2. What are the socio-economic challenges experienced in your community due to alcohol abuse?	

ANNEXURE 12: INTERVIEW SCHEDULE: COMMUNITY SUPPORT NETWORK

1. What are the socio-economic effects of binge drinking in your area of operation?
2. Which intervention strategies are used to address the problems?
3. What are challenges that are experienced by you as a service provider that could negatively affect your intervention strategies?
4. In your view, what should be done to address the problems that lead to or cause binge drinking?

COMBINED BIBLIOGRAPHY

ABBEY, A., ZAWACKI, T., BUCK, P. O., CLINTON, A. M. & McAUSLAN, P. 2001. Alcohol and Sexual Assault. National Institute on Alcohol Abuse and Alcoholism, *Alcohol Health and Research World,* 25, (1).

ADDICTION RECOVERY BASICS – How alcohol abuse affects Family. 23 July 2008. http://addictionrecoverybasics.com. Date of access 13 October 2008.

ADELEKAN, M. L. 1998. Substance use, HIV infection and the harm reduction approach in Sub-Saharan Africa. *International Journal of Drug Policy*, 9: 315-323.

AGARWAL, D. P. 2002. Cardioprotective effects of light –moderate consumption of alcohol: a review of putative mechanisms. *Alcohol Alcohol,* 37(5): 409-415.

ALCOHOL HARM REDUCTION STRATEGY FOR ENGLAND. 2004. www.cabinetoffice.gov.uk/media. Date of access: 12 May 2009.

AMERICAN PSYCHIATRIC ASSOCIATION. 2000. Diagnostic and Statistical Manual of Mental Disorders (4th ed.). Washington, D. C.:APA

ANDERSON, P. & BAUMBERG, B. 2006. Alcohol in Europe: A Public Health Perspective. London: Institute of Alcohol Studies.

BABBIE, E. R. 2009. The Practice of Social Research. (12th ed). Belmont, CA:Wadsworth.

BABBIE, E. R. & MOUTON, J. The Practice of Social Research. Oxford University Press: Cape Town.

BALETA, A. 1998. South Africa takes steps to restrict smoking and alcohol consumption. *The Lancet*, 352: 9126.

BARKER, R. L. 2003. The Social work dictionary. (5th ed). Washington, DC: NASW Press.

BECKER, H. A. & VANCLAY, F. 2003. The International Handbook of Social Impact Assessment: Conceptual and Methodological Advances. Northampton, MA: Edward Elgar Publishing.

BERKMAN, L. F. & KAWACHI, I. 2000. Social Epidemiology. New York: Oxford University Press.

BEZUIDENHOUT, F. J. 2004a. Divorce. (*In* Bezuidenhout FJ, (ed). A Reader on Selected Social Issues. (3rd ed). Pretoria: Van Schaik Academic, 13-30).

BEZUIDENHOUT, F. J. 2004b. Substance abuse and addiction: drugs and alcohol. (*In* Bezuidenhout FJ, ed. A Reader on Selected Social Issues. 3rd ed. Pretoria: Van Schaik Academic, 127-128).

BOLES, S.M. & MIOTTO, K. 2003. Substance abuse and violence: a review of the literature. *Aggression and Violent Behavior,* 8: 155-174.

BOPAPE, M. 1993. Social networks and social support as a basis of community development in Lebowa. Pretoria: Human Sciences Research Council.

BORGATTI, S. 2005a. Social Support. UCINET 5 for Windows: software for social network analysis. Natick; MA: Analytic Technologies. http://www.analytictech.com/networks/socsup.html. Date of access: 22 Aug. 2007.

BORGATTI, S.P. 2005b. The Key Player Problem (KPP) – The Centrality Approach. UCINET 5 for Windows: software for social network analysis. Natick; MA: Analytic. Technologies. http://www.analytictech.com/networks/socsup.html. Date of access: 22 Aug. 2007.

BOSLAUGH, S. 2007. Secondary Data Sources for Public Health: A Practical Guide (Practical guides to Biostatistics and Epidemiology). Excerpt. London:Cambridge University Press.

BRAUDE, D. & FRANCISCO-LA GRANGE, F.H. 1993. Support systems in the life situation of children of divorce. Pretoria: Human Sciences Research Council.

BRYSIEWICZ, P. 2001. Trauma in South Africa. *International Journal of Trauma Nursing,* 7(4): 129-132.

BUTCHART, A., KRUGER, J. & LEKOBA, R. 2000. Perceptions of injury causes and solutions in a Johannesburg township: implications for prevention. *Social Science & Medicine*, 50(3): 331-344.

CLAUSEN, T., ROMOREN, T. I., ROSSOW, I., INGSTAD, B., MOLEBATSI, R. M. & HOLMBOE-OTTESEN, G. 2005. Patterns of alcohol consumption among older persons in Botswana. *Contemporary Drug Problems*, 1-6. Date of access: 26 March 2009.

COLDITZ, G. A., GIOVANNUCCI, E., RIMM, E. B., STAMPFER, M. J., ROSNER, B., SPEIZER, F. E., GORDIS, E. & WILLET, W. C. 1991. Alcohol intake in relation to diet and obesity in women and men. *The American Journal of Clinical Nutrition,* 54(1): 49-55.

COMPTON, B. R., GALAWAY, B. & COURNOYER, B. R. 2005. Social Work Processes. (7th ed). Pacific Grove: Brooks/Cole.

CORDEN, A. & HIRST, M. 2008.Implementing a Mixed Methods Approach to Explore the Financial Implications of Death of a Life Partner. *Journal of Mixed Methods Research,* 2(3): 208-220.

COUCH, S., FELSTEHAUSEN, G. & HALLMAN, P. 1997. Skills for life. New York: West Publishing.

COURNOYER, B. 2000. The Social Work Skills Workbook. Pacific Grove: Wadsworth Publishing.

CRESWELL, J. W. 2003. Research design: qualitative, quantitative, and mixed methods approaches, (2nd ed). Thousand Oaks, California: Sage Publications.

CRESWELL, J. W. 2007. Qualitative inquiry & research design: Choosing among five approaches. (2nd ed). London: Sage Publications.

CRESWELL, J. W. 2009. Research design: Qualitative, Quantitative, and Mixed Methods Approaches. (3rd ed). Los Angeles: Sage Publications.

CUNNINGHAM, J. A., VAN MIERLO, T. & FOURNIER, R. 2008. An online support group for problem drinkers: AlcoholHelpCenter.net. *Patient Education and Counseling*, 70(2): 193-198.

D'SOUZA, V. P. 2003. These grapes aren't sour. *The New York Amsterdam News* 2003; November 27 – December 3: 2.

DE GAETANO, G., DI CASTELNUOVO, A., DONATI, M. B. & IACOVIELLO, L. 2003. The Mediterranean lecture: wine and thrombosis-from epidemiology to physiology and back. *Pathophysiology Haemostasis and Thrombosis,* 33(5/6): 466-71.

DENSCOMBE, M. Communities in Practice: A Research Paradigm for the Mixed Methods Approach. *Journal of Mixed Methods Research*, 2 (3) 270- 283.

DE VOS, C. S. L. 2005. (*In* de Vos, A. S., Fouché, C. B., Delport, C. S. L. & Strydom, H. 3rd *ed.*, Research at grass roots: for the Social Sciences and Human Services) Professions. Pretoria: Van Schaik Academic, 357- 366).

DEPARTMENT OF HEALTH AND COUNCIL FOR SCIENCE AND INDUSTRIAL RESEARCH. 2003. Analysis of Homebrewed "Concoctions". Pretoria.

DEPARTMENT OF HEALTH. 2002. South African Demographic and Heath Survey, 1998. www.doh.gov.za/facts/index.html. Date of access 2 April 2008.

DONOVAN, J.H. 2007, July. Coaching: Create a work environment full of support, encouragement and truth. *BizTimes*.

DUCHARME, L. J. & MARTIN, J. K. 2000. Unrewarding work, coworker support and job satisfaction. *Work Occupation,* 27: 223-243.

EBERSÖHN, L. & ELOFF, I. 2006. Life skills and Assets (2nd ed). Pretoria: Van Schaik Academic.

ETTNER, S. L. 1997. Measuring the Human Cost of a Weak Economy: Does unemployment lead to alcohol abuse? *Social Science and Medicine,* 44(2): 251-260.

EVERETT, M. & BORGATTI. S. P. 2005. Ego network betweenness. *Social networks*, 27: 31-38.

FATOUT, M. 1990. Consequences of abuse on the relationships of children. *Families in Society: The Journal of Contemporary Human Services,* 76 – 81. Date of access: 30 October 2009.

FEINMAN, L. 1989. Absorption and utilization of nutrients in alcoholism. *Alcohol Health & Research World,* 13(3): 207-210.

FREEMAN, J. (undated) Services Seta Employee Assistance Programme Toolkit: Addiction – managing Substance abuse in the workplace.

FREEMAN, L. N. 2004. The development of social network analysis: A study in the Sociology of Science. Cambridge: Empirical Press.

FU, S. K., ANDERSON, D., COURTNEY, M. & HU, W. 2007. The relationship between culture, attitude, social networks and quality of life in midlife Australian and Taiwanese citizens. *Maturitas,* 58: 285-295.

GALLANT, D. M. 1993. Unemployment and alcohol consumption. *Alcohol Clin Exp Res,* 17(3): 722-3.

GANS, S. 2003. What is alcohol abuse? Alcohol – Getting the Facts. About.com.Alcoholism. Date of access: 4 February 2008.

GASS, J.S., WEITZEN, S., CLARK, M. & DIZON, D.S. 2007. Defining social support systems for women with breast cancer. *The American Journal of Surgery,* 194:501-503.

GERMAIN, C. B. 1980. Social Work Practice in Health Care: An ecological perspective. New York: Columbia University Press.

GOPANE, R. E., PISA, P. T., VORSTER, H. H., KRUGER, A &, MARGETTS, B. M. 2008. Relationships of alcohol intake with biological health outcomes in an African population in transition: the Thusa study. *South African Journal of Clinical Nutrition* {Submitted}.

GREEF, M. 2005. Information collection: Interviewing. (*In* de Vos, A. S., Fouché, C. B., Delport, C. S. L. & Strydom, H. (3rd *ed).*, 2005. Research at grass roots: for the Social Sciences and Human Services Professions. Pretoria: Van Schaik Academic, 286 – 313).

GROH, D. R., JASON, L. A. & KEYS, C.B. 2008. Social network variables in alcoholics anonymous: A literature review. *Clinical Psychology Review,* 28(3): 430- 450.

GRUCHOW, H. W., SOBOCINSKI, K. A., BARBORIAK, J. J. & SCHELLER, J.G. 1985. Alcohol consumption, nutrient intake and relative body weight among U.S. adults. *The American Journal of Clinical Nutrition,* 42(2): 289-295.

HARTMAN, A. 1995. Diagrammatic Assessment of Family Relationships. *Families in Society, The Journal of Contemporary Human Services,* 76 (2): 111-112.

HOCHFELD, T. 2007. Missed opportunities: Conservative discourses in the draft National Family Policy of South Africa. *International Social Work*, 50(1): 79-91. Date of Access: 11 August 2009.

HULL, Jr. G.H. & MATHER, J. 2006. Understanding Generalist Practice with Families. Belmont, CA: Brooks/Cole.

HUPCEY, J. E. 1998. Clarifying the social support theory - research linkage. *Journal of Advanced Nursing*, 27: 1231- 1241.

INSERM COLLECTIVE EXPERT REPORT. 2003. Alcohol: Social Damage, Abuse and Dependence. http://ist.inserm.fr/basispresse/DP/DPanglais/25/february2003.pdf.

IVANKOVA, N. V., CRESWELL, J. W. & PLANO CLARK, V. L. 2007 Foundations and approaches to mixed methods research. (*In* Maree, K. (ed). Creswell, J. W., Ebersöhn, I., Eloff, R., Ferreira, N. V., Jansen, J. D., Nieuwenhuis, J., Pietersen, J., Plano Clark, V. L. & van der Westhuizen, C. 2007. First Steps in research. Pretoria: Van Schaik Academic, 254 – 282).

JACOBS, M., SHUNG-KING, M. & SMITH, C. 2005. South African Child Gauge University of Cape Town: Children's Institute, 22.

JANSEN, J.D. 2007. The language of research (*In* Maree, K. (ed). Creswell, J. W., Ebersöhn, I., Eloff, R., Ferreira, N. V., Jansen, J. D., Nieuwenhuis, J., Pietersen, J., Plano Clark, V. L. & van der Westhuizen, C. 2007. First Steps in research. Pretoria: Van Schaik Academic, 14 – 22).

JERNIGAN, D. H. 2001. Global status report – Alcohol and Young people. World Health Organization, Geneva, Switzerland. Date of access: 10 September 2009.

JERNIGAN, D. H., 2004. Alcohol in Developing Societies: A Public Health approach, Summary. Finland, World Health Organization.

JERNIGAN, D. H., MONTEIRO, M., ROOM, R. & SAXENA, S. 2000. Towards a global alcohol policy: alcohol, public health and the role of WHO. *Bulletin of the World Health Organization*, 78(4): 491-499.

JEWKES, R., LEVIN, J. & PENN-KEKANA, L. 2002. Risks factors for domestic violence. Findings from a South African cross sectional study. *Social Science and Medicine,* 55(9):1603-1617.

JUKKALA, T., MÄKINEN, I.K., KISLITSYNA, O., FERLANDER, S. & VÅGERÖ, D. 2008. Economic strain, social relations, gender, and binge drinking in Moscow. *Social Science and Medicine.* 66: 663-674.

KALICHMAN, S.C., SIMBAYI, L. C., CAIN, D. & JOOSTE, S. 2007. Alcohol expectancies and risky drinking among men and women at high-risk for HIV infection in Cape Town South Africa. *Addiction Behavior,* 32(10): 2304-2310.

KAWACHI, I. & BERKMAN, L. F. 2001. Social ties and mental health. *Urban Health*, 78 (3):458-467. Date of access: 17 October 2009.

KERR-CORRÊA, F., IGAMI, T.Z., HIROCE, V. & TUCCI, A.M. 2007. Patterns of alcohol use between genders: A cross-cultural evaluation. *Journal of Affective Disorders*, 102: 265-267.

KLINGEMANN, H. 2001. Alcohol and its social consequences – the forgotten dimension. World Health Organization – Regional Office for Europe.

KUUNDERS, M. 2008a. Alcohol use: Consequences for individuals and society. www.euphix.org/object_document/05203n27408.html. Date of access: 8 July 2008.

KUUNDERS, M. 2008b. Alcohol use: Causes and risk factors. www.euphix.org/object_document/05209n27408.html. Date of access: 8 July 2008.

LA HAUSSE, P. 1988. Brewers, Beer halls and Boycotts. *A History of liquor in South Africa.* Johannesburg: Ravan Press, 2-12.

LEVESQUE, R. 2007. SPSS Programming and Data Management: A Guide for SPSS and SAS Users, (4th ed.), SPSS Inc., Chicago I11. www.spss.com/spss/SPSSdatamgmt_4e.pdf. Date of access: 13 September 2009.

LINCOLN, K. D. 2000. Social support, negative social interactions, and psychological well-being. *Social Service Review*, 6: 231- 252. Date of access: 2 September 2009.

LITT, M D. & MALLON, S. D. 2003. The design of social support networks for offenders in outpatient drug treatment. *Federal Probation,* 67(2) 15 - 21.

LONDON, L. 2000. Alcohol consumption amongst South African farm workers: a challenge for post-apartheid health sector transformation. *Drug Alcohol Dependence,* 59(2): 199-206.

LONG, D. D., TICE, C. J. & MORRISON, J. D. 2006. Macro social work Practice: A Strengths Perspective. Belmont, CA: Brooks/Cole.

LYNCH, J. & KAPLAN, G. 2000. Socio-economic Position, (*In* Berkman, L. F. & Kawachi, I. (eds) Social Epidemiology. New York: Oxford University Press, 13 - 35).

MABANDLA, B. 2007. Conference presentation by the former Minister of Justice and Constitutional Development, 28 May.

MADU, S.N. & MATLA, M.P. 2003. Illicit drug use, cigarette smoking and alcohol drinking behaviour among a sample of high school adolescents in the Pietersburg area of the Northern Province, South Africa. *Journal of Adolescence*, 26 (1): 121-136.

MAGUIRE, L. 1991. Social Support Systems in Practice: A Generalist Approach. Silver Springs, MD: NASW Press.

MALLET, S., ROSENTHAL, D. & KEYS, D. 2005. Young people, drug use and family conflict: Pathways into homelessness. *Journal of Adolescence*; 28: 185-199.

MAREE, A. 2003. Criminogenic Risk Factors For Youth Offenders. (*In* Bezuidenhout C, Jourbert S, (eds). Child and Youth Misbehaviour in South Africa A holistic view. 1st ed. Pretoria: Van Schaik, 43-63).

MARTINIC, M. 2006. Patterns of drinking and the need for targeted interventions. *(In* Conference Report - Buning, E., ed. Paper presented at the 3rd International Conference on Alcohol and harm reduction – Creating realistic and concrete solutions, 22 – 25 October 2006, Cape Town: South Africa. 1-73). Date of access: 2 August 2009.

MAY, P. A., GOSSAGE, J. P., BROOKE, L. E., SNELL, C. L., MARAIS, A., HENDRICKS, L. S., CROXFORD, J. A. & VILJOEN, D. L. 2005. Maternal Risk Factors for Fetal Alcohol Syndrome in the Western Cape Province of South Africa: A Population-Based Study. *American Journal of Public Health,* 95(7): 1190-1199.

McKENDRICK, B. (ed) 1987. Introduction to Social Work in South Africa. Pinetown: Owen Burgess Publishers.

MCKINSTRY J. 2005. Using the past to step forward Fetal Alcohol Syndrome in the Western Cape Province of South Africa. *American Journal of Public Health,* 95(7): 1097-1099.

MEAD MADE COMPLICATED: 2003a. Alcohol consumption patterns. www.meadmadecomplicated.org/society/consumptionpatterns.html. Date of access: 8 July 2008.

MEAD MADE COMPLICATED: 2003b. Alcohol and Culture. www.meadmadecomplicated.org/society/culturepatterns.html. Date of access: 15 August 2008.

MEDICAL RESEARCH COUNCIL. Fact sheet – alcohol use in South Africa. Prepared by Alcohol and Drug Research Group, www.sahealthinfo.org/admodule/alcohol.htm. Date of access: 13 April 2009.

MEDICINENET – The alcohol and alcoholism glossary of terms-MedineNet.Inc. www.medicinenet.com/alcohol. Date of access: 1 September 2009.

MEDINA-MORA, M. E. 2005. Prevention of substance abuse: a brief overview. *World Psychiatry* 4(1): 25 – 30.

MEEL, B. L. 2006. Alcohol-Related Traumatic Deaths in Transkei, South Africa. *Internet Journal of Medical Update,* 1, (1) Jan –June.

MESSINA, J.J. & MESSINA, C.M. 1999-2007. The SEA's tools for recovery lifestyles – Social Support in recovery. http://www.coping.org/selfesteem/lifestyle/support.htm. Date of access: 22 Aug. 2007.

MKHIZE, B. 2006. Need for ambassadors, champions and role models to tell the message (*In* Conference Report - Buning, E., ed. Paper presented at the 3rd International Conference on Alcohol and harm reduction – Creating realistic and concrete solutions, 22 – 25 October 2006, Cape Town: South Africa. 1-73).

MOKDAD, A.H., BREWER, R.D., NAIMI, T. & WARNER, L. 2007. Binge drinking is a problem that cannot be ignored. *American Journal of Preventive Medicine,* 44 (4) 303-304.

MONTEIRO, M. 2001. A World Health Organization Perspective on Alcohol and Illicit drug Use and Health. *European Addiction Research*, 7(3): 98-103.

MOROJELE, N.K., KACHIENG, M.A., MOKOKO, E., NKOKO, M.A, PARRY, C., NKOWANE, A.M., MOSHIA, K.M. & SAXENA, S. 2006. Alcohol use and sexual behaviour among risky drinkers and bar and shebeen patrons in Gauteng province, South Africa. *Social Science and Medicine*, 62(1): 217-227.

MOROJELE, N. K., PARRY, C. D. H. & BROOK. 2009. Substance abuse and the young: Taking Action. *Medical Research Council Research Brief:* June

MORRIS, D. H. 2003. Encouraging plus coaching: Mapping your social network. *The Encourager Newsletter*, 2. Date of access: 30 September 2009.

MPHI, M. 1994. Female alcoholism problems in Lesotho. *Addiction,* 89: 945-949.

MSENGANA-NDLELA, M. 2006. Preview on Bophirima District Municipality, by the Director-General: Department of Provincial and Local Government (the dplg). http://www.thedplg.gov.za. Date of access: 15 August 2008.

MURRAY, R. P., CONNETT, J. E., TYAS, S. L. BOND, R., EKUMA, O., SILVERSIDES, C. K. & BARNES, G. E. 2002. Alcohol volume, drinking pattern, and cardiovascular disease morbidity and mortality: Is there a U-shaped function? *American Journal of Epidemiology,* 155(3): 242 – 248.

NAIMI, T.S., BREWER, R.D., MILLER, J., OKORO, C. & MEHRTRA, C. 2007. What do Binge drinkers drink? Implications for alcohol control policy. *American Journal of Preventive Medicine,* 33(3) 188-193.

NARABAYASHI, R. 2006. Family therapy in Japan- context and development. *International Congress Series*, 1287: 150-153.

NEUMAN, W. L. 2000. Social Research Methods: Qualitative and Quantitative Approaches. Boston: Allyn and Bacon.

NEW DICTIONARY OF SOCIAL WORK, 1995. Cape Town: CTP book printers

NIELSON M. F.J., RESNICK C. A. & ACUDA, S. W. 1989. Alcoholism Among Outpatients of a Rural District General Hospital in Kenya. *British Journal of Addiction,* 84: 1343-1351.

NIEUWENHUIS, J. 2007. Analysing qualitative data. (*In* Maree, K. (ed). Creswell, J. W., Ebersöhn, I., Eloff, R., Ferreira, N. V., Jansen, J. D., Nieuwenhuis, J., Pietersen, J., Plano Clark, V. L. & van der Westhuizen, C. First Steps in research. Pretoria: Van Schaik Academic, 99 -117).

NORMAN, P., ARMITAGE, C.J. & QUICKLEY, C. 2007. The theory of planned behaviour and binge drinking: Assessing the impact of binge drinking prototypes. *Addictive Behaviors,* 32(9): 1753-1768.

NORTH WEST PROVINCIAL GOVERNMENT: 2004. North West Provincial Growth and Development Strategy: 2004 -2014. http://www.environment.gov.za/soer/reports/northwest/01%20contents.pdf. Date of access: 15 August 2008.

NQAKULA, C. 2006. Crime Prevention and Combating (Monitoring and evaluation media briefing. www.info.gov.za/speeches/2006/06092810451001.htm.

NZIMAKWE, T. I. 2008. Addressing unemployment and poverty through public works programmes in South Africa. *International NGO Journal*, 3 (12) 207-212.

OBOT, I. S. 2000. The measurement of drinking patterns and alcohol consumption in Nigeria. 2000. *Journal of Substance Abuse,* 12(1-2): 169-181.

OBOT, I. S., KARURI, G. S. & IBANGA, A. J. 2003. Substance use and other risky behaviours of secondary school students in a Nigerian urban area. *African Journal of Drug and Alcohol Studies,* 2 (1 & 2), 57 - 65.

OLAGNERO, M., MEO, A. & CORCORAN, M. 2005. Social support networks in impoverished European neighbourhoods. *European Societies,* 7(1): 53-79.

OLLEY BO, SEEDAT S, GXAMZA F, REUTER H, STEIN OJ. 2005. Determinants of unprotected sex among HIV-positive patients in South Africa. *AIDS Care,* 17(1): 1-9.

OTT, K. 2008. Family Support: An important dimension of CISM for emergency workers. *Emergency support network,* www.emergencysupport.com. Date of Access: 22 April 2009.

PARRY, C. & BENNETS, A. 1998. Alcohol Policy and Public Health in South Africa. United Kingdom: Oxford University Press.

PARRY, C. D. H. 1998. Substance abuse in South Africa: Country Report focusing on young persons. WHO/UNDCP Regional Consultation, 24-26 February, Zimbabwe.

PARRY, C. D. H. 2000. Alcohol problem in developing counties: Challenges for the new millennium. *Suchtmed* 2 (4): 216-220. Date of Access: 11 August 2009.

PARRY. C. D.M., BHANA, A., MYERS, B., PLUDDEMANN, A., FLISHER, A. J., PEDEN, M. M. & MOROJELE, N. K. 2002. Alcohol use in South Africa: findings from the South African community epidemiology network on drug use (SACENDU) project. *Journal of studies on alcohol*, 63: 430-435.

PARRY, C. D. H., LOUW, A. & PLÜDDEMANN, A. 2004. Drugs & Crime in South Africa The MRC/ISS 3- Metros Arrestee Study (Phase 3). Medical Research Council: Institute for Security Studies.

PARRY, C. D. H., MYERS, B., MOROJELE, N. K., FLISHER, A. J., BHANA, A., DONSON, H. & PLŰDDEMANN, A. 2004. Trends in adolescent alcohol and other drug use: findings from three sentinel sites in South Africa (1997-2001). *Journal of Adolescence*, 27: 429-440.

PARRY, C. D. H. 2005. South Africa: Alcohol today. *Addiction*, 100: 426-429.

PARRY, C. D. H., PLŰDDEMAN, A., STEYN, K., BRADSHAW, B., NORMAN, R. & LAUBSHER, R. 2005. Alcohol use in South Africa: Findings from the first demographic and health survey. *Journal of Studies in Alcohol,* 66: 91-97.

PARTANEN, J. 1993. Failures in alcohol policy: Lessons from Russia, Kenya, Truk and history. *Addiction,* 88: 129S-134S.

PATEL, V. 2007. Alcohol use and mental health in developing countries. *AEP*17: S87-S92.

PATHWAYS. 2001. Causes and consequences. *Parity,* 14(8): 27-29.

PELTZER, K. & RAMLAGAN, S. 2009. Alcohol Use Trends in South Africa. *Journal of Social Sciences*, 18(1): 1-12.

PELTZER, K. 2003. Drinking motives, behaviours and problems among black South African university students. *African Journal of Drug & Alcohol Studies, 2 (1 & 2):1 -10.* Date of Access 12 July 2008.

PIENAAR, J. & ROTHMANN, S. 2005. Suicide ideation in the South African Police Service. *South African Journal of Psychology,* 35(1): 58-72.

PILLARI, V. & NEWSOME, Jr., M. 1998. Human Behavior in the Social Environment Families, Groups, Organizations and Communities. Pacific Grove: Brooks/Cole Publishing.

PISA, P. T. 2008. Association between biological alcohol consumption markers, reported alcohol intakes, and biological health outcomes in an African population in transition. *Thesis,* North West University, Potchefstroom Campus.

PISA, P. T., LOOTS, D. T. & NIENABER, C. 2008. Alcohol metabolism and the health hazards associated with alcohol abuse in a South African Context: a narrative review. *South African Journal of Clinical Nutrition.* {Submitted}.

PISA, P.T. & LOOTS, D. T. 2008. The cardioprotective effect and putative mechanisms of light to moderate consumption of alcohol: a narrative review. *South African Journal of Clinical Nutrition.* {Submitted}.

PLANT, M. & PLANT, M. 2006. Binge Britain – Alcohol and National response. London: Oxford University Press.

POULIN, J. 2005. Strengths-based Generalist Practice: A Collaborative Approach. (2nd ed). Belmont, CA: Brooks/Cole.

PRIDEMORE, W. A. 2006. Weekend effects on binge drinking and homicide: the connection between alcohol and violence in Russia. *Addiction,* 99(8): 1034-1041.

RASOOL, S., VERMAAK, K., PHARAOH, R., LOUW, A. & STAVROU, A. 2002. Violence against Women A National Survey. Pretoria: Institute for Social Security Studies, 42-43.

RATAEMANE, S. & RATAEMANE, L. 2006. Alcohol consumption in South Africa. *International Journal of Drug Policy,* 17: 373 – 375. Date of Access: 10 August 2008.

RATAEMANE, S. 2004. Central Drug Authority Report. www.dsd.gov.za/docs_guidelines/2005/docs/cda2004.doc

REDDY, S. P., PANDAY, S., SWART, D. JINABHAI, C. C., AMOSUN, S. L., JAMES, S., MONYEKI, K. D. STEVENS, MOROJELE, N. K., KAMBARAN, N.S., OMARDIEN, R.G. & van den BORNE, H. W. 2003. Umthenthe uhlaba usamila – The South African Youth Risk Behaviour Survey (2002), Cape Town: Medical Research Council.

REHM, J., REHN, N., ROOM. R., MONTEIRO, M., GMEL, G., JERNIGAN, D. & FRICK, U. 2003. The global distribution of average volume of alcohol consumption and patterns of drinking. *European Addiction Research,* 9, 147-156.

REIS, H.T. & RUSBULT, C. E. 2004. Close relationships. New York: Psychology Press.

ROBSON, G. & MARLATT, G. A. 2006. Harm reduction and alcohol policy. *International Journal of Drug Policy*, 255 -257. Date of access: 2 October 2009.

ROCHA-SILVA, L. 1989. Attitudes towards drinking and drunkenness in the RSA. Pretoria: Institute of Sociological and Demographic Research, Human Sciences Research Council.

ROMAN, P. M. 1981. Job characteristics and the identification of defiant drinking. *Journal of Drug Issues,* Summer: 357-364.

ROSE-INNES, O. 2007. Drugs don't Work at Work. *City Press,* February 25:31.

SALEEBEY, D. 2006. The strength perspective in social work practice. (4th ed) Boston: Allyn and Bacon.

SANCA National Annual Report. 2004/2005. Johannesburg: NLDT printers.

SATO, M. & LIEBER, C. S. 1981. Hepatic vitamin A depletion after chronic ethanol consumption in baboons and rats. *The Journal of Nutrition,* 111: 2015-2023.

SCHLER L. 2002. Looking Through A Glass of Beer: Alcohol in the Cultural Spaces of Colonial Douala, 1910-1945. *International Journal of African Historical Studies,* 35 (2-3): 315-334.

SEED, P. 1990. Introducing Network Analysis in Social Work. London: Jessica Kingsley Publishers.

SERFONTEIN, M., VENTER, C., KRUGER, A. & MACINTYRE, U. 2008. Alcohol intake and micronutrient density in a population in transition: the THUSA study. *South African Journal of Clinical Nutrition* {Submitted}.

Shebeen owners protest W Cape liquor Act. (27 January 2009) *MAIL & GUARDIANonline.* Date of Access: 2 August 2009.

SKWEYIYA, Z. 2005. Speech by the former Minister of Social Development - Ke Moja Rollout, Goldreef City 11th, March.

SKWEYIYA, Z. 2007. Statement by the former Minister of Social Development, Substance Abuse Media Briefing, Pretoria, 20 August 2007. http://www.dsd.gov.za. Date of access: 4 Oct. 2007.

SKWEYIYA, Z. 2008. Statement by the former Minister of Social Development, Substance Abuse Media Briefing, Pretoria, 29 May 2008. http://www.dsd.gov.za. Date of access: 30 May 2008.

SOCIAL ISSUES RESEARCH CENTRE 2009. SOCIAL AND CULTURAL ASPECTS OF DRINKING – Culture Chemistry and Consequences, 2009. www.sirc.org/publik/drinking6.html Date of Access: 17 April 2009.

SOROCK, G.S., CHEN, L., GONZALGO, S.R. & BAKER, S. 2006. Alcohol-drinking history and fatal injury in older adults. *Alcohol*, 40 (3): 193-199.

SOUL CITY INSTITUTE, Health & Development Communication. 2007. Alcohol and You. South African Broadcasting Corporation. Jacana Media Publishers.

SOUTH AFRICA. Department of Social Development. 2007. Policy on the Management of Substance Abuse, , March, 1-2. Unpublished.

SOUTH AFRICA. Liquor Act No 59 of 2003. Cape Town: Government Printers, 10-16.

SOUTH AFRICA: National Drug Master Plan 2006 – 2011. www.dsd.gov.za/Documents/2007. Date of Access: 7 July 2009.

SOUTH AFRICA: PREVENTION OF AND TREATMENT OF SUBSTANCE ABUSE ACT No 70 of 2008. Gazette No. 32150. Cape Town: Government Printers.

SOUTH AFRICA: WESTERN CAPE LIQUOR ACT No 4 of 2008. 6582 – 27 November 2008.Cape Town: Provincial Gazette Extraordinary.

SOUTH AFRICA: WHITE PAPER FOR DEVELOPMENTAL SOCIAL WELFARE, February 1997.

SOUTH AFRICAN BROADCASTING CORPORATION (SABC) 3 February 2009. Homebrew: Mbamba, Special Assignment Programme.

STANTON-SALAZAR, SPINA, R. D. & URSO, S. 2005. Adolescent peer networks as a context for social and emotional support. *Youth & Society*, 36 (4): 379-417.

STATISTICS SOUTH AFRICA. Labour force survey P0210, 9, 2006. http://www.statssa.gov.za Date of access: 14 April 2007.

STIMSON, G. 2006. Reducing alcohol related harm- what are the options and what can we do.(*In* Conference Report - Buning, E., (ed). Paper presented at the 3rd International Conference on Alcohol and harm reduction – Creating realistic and concrete solutions, 22 – 25 October 2006, Cape Town: South Africa, 1-73).

STRATHDEE, R. 2005. Social exclusion and the remaking of social networks. London: Athenaeum Press.

STRIJDOM, J. L. 1992. A drug policy and Strategy for Namibia. DPhil thesis, University of Bophuthatswana,.

STRYDOM, H. 2005. Ethical aspects of research in the social sciences and human service professions (In de Vos, A. S., Fouché, C. B., Delport, C. S. L. & Strydom, H. (3rd ed*)*. Research at grass roots: for the Social Sciences and Human Services) Professions. Pretoria: Van Schaik Academic, 56 -70).

SZMIGIN, I., GRIFFIN, C., MISTRAL, W., BENGRY-HOWELL, A., WEALE, L. & HACKLEY, C. 2007. Re-framing 'binge drinking' as calculated hedonism-Empirical evidence from the UK. *International Journal of Drug Policy,* 19:359-366.

TASHAKKORI, A. 2009. Are We There Yet? The State of the Mixed Methods Community. *Journal of Mixed Methods Research*, 3 (4):287 – 291.

TEDDLIE, C. & TASHAKKORI, A. 2009. Foundations of Mixed Methods Research: Integrating Quantitative and Qualitative Approaches in the Social and Behavioral Sciences. Thousand Oaks, CA.: Sage Publications.

TRACY, E. M. & MARTIN, T. C. 2007. Children's roles in the social networks of women in substance abuse treatment. *Journal of Substance abuse*, 32: 81 – 88.

TRACY, E. M. & WHITTAKER, J. K. 1990. The Social Network Map: Assessing Social support in clinical practice. *Families in Society: The Journal of Contemporary Human Services*, 8: 461- 470. Date of access: 10 September 2009.

TRACY, E. M., WHITTAKER, J. K., PUGH, A., KAPP, S. N. & OVERSTREET, E. J. 1994. Support networks of primary caregivers receiving family preservation services: An exploratory study. Families *in Society: The Journal of Contemporary Human Services*, 481-489. Date of access: 2 September 2009.

TRICE, H. M. & ROMAN, P. M. 1978.Spirits and demons at work: Alcohol and other drugs on the job, (2nd ed). New York: Cornell University.

TURNER, F. J. 1996: Social work treatment: interlocking theoretical approaches. New York: Free Press.

TURNING POINT. 2006. Bottling it up: The effects of alcohol misuse on children, parents and families. Turning point, London. www.turning point.co.uk. Date of access: 13 April 2008.

VALENZUELA, C. F. 1997. Alcohol and neurotransmitter interactions. *Alcohol Health and Research World,* 21(2):144-147.

VAN AS, S. 2004. The taxing issue of alcohol abuse: Establishing an alcohol injury fund. *Science in Africa.* Date of access: 13 April 2008.

VAN HEERDEN, I. V. & PARRY, C. D. H. 2001. If you drink alcohol, drink sensibly. *South African Journal of Clinical Nutrition,* 14(3):S71-S77.

VEIEL, H.O.F. & BAUMANN, U. 1992. The Meaning and Measurement of Social Support. New York: Hemisphere Publishing Corporation.

VELLEMAN, R. & TEMPLETON, L. 2003. Alcohol, Drugs and the Family: Results from a long-running research programme within the UK. *European Addiction Research*, 9, (3).

VICTORIAN HEALTH PROMOTION FOUNDATION – Research summary, 2005: Social inclusion as a determinant of mental health and wellbeing. www.vichealth.vic.gov.au/MHWU/. Date of Access: April 2009.

VORSTER, H. H., LOVE, P. & BROWNE, C. 2001. Development of Food-Based Dietary Guidelines for South Africa – The Process. *South African Journal of Clinical Nutrition* 14(3): S3-S6.

VORSTER, H. H., MARGETTS, B. M., VENTER, C. S. & WISSING, M. P. 2005. Integrated nutrition science: from theory to practice. *Public Health Nutrition*, 8 (6a), 760-765.

WALMSLEY, D. & WALMSLEY, D. 2002. North West Province State of the environment report: Overview. www.environment.gov.za/soer/reports/northwest/01%20contents.pdf. 15 August 2008.

WECHSBERG, W. M., LUCENO, W. K., KARG, R. S., YOUNG, S., RODMAN, N. MYERS, & PARRY, C. D. M. 2008. Alcohol, cannabis, and methamphetamine use and other risk behaviours among Black and Coloured South African women: A small randomized trial in the Western Cape. *International Journal of Drug Policy,* 19: 130 -139.

WECHSLER, H. & NELSON, T. F. 2001. Binge Drinking and the American College Student: What's five drinks. *Psychology of Addictive Behaviors,* 15(4):287-291.

WECHSLER, H., DAVENPORT, A., DOWDALL, G. T. F. 2001 "Health and Behavioral Consequences of Binge drinking in College: A National Survey of Students on 140 Campuses. *Journal of the American Medical Association* 272:1672-1677.

WELCH, G. 1987. An Integrated approach to practice (*In* McKendrick, B. W. (ed) 1987. Introduction to Social Work in South Africa. Pine town: Owen Burgess Publishers, 152 -176).

WELLMAN, B. & BERKOWITZ, S. D. 1988. Social Structures: a network approach. New York: Cambridge University Press.

WEST, M. O. 1997. Liquor and Libido: "Joint Drinking" And The Politics of Sexual Control in Colonial Zimbabwe, 1920s – 1950s. *Journal of Social History,* 30(3): 645-667.

WEYERS, M. L. 2001. The theory and Practice of Community Work: a South African Perspective. Potchefstroom: Keurkopie Publishers.

WHITTAKER, J. K. & GARBARINO, J. 1983. Social support networks: informal helping in the human services. New York: Aldine.

WHO see WORLD HEALTH ORGANIZATION

WILLIS J. 2006. Drinking Crisis: Change and Continuity in Cultures of Drinking in Sub-Saharan Africa. *African Journal of Drug and Alcohol Studies,* 5(1): 1-15.

WORLD HEALTH ORGANIZATION REPORT (WHO) 2000. Health Systems: Improving performance. Geneva, Switzerland.

WORLD HEALTH ORGANIZATION, 2000. Global status report on alcohol. Geneva, Switzerland.

WORLD HEALTH ORGANIZATION REPORT. 2002. Reducing risks, promoting healthy life. Geneva, Switzerland.

WORLD HEALTH ORGANIZATION. 2003. WHO definition of health. www.who.int/about/definition/en/print.html: Date of access: 19 August 2009.

WORLD HEALTH ORGANIZATION. 2004. *Global Status Report on Alcohol.* Department of Mental Health and Substance Abuse. Geneva: *World Psychiatry* 4 (1):25 – 30.

WORLD HEALTH ORGANIZATION – Europe. 2005 Policy Briefing – Alcohol and Interpersonal violence.

WORLD HEALTH ORGANIZATION – Africa. 2008. Actions to reduce the harmful use of alcohol. Regional Committee for Africa.

WORLD HEALTH ORGANIZATION – Global Campaign for violence prevention. Youth violence, alcohol and nightlife. Fact sheet 4 –Preventing sexual violence in nightlife environments.

ZAWAIRA, F. 2009. The Burden of alcohol consumption in the African Region. World Health Organization.