African Journal of Drug and Alcohol Studies
Volume 23, Numbers 1 2024
Journal homepage: www.crisaafrica.org/ajdas
https://dx.doi.org/10.4314/ajdas.v23i1.2

SOCIAL AND CULTURAL PERCEPTIONS OF ALCOHOL USE IN ZAMBIA: A QUALITATIVE STUDY

Jason Paltzer, Jennifer Hatzfeld, Alisad Banda, & Brian Chiluba

The Meros Center, Zambia

ABSTRACT

Alcohol is a global leading risk factor for death and disease among individuals 15-49, with highest rates of heavy alcohol consumption among drinkers in Sub-Saharan Africa. Given identified gaps in mental, neurological, and substance use services, community- and church-based services are needed to support individuals looking to reduce or quit harmful substance use. This qualitative study identified social and cultural perceptions of alcohol among drinkers, community health workers, and Christian pastors in rural and peri-urban Zambia. Themes included roles of alcohol, reasons for drinking, benefits and problems with drinking, Possible interventions, and impacts of quitting. Aligning alcohol perceptions between drinkers and brief intervention practitioners like health workers and pastors is an opportunity to fill the gap in substance use services.

Keywords: Alcohol consumption, substance use, community support, church-based interventions, Zambia, health workers, drinking motivations, alcohol interventions

INTRODUCTION

Alcohol use disorders (AUDs) continue to be a global issue given the health burden and economic costs (e.g., health care, law enforcement, productivity loss) emanating from such disorders (Peacock et al., 2018). Sub-Saharan Africa (SSA) has the highest rate of heavy alcohol consumption among drinkers, exceeding 60% in some countries (World Health Organization, 2019). In Zambia, growth in adolescent and young adult consumption suggests a growing burden of AUD. In a school-based alcohol survey, 36.7% of boys and 45.2% of girls reported ever drinking alcohol (Siziya et al., 2013; Swahn et al., 2011). Among young adults 15-24 years living in Lusaka townships, 80% reported consuming alcohol monthly or more, with 27% reporting drinking alcohol daily (Mungandi et al., 2022). While limited, research reporting substance use prevention and care in southern Africa suggests that the major problems are in urban areas. Yet, the shift to widely marketed and distributed commercial alcohol products contributes to the increasing burden of alcohol and other drug use in rural areas (McCall, 2017).

Corresponding Author: Jason Paltzer, Executive Director, The Meros Center, Visiting Professor, Wisconsin Lutheran College, jason@meroscenter.org, +1-602-882-9586

AUD (and other mental and neurological disorders) treatment gaps in southern Africa are some of the largest in the world, ranging from 75 to 90% in some countries (Alem et al., 2009; Lund et al., 2015; Williams et al., 2008). Scaling up AUD services in Zambia needs to address barriers to cost-effectiveness, adequate mental health indicators, and social stigma (Mwape et al., 2012). Effective treatments must address relevant etiologic factors to develop context-driven adaptations of AUD services. The World Health Organization suggests using Screening and Brief Intervention (SBI) in primary care settings (World Health Organization, 2024). The SBI model (SBI) is conceptually simple and typically consists of a brief screen (1-10 questions) to identify potentially harmful substance use followed by a brief intervention consisting of 1-4 motivational interviewing style conversations with a health educator or provider. Despite the evidence of SBI from high-income countries (Moyer, 2013), results from lower- and middle-income countries are mixed (Ghosh et al., 2022). A positive effect was associated with alcohol brief intervention among adults with HIV in Zambia, along with barriers leading many to return to harmful drinking levels (Asombang et al., 2022). This inconsistency in SBI effectiveness requires a better understanding of "context-driven adaptation and innovation in service delivery," building on variation in local areas while leveraging a global understanding of substance use disorders (Baingana et al., 2015). Evidence suggests a brief intervention might be as effective as a more intensive screening and brief intervention strategy (Ghosh et al., 2022; Joseph & Basu, 2017).

Key factors contributing to an efficient and effective brief intervention include provider knowledge, time, social motivations, and finances, leading to the receipt of appropriate services (Asombang et al., 2022). Community Health Workers (CHW) have proven effective in delivering lower-cost health services in southern Africa, including mental health interventions (Chibanda, 2017). Studies of health educator-administered substance use brief intervention in primary care settings in the United States showed positive healthcare use effects (Paltzer et al., 2019).

Given the lack of cultural-specific evidence of alcohol use in Zambia, this qualitative study aimed to identify etiologic factors that could inform an SBI-like community- or church-based approach. The research questions explored the social, environmental, and cultural beliefs associated with alcohol use in peri-urban and rural Zambia and the knowledge, attitudes, and cultural opportunities or barriers that could hinder the implementation of community- or church-based interventions.

METHOD

This qualitative study used focus groups to gather community member perspectives regarding current factors influencing substance use, specifically heavy alcohol consumption and recovery efforts. Focus groups were organised among three specific groups within the community 1) current drinkers, 2) community health workers, and 3) pastors/spiritual leaders. Questions focused on the social, cultural, and environmental factors influencing substance use and not on individual practices or behaviours to avoid public disclosure of personal information and any harm associated with stigma. The

questions were translated into the local language of Chinyanja and Chibemba by the study team members, and the focus groups were conducted in English and Chinyanja or Chibemba. Focus group sessions were conducted in the community setting in Chongwe, a peri-urban residential area located approximately 40 kilometres away from the capital city of Lusaka, Kamanga, a suburb of Lusaka, and in a rural setting of the Kasama District, located in the northern part of Zambia.

All participants were required to be adults aged 18 to 45 years and residents of Zambia. Current drinkers, defined as reporting drinking alcohol in the last 30 days, were recruited from individuals identified at drinking places (Shabin) or known as drinkers in the community. The Community Health Workers (assigned to an active local health centre recognised by the Ministry of Health and active for at least one year) were recruited from local clinics or known by the research assistants as lay community health workers or psychosocial counsellors. Pastors (those leading a local congregation of at least 30 regular attendees and in the pastoral ministry for at least one year) from different denominations were recruited from local Christian churches. The snowball method was used to identify approximately 12 members per focus group.

Ethics approval was received from the University of Zambia and the National Health Research Authority of Zambia. The primary interviewer in the peri-urban setting was a PhD trained researcher (male) from the University of Zambia. The research assistant was an MPH candidate (male) from the University of Zambia. The primary interviewer in Kasama was a licensed clinical officer and counsellor. The focus group participants were given information about the study prior to the discussion.

Participants voluntarily participated in the study, and the consent form was read to the participants in the local language to ensure comprehension. Verbal consent was obtained given the nature of the qualitative focus groups and questions, and participants were informed they could leave the discussion at any time. Mobile phone cards (talk time) equivalent to approximately $5 were given to the participants as appreciation for their time after the session. Sessions were conducted between October 2020 and April 2021 and either audio recorded when focus groups had a single facilitator or had a dedicated notetaker to transcribe individual comments during the group discussion. Following the focus group sessions, transcripts or notes were translated into English.

Qualitative data were analysed using a six-step method of thematic analysis (Braun & Clarke, 2021). To accomplish Step 1, the team read through the transcripts/notes in their entirety to become familiar with the data. Using a cloud-based spreadsheet (Google Sheets) platform, individual quotes with transcript and line numbers were individually coded by one member of the team (Step 2), and then reviewed and revised with a second member of the team using an iterative process. Meeting virtually, these two team members identified common themes (Step 3), which were then reviewed in person with the team members in Zambia to review and revise the codes and themes with their input (Step 4). Following the team meeting, themes were defined, and exemplar quotes were identified for key codes (Step 5). Of note, the final step in the thematic analysis is to write up the results for dissemination.

RESULTS

As summarised in Table 1, 12 focus groups were conducted with a total of 123 participants. Five focus groups were in a sub/peri-urban setting and seven were in a rural setting. Six of the focus groups comprised of current drinkers, five groups consisted of Community Health Workers, and one group consisted of Christian pastors in the peri-urban setting. Only one pastor focus group was conducted due to a change in study personnel in Kasama and the time constraints of the study.

Six themes identified with key codes and identified exemplar codes, which are provided in Table 2. Of the themes, a major theme was the Role of Alcohol in the community. This included codes that addressed 'Beer for Food,' 'Gender Differences,' and 'Too Much Drinking,' although there was little consensus about overall rates of drinking. One current drinker stated, "*The percentages are very high, [it's] not easy to estimate*." Responses also varied across groups and even within focus groups to whether alcohol was appropriate for use in community events like weddings and funerals and whether the locally brewed, traditional beer was less dangerous than commercially sold alcohol. Similarly, there was no consensus about whether alcohol use was more common among men, women, or the youth. One current drinker stated, "*Men drink more than women*", but another participant in the same group disagreed, saying, "*Personally, I think women drink a lot more than men,*" which was a view mentioned slightly more often among current drinkers. Although not a common sentiment among all participants, another current drinker said, "*Bars are full of under 18 years [the legal drinking age in Zambia]… people, we see these things*."

There was, however, a clear consensus on the Reasons for Drinking, which was another major theme. Both current drinkers, community workers, and pastors all agreed that their primary reason for drinking was a lack of employment. As one community health worker stated, "*We have more people that drink …. because of lack of jobs, especially the young ones*". Peer pressure was also identified as a reason for drinking, as described by one current drinker: "*According to what I see, young ones change on their own due to group influences*." Family influence was also identified, as described by a pastor "*as a father drinks from Monday to Sunday and children learn all these from some parents and children take it as normal life*."

The Benefits of Drinking and Problems with Drinking were two additional themes. Interestingly, few of the community health workers and none of the pastors identified

Table 1. Focus Group Characteristics

Groups	Peri-Urban Setting (Chongwe; Kamanga Suburb)		Rural Setting (Kasama District)	
	Groups	Participants	Groups	Participants
Current Drinkers	2	24	4	37
Community Health Workers	2	24	3	26
Pastors	1	12	0	0
Total	5	60	7	63

Table 2. Themes and codes identified from qualitative analysis

Theme	Key Codes	Exemplar Quotes	Focus Group
Role of Alcohol	Beer for food	*Chibuku, Katata are taken as both food and beer at the same time*	Current drinker, Kasama Group 1
	Gender Issues	*Women are drinking more than men and it is causing quarrels in homes between spouses and to prostitution among women.*	Current drinker, Kasama Group 3
	Youth Issues	*Bars are full of under 18 years people we see these things.*	Current drinker, Kamanga Group 2
Reasons Drinking Starts	Lack of Employment	*We drink … because there are no proper jobs*	Current drinker, Kamanga Group 1
	Group (peer) Influence	*According to what I see young one change on their own due to group influences.*	Current drinker, Kamanga Group 2
	Family Influence	*…as a father drinks from Monday to Sunday and children learn all these from some parents and children take it as normal life. All in all, our parents have no time to teach their children.*	Pastor, Chongwe Group
Benefits of Drinking	No Benefit	*Alcohol has no benefits at all, it makes people waste their money on it rather than on profitable things.*	Community Health Worker, Kasama Group 2
	To Socialize	*Beer is good because it brings us together*	Current drinker, Kasama Group 2
	Profit	*Distillers/brewers are making money through selling beers, it is helping us to take our children to school.*	Current drinker, Kasama Group 1
	Culture	*Beer is good in our culture because it is used during traditional marriage counselling and during traditional ceremony.*	Current drinker, Kasama Group 2
	Beer Gives Energy	*…we drink chibuku when we are about to do some hard jobs/work and the beer gives us power/energy.*	Current drinker, Kamanga Group 1
	Find Employment	*…we drink because it is at the bar where we meet friends who give us job*	Current drinker, Kamanga Group 1
Problems with Drinking	Financial Impact	*…others don't want to waste their money on food, they would rather use the money to buy beer.*	Current drinker, Kasama Group 4
	Family Impact	*…when you get home, you end up beating up the children and these children end up running away from home and become street kids*	Current drinker, Kamanga Group 2
	Health Problems	*...beer gives us pleasure but when you take a lot of it you develop headache, fast heart beats and you lose appetite.*	Current drinker, Kasama Group 1
	Community Impact	*When people abuse alcohol they insult their neighbours, make noise with and play loud music embarrassing their neighbours*	Community Health Worker, Kasama Group 2
Proposed Solutions	One Can Stop	*…we drink just bit by bit and one can stop then one can stop.*	Current drinker, Kamanga Group 2
	Activities	*Introduce activities within the community which can employ the youth*	Community Health Worker, Kasama Group 5
	Counseling	*Counselling them at their drinking places and in their home using the right counselling approach.*	Community Health Worker, Kasama Group 2
	Church Support	*Churches help a lot: by going to church itself and by participating in some church activities and being involved in some church groups like youth, men and women clubs.*	Community Health Worker, Kasama Group 1
Impact of Quitting	Making Plans	*I would start thinking clearly and planning for my future if I could stop drinking*	Current drinker, Kasama Group 3
	Community is Happy	*Community is happy, there is peace at home in the neighbourhood.*	Community Health Worker, Kasama Group 2

a benefit of drinking, although current drinkers identified several reasons they felt drinking was beneficial. One current drinker stated, "*Beer is good in our culture because it is used during traditional marriage counselling and during traditional ceremony*." Another stated, "*we drink Chibuku [a local commercial sorghum-based beer] when we are about to do some hard jobs/work and the beer gives us power/energy*." One other current drinker said, "*we drink because it is at the bar where we meet friends who give us job*." However, most participants agreed there was no benefit to drinking. As one community health worker stated, "*Alcohol has no benefits at all, it makes people waste their money on it rather than on profitable things*." Even current drinkers agreed with one saying, "*There are no benefits but what makes us drink is to forget about problems but there is no profit*." Other current drinkers mentioned the negative impact of drinking on their health and their family, with one stating, "*when you get home, you end up beating up the children and these children end up running away from home and become street kids*." Community health workers and pastors, however, more often brought up the negative impact of alcohol use on the community as a whole, with one sharing, "*When people abuse alcohol they insult their neighbors, make noise with and play loud music embarrassing their neighbors*."

When discussing potential ways to stop drinking, two additional themes addressed Possible Interventions and the Impact of Quitting. A majority of current drinkers responded that if they wanted to quit, they would just decide to stop. One current drinker stated, "*we drink just bit by bit and one can stop then one can stop*." However, community health workers and pastors identified the need for larger community-based programs, including youth activities, counseling services, and even church support. As one community health worker mentioned, "*Churches help a lot by going to church itself and by participating in some church activities and being involved in some church groups like youth, men and women clubs*." When thinking about the potential impact of not drinking, current drinkers highlighted the health benefits and their ability to make plans, with one participant stating, "*I would start thinking clearly and planning for my future if I could stop drinking*." Community health workers and pastors were again more often focused on the impact on the community, with one community health worker in the peri-urban setting saying, "*Community is happy, there is peace at home in the neighborhood and the person regains back his or her normal health*."

DISCUSSION

The primary themes identified from this qualitative study included The Role of Alcohol, Reasons for Drinking, Benefits of Drinking, Problems with Drinking, Possible Interventions, and the Impact of Quitting, with a clear consensus that a lack of employment was the primary cause of alcohol use, especially among youth. Similarly, there was a consensus that there were problems with drinking that had an impact at either the personal or community level. These high-level findings provide evidence there is widespread support for programs and interventions that could address the prevention and treatment of alcohol use in Zambia.

The lack of consensus on the role of alcohol in the community, for both the

peri-urban and rural settings, suggests a community wrestling with the role of alcohol in society more broadly. This lack of consensus influences the enforcement of the existing alcohol policies in Zambia, as identified by Mungandi et al. (2022). In Zambia, there are commercial and home-based alcohol options with differing alcohol content and limited community-level education about appropriate alcohol use. Few education programs exist, such as SHARPZ (Serenity Harm Reduction Program of Zambia) and the Grow Free / Grow Strong curriculum, but there is a need for more evidence regarding the effectiveness of such programs in non-urban areas (Habulembe, 2013). Given such approaches and growing alcohol use among youth (Siwale & Siziya, 2019), future research should look to develop and scale rural and peri-urban alcohol intervention strategies addressing the economic, employment, social, and spiritual context (Mwape et al., 2012).

Although not surprising, the different perspectives on the community-level impact of alcohol between current drinkers and community health workers (as well as pastors) is an important aspect to acknowledge. Some community health workers and pastors are trained in how to evaluate mental health on the community level (Chibanda, 2017), so they may need to be prepared to share that perspective with current drinkers during any brief intervention programs. As noted earlier, provider knowledge and social motivation are two indicators for successful screening and brief intervention strategies (Asombang et al., 2022). However, community health workers and pastors were unable to articulate specific benefits to drinking alcohol that may both attract and keep current drinkers using alcohol. This may be a helpful topic to include in any training for community members who are interested in becoming part of an alcohol brief intervention program to relate to those they are looking to serve. Future research could study mixed focus group discussions to evaluate this sharing of perspectives between community groups such as drinkers and community health workers or pastors.

Proposed interventions also differed significantly between current drinkers and the community health workers and pastors. Self-efficacy is associated with lower rates of alcohol use in the community setting (Gómez Plata et al., 2022), which would be helpful to integrate into plans for any interventions. Although some community health workers and pastors mentioned drinkers being able to decide to stop drinking alcohol, it was not a widely endorsed perspective by non-drinker participants, so this also may need to be an educational topic for community leaders who may be developing future intervention programs.

A strength of this study is the ability to compare community groups and identify similarities and differences in perspectives on alcohol use. Specifically, understanding the benefits of the drinker perspective is helpful in identifying potential hooks that keep an individual participating in alcohol consumption even with a desire to reduce and quit drinking. Another strength of the study is the comparison of two different regions in Zambia and the recognition of common themes between the two areas. Future research should test themes around harmful alcohol consumption as a starting point for a brief screen and leverage different perspectives between groups as brief intervention or education topics.

There were several challenges and limitations to this study, particularly the timing of data collection occurring during a critical time of COVID-19 in late 2020 and early 2021. This impacted participants' willingness to join a focus group and identify larger meeting spaces to accommodate distancing during the discussions. Additionally, the lack of audio recordings or malfunctioning of phones as audio recorders for some focus group sessions limited the level of detail for specific participant comments. However, using a dedicated transcriber helped to capture the key components and provided valuable data for analysis. Only one focus group of pastors limited the input from the religious perspective, particularly in the rural setting. However, the transcript from the pastor's focus group was rich and provided a helpful perspective on the impact of alcohol in their community. Another potential limitation of the study is that the focus groups were not heterogeneous, which limited the opportunity to explore key beliefs about alcohol use in more depth among the differing perspectives. However, we believe allowing current drinkers to share their personal experiences without implicit (or explicit) concern of being chastened by community leaders allowed for a more open and honest conversation about the impact of alcohol on their personal lives. Lastly, the research assistant was a member of a local church in one of the focus group areas, which could have resulted in participants providing biased responses.

CONCLUSION

The results of this qualitative study suggest a misalignment between the knowledge and perceptions of community leaders and the beliefs of drinkers. Screening instruments need to integrate motivations that align with a drinker's sense of problems associated with alcohol use, benefits of use, and motivation to seek services. This study confirms the need to consider provider knowledge, time, social motivations, and finances in future screening and brief intervention models in Zambia. Zambian communities are struggling with how alcohol should fit within society, and yet eager to pursue avenues to address the harmful impact alcohol use has on the personal and community levels.

ACKNOWLEDGEMENTS

This paper honours the life and service of Dr Brian Chiluba who passed away unexpectedly in May 2024. He was an outstanding researcher, collaborator, friend, and mentor. His contribution to public health, Zambia, and the faith community will not be forgotten.

Funding: Baylor University Faculty Research Funds

REFERENCES

Alem, A., Kebede, D., Fekadu, A., Shibre, T., Fekadu, D., Beyero, T., . . . Kullgren, G. (2009). Clinical course and outcome of schizophrenia in a predominantly treatment-naive cohort in rural Ethiopia. *Schizophr Bull*, *35*(3), 646-654. https://doi.org/10.1093/schbul/sbn029

Asombang, M., Helova, A., Chipungu, J., Sharma, A., Wandeler, G., Kane, J.

C., . . . Vinikoor, M. J. (2022). Alcohol reduction outcomes following brief counseling among adults with HIV in Zambia: A sequential mixed methods study. *PLOS Glob Public Health*, *2*(5), e0000240. https://doi.org/10.1371/journal.pgph.0000240

Baingana, F., al'Absi, M., Becker, A., & Pringle, B. (2015). Global research challenges and opportunities for mental health and substance-use disorders. *Nature*, *19*(527), S172-177.

Braun, V., & Clarke, V. (2021). *Thematic analysis: a practical guide.* Sage.

Chibanda, D. (2017). Reducing the treatment gap for mental, neurological and substance use disorders in Africa: lessons from the Friendship Bench in Zimbabwe. *Epidemiology and psychiatric sciences*, *26*(4), 342-347. https://doi.org/10.1017/S2045796016001128

Ghosh, A., Singh, P., Das, N., Pandit, P. M., Das, S., & Sarkar, S. (2022). Efficacy of brief intervention for harmful and hazardous alcohol use: a systematic review and meta-analysis of studies from low middle-income countries. *Addiction*, *117*(3), 545-558. https://doi.org/10.1111/add.15613

Gómez Plata, M., Laghi, F., Zammuto, M., & Pastorelli, C. (2022). Refusal self-efficacy and alcohol-related behaviours in community samples: A systematic review and meta-analysis. *Current Psychology: A Journal for Diverse Perspectives on Diverse Psychological Issues*, No Pagination Specified-No Pagination Specified. https://doi.org/10.1007/s12144-022-03954-7

Habulembe M. (2014). *Reducing Alcohol and Drug Abuse among the Youths of Chibolya Township- A Case Study of Participatory Communication Strategies by Serenity Harm Reduction Program Zambia (SHARPZ). Thesis.* The University of Zambia. [Google Scholar]

Joseph, J., & Basu, D. (2017). Efficacy of Brief Interventions in Reducing Hazardous or Harmful Alcohol Use in Middle-Income Countries: Systematic Review of Randomized Controlled Trials. *Alcohol Alcohol*, *52*(1), 56-64. https://doi.org/10.1093/alcalc/agw054

Lund, C., Alem, A., Schneider, M., Hanlon, C., Ahrens, J., Bandawe, C., . . . Susser, E. (2015). Generating evidence to narrow the treatment gap for mental disorders in sub-Saharan Africa: rationale, overview and methods of AFFIRM. *Epidemiol Psychiatr Sci*, *24*(3), 233-240. https://doi.org/10.1017/s2045796015000281

McCall, C. (2017). Alcohol industry looks to boost drinks sales in Africa. *Lancet*, *389*, 589-590.

Moyer, V. A. (2013). Screening and behavioral counseling interventions in primary care to reduce alcohol misuse: U.S. preventive services task force recommendation statement. *Ann Intern Med*, *159*(3), 210-218. https://doi.org/10.7326/0003-4819-159-3-201308060-00652

Mungandi, K., Likwa, R. N., Hamoonga, T. E., Banda, J., & Zyambo, C. (2022). Predictors of alcohol consumption among adolescents and young adults in Lusaka, Zambia. *Afr Health Sci*, *22*(4), 704-715. https://doi.org/10.4314/ahs.v22i4.77

Mwape, L., Mweemba, P., & Kasonde, J. (2012). Strengthening the health system to enhance mental health in Zambia: a policy brief. *Int J Technol Assess Health Care*, *28*(3), 294-300. https://doi.org/10.1017/s0266462312000347

Paltzer, J., Moberg, D. P., Burns, M., & Brown, R. L. (2019). Health Care Utilization After Paraprofessional-administered Substance Use Screening, Brief Intervention, and Referral to Treatment: A Multi-level Cost-offset Analysis. *Med Care*, *57*(9), 673-679. https://doi.org/10.1097/mlr.0000000000001162

Peacock, A., Leung, J., Larney, S., Colledge, S., Hickman, M., Rehm, J., . . . Degenhardt, L. (2018). Global statistics on alcohol, tobacco and illicit drug use: 2017 status report. *Addiction*, *113*(10), 1905-1926. https://doi.org/10.1111/add.14234

Siwale, CC., Siziya, S. (2019) Factors associated with alcohol consumption among students in high costs schools in Lusaka, Zambia' *International Journal of Translational Medical Research and Public Health,* 3:21–30.

Siziya, S., Muula, A. S., Besa, C., Babaniyi, O., Songolo, P., Kankiza, N., & Rudatsikira, E. (2013). Cannabis use and its socio-demographic correlates among in-school adolescents in Zambia. *Ital J Pediatr*, *39*, 13. https://doi.org/10.1186/1824-7288-39-13

Swahn, M. H., Ali, B., Palmier, J. B., Sikazwe, G., & Mayeya, J. (2011). Alcohol marketing, drunkenness, and problem drinking among Zambian youth: findings from the 2004 Global School-Based Student Health Survey. *J Environ Public Health*, *2011*, 497827. https://doi.org/10.1155/2011/497827

Williams, D. R., Herman, A., Stein, D. J., Heeringa, S. G., Jackson, P. B., Moomal, H., & Kessler, R. C. (2008). Twelve-month mental disorders in South Africa: prevalence, service use and demographic correlates in the population-based South African Stress and Health Study. *Psychological medicine*, *38*(2), 211-220. https://doi.org/10.1017/S0033291707001420

World Health Organization. (2019). *Global Status Report on Alcohol and Health - 2018*.

World Health Organization. (2024). *Screening and brief intervention for alcohol problems in primary health care*. Retrieved 31 May 2024 from https://www.who.int/teams/mental-health-and-substance-use/alcohol-drugs-and-addictive-behaviours/alcohol/our-activities/screening-and-brief-intervention-for-alcohol-problems-in-primary-health-care