Community response to alcohol-related problems

Review of an international study

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Acknowledgements

The volume of information derived from the Study on Community Response to Alcohol-related Problems was so extensive that a review must, of necessity, reduce it to a crude representation of the findings, the most interesting of which have been selected for inclusion. Gratitude is expressed to those, listed in Annex 1, whose work enabled the substantive information to be assembled.

The WHO sponsored and coordinated study received support from the Government of Mexico, the Government of the United Kingdom of Great Britain and Northern Ireland, the Government of Zambia, the National Institute on Alcohol Abuse and Alcoholism of the United States of America, and the World Health Organization. The financial support from the National Institute on Alcohol Abuse and Alcoholism; Alcohol, Drug Abuse and Mental Health Administration; Department of Health and Human Services, was provided under Contracts ADM 281-76-0028 and ADM 281-79-0018.
Preface

The most extensive project so far undertaken by the World Health Organization in relation to its programme on alcohol-related problems has been the collaborative study on community responses carried out in Mexico, Scotland, and Zambia, with associated studies in several other countries. This multifaceted study employed a number of different methods to investigate and test means of improving formal and informal community responses to alcohol-related problems in rural and urban areas, paying specific attention to the needs of developing countries. In the first phase of the study, which commenced in 1977, drinking patterns and problems, and attitudes to drinking and the ways in which the community could respond to problematic drinking were studied in different communities: in probability samples of the general population, and in the staff and clientele of a wide variety of community health and social agencies. The approaches and findings were discussed and disseminated at national and international meetings and, on the basis of the information obtained during the first phase, intervention models were tried out and assessed during a second phase of the study. The emphasis placed on intervention at the community level enabled a set of approaches and a methodology to be initiated which will have wider applicability.

Because of the volume of information derived from the study, it was considered appropriate to prepare a review aimed at stimulating the interest of a wider readership, and encouraging further international research. For readers wishing to carry out similar studies a handbook entitled *Guidelines for investigating alcohol problems and developing appropriate responses* has been published by the World Health Organization (WHO Offset Publication, No. 81).
1. Inception and organization of the study

The Background of Growing World Concern

The production and consumption of alcoholic beverages continue to increase throughout the world. Between 1965 and 1980 total commercial production rose, in terms of 100% ethanol, by almost 50%, which on a per capita basis amounts to a rise of 15%. The figure of 15% includes a rise in production per capita of 70% in North America, of 90% in Japan, and of 66% in Australia and New Zealand. In some parts of the world the increase in total alcohol consumption per capita has been very rapid. This is particularly striking in relation to beer; a number of developing countries in Africa, Latin America, and Asia, where initially consumption was quite low, have shown very sharp rates of increase which, if sustained for another decade, will place them on a par with those countries of Europe that have relatively high rates of consumption (1). The social and medical consequences of this trend in terms of personal suffering and disrupted family life are inescapable (2). The costs to employers, the social services, and the health services must also be taken into account. As an example, 20% of male admissions to the medical ward of a general hospital in Scotland were found to have alcohol-related problems (3). While this represents a significant enough burden on the health budget of a relatively well endowed, industrialized nation, the impact of a similar situation on the budget of a developing country would be formidable. Many governments have come to recognize that careful thought must be given to developing a national response to the use of alcohol, if costs to the economy and the health and social services are not to grow.

At the Twenty-eighth World Health Assembly in 1975 the Director-General was requested "to direct special attention in the future programme of WHO to the extent and seriousness of the individual, public health and social problems associated with the current use of alcohol in many countries of the world and the trend toward higher levels of consumption" and "to study in depth... what measures could be taken in order to control the increase in alcohol consumption involving danger to public health".¹

In response to that request, a collaborative study on the community response to alcohol-related problems was undertaken from 1977 to 1981 with the technical and financial commitment of the countries taking part and support from the National Institute on Alcohol Abuse and Alcoholism of the United States of America. The purpose was to explore the ways in which communities, with support from their governments, could respond in an intelligent and relevant manner to the alcohol-related problems in their midst, and to formulate models that would be of relevance to the situations in countries at different levels of socioeconomic development. The aims, as presented in the original work plan, were to:

1. Obtain basic epidemiological and psychosocial data from samples of populations living in widely differing cultural and socioeconomic environments, including at least one undergoing rapid social change;
2. Ascertain the types of community resources available, and their extent, and the capability of the community to deal with alcohol-related problems in these differing environments;
3. Initiate and build up a long-term, multinational collaborative programme on community response to alcohol-related problems.

**Conceptual Background to the Study**

**Drinking practices and problems in the community**

Knowledge of the drinking habits in various countries is derived from many different sources, ranging from travellers' tales to carefully conducted national surveys. The ethnographic studies of anthropologists, which often refer to traditional village cultures, can provide an understanding of the drinking habits in the rural areas of developing countries. Apart from a few careful studies, anecdotes have to be relied on to furnish an understanding of the drinking patterns existing among their rapidly increasing urban populations. As far as the industrialized nations are concerned, particularly Canada, the United Kingdom of Great Britain and Northern Ireland, the United States of America, and the Nordic countries, understanding often comes from general population surveys. Each approach has its strengths and weaknesses. The clearest sense of meaning can be obtained from ethnographic studies, while a social survey provides a demographic picture at a particular time.

General population surveys have shown that most individuals with alcohol-related problems are not in touch with an official health or social work agency. Insights into informal caring or controlling responses may, however, be more useful than information obtained from official agencies in providing an understanding of the community response to such problems. This type of response may be more common
within the communities of non-industrialized countries, where caregiving has not yet been institutionalized.

Community responses to alcohol-related problems

The fact that a person is said to have a “drinking problem” often reveals as much about the environment in which he lives and his family as it does about the person himself. The social process that leads to drinking behaviour becoming defined as problematic is therefore an important area for study.

It is useful to conceptualize alcohol-related problems as two worlds, one containing individuals whose problems are known to an agency, and the other the much larger number of “problem drinkers” in the general population, who have never been in touch with a health or social work agency. The two worlds formulation suggested a number of areas for research, since a patient is not born into the clinical population but enters it voluntarily or is elected to it by others. The questions to be asked were:

(1) To what extent and in what manner is the clinical population drawn from the general population?

(2) If it is correct to speak of those under treatment for an alcohol-related problem as having been extruded from, or picked out of, the general population, how does the process of extrusion work?

(3) In which circumstances do the informal social controls surrounding drinking behaviour cease to be effective and how and by whom are the more formal responses of the alcoholism treatment or other social agencies brought into play?

The study sought to elucidate the extrusion process in the chosen communities by seeking out the individuals with alcohol-related problems in the three following contexts and simultaneously studying the responses evoked by the types of problem they experienced:

(1) those who said they had alcohol-related problems during the population surveys but who were not in touch with a community agency;

(2) those in touch with a community agency, discovered to have alcohol-related problems that had apparently gone unrecognized;

(3) those known to be problem drinkers, either attending a specialized agency or in touch with another type of community agency and labelled as problem drinkers.

Once the situation was understood, a second phase of the study was initiated, during which the information obtained was translated into action at community level and progress monitored and evaluated. It was hoped to strengthen existing support systems, rather than to impose culturally inappropriate and often more costly patterns of service.
Organization

For financial and organizational reasons, it was not possible to involve too many countries in the study at the outset. It was intended that those chosen should be representative of countries at different levels of socioeconomic development whose governments had expressed concern about alcohol-related problems and were willing to make a commitment to the community response study. Several countries met those criteria. In the end the Governments of three, Mexico, the United Kingdom of Great Britain and Northern Ireland (Scotland), and Zambia agreed to collaborate. The problems inherent in translating very specific community findings to the global perspective had to be kept in mind and it had to be assumed that the basic data obtained might not be relevant for application in other settings. What it was hoped to gain from the study was a method of approach, and an idea of the implications of the issues raised, which would have to be addressed afresh in other communities. As the study progressed colleagues from other countries became interested, recognizing the need to develop their own national responses to alcohol-related problems.

The Government of each country had shown interest in responding to alcohol-related problems at national level and in each there existed a nucleus of workers interested in taking part in the study. Defined communities were chosen in areas that, on the basis of local knowledge, were regarded as administrative units within which a response might be planned. The aim was to forge a link between the research activities and community action, which would engender a sense of local responsibility and enthusiasm for the study. At the same time, it had to be recognized that local and national interests were interdependent in regard to the measurement of problems and the planning of responses. It was considered to be essential that the activities undertaken should be practical and demonstrably relevant to the needs of the chosen communities and not overridden by concern for international cooperation and comparability.

The interest of local and national bodies had to be engaged from the outset and communities chosen, in both rural and urban areas, on the basis of the following criteria:

1. the areas in which they were situated were not to be grossly unrepresentative of the country;
2. they were to be accessible;
3. they were preferably to comprise recognizable administrative units;
4. disturbing numbers of alcohol-related problems were to have been noted;
5. there was to be a willingness on the part of the community leaders to undertake research, and potential for response.
The following were selected: in Mexico, one urban and one rural community in Tlatpan, an area 23 km from the centre of Mexico City; in Scotland, the Lothian Region, incorporating the City of Edinburgh and surrounding semi-rural areas; in Zambia, the City of Lusaka and its surroundings, and a rural health demonstration zone.

In each country, a principal investigator was appointed, experienced in research and in developing services for problem drinkers. Initially, the principal investigators, who were psychiatrists, worked alone but later they were joined by sociologists, psychologists, and experts in data processing. An administrative secretary, who also acted as research assistant, was appointed to each national team. WHO appointed a project manager to coordinate activities and a group of experts constituted an advisory group. From time to time, other experts were invited to advise on specific issues. A list of all those who took part in the study is given in Annex 1.

Regular 6-monthly meetings of the principal investigators and members of the advisory group were organized throughout the period of the study, with each study site as the venue at least once. Thus coordination existed at two levels: within the individual communities being studied, where the work was constantly evaluated; and among the members of the three national teams and the advisory group. By this means the work was kept on target, and each meeting had the effect of revitalizing the endeavours of the team members and enhancing their understanding of overall progress.

**Approaches and methods**

Once the teams had been constituted, it became possible to determine the approaches and methods to be used in attaining the aims of the study. The following six interrelated approaches were determined:

1. description and measurement of the extent and nature of drinking patterns and alcohol-related problems in the community;
2. description and measurement of the responses to such problems;
3. exploration of the factors contributing to the problems and the types of response used;
4. assessment of the strength and effectiveness of the existing responses;
5. formulation of proposals for desirable changes in the existing responses, and methods of achieving them;
6. promotion of interest in developing policies for the prevention and alleviation of alcohol-related problems.

The methods described below were used to apply the approaches and obtain the information required.

*Collation of existing background information*

Workers are often unaware that information relevant to their interests is being collected elsewhere in the same community for another
purpose. Guidelines were established for the collection, from the national and local archives, of as much information on alcohol-related problems as possible. This enabled the areas where data were lacking to be identified and provided a basis on which the community studies could be planned. A useful side effect was that, in the process of collating this information, members of the teams became known to national and local authorities and agencies and were able to interest them in the study.

**General population surveys**

It was decided to use population surveys as the principal means of obtaining an idea of the drinking practices existing in each community and an understanding of the attitudes prevailing in regard to alcohol consumption and alcohol-related problems. The questionnaires were compiled on the basis of experience derived from earlier surveys, mainly in North America and Europe. They were tested in each community before consensus was reached on their content. In each community, a representative sample of the adult population was interviewed by trained interviewers. Comparability between countries was ensured as far as possible. The procedures adopted had to vary in detail according to the local resources available. Confidentiality was ensured throughout.

**Surveys of agency workers**

An understanding of the existing formal responses to alcohol-related problems in each community was considered to be crucial to the study. Lists were compiled of the various community agencies appearing to respond to such problems, whether or not they were specifically known to be alcohol-related. There was a great number and variety of agencies. In some areas no agency dealing specifically with alcohol-related problems existed; in others it was extremely difficult to choose suitable agencies from among the numerous possibilities. In the end, the following categories were defined for inclusion as community agencies: medical, social, specialized alcoholism treatment, penal, and non-statutory (religious, political, traditional). Workers at different levels within each agency selected were interviewed as to how they perceived and responded to alcohol-related problems.

The interview, which lasted 1 hour, took the form of a free-ranging discussion of previously selected key issues and themes, such as:

(i) the worker’s perception of alcohol-related problems;
(ii) the agency’s sensitivity to the existence of an alcohol-related problem;
(iii) the access the agency had to the resources of other agencies;
(iv) the competence of the worker to respond to alcohol-related problems and his confidence in doing so;
(v) the extent to which the worker personally dealt with alcohol-related problems.
Table 1. Components of the study

Phase 1
1. Collation of existing background information
   - National
     - general
     - alcohol specific
   - Local
     - general
     - alcohol specific
2. General population surveys
   - Representative samples from rural and urban communities
3. Surveys of agency workers
   - Interview with workers in:
     - Emergency and accident departments
     - Chronic clinical agencies
     - Social agencies
     - Non-statutory, including religious, agencies
     - Specialized agencies
     - Police departments
4. Surveys of agency clients
   - Completion of case report forms in:
     - Emergency and accident departments
     - Chronic clinical agencies
     - Social agencies (except in Mexico)
     - Religious agencies (only in Mexico)
     - Specialized agencies (only in Scotland)
     - Police departments
   - Clients with alcohol-related problems
   - Completion of client interview forms in:
     - Emergency and accident departments
     - Chronic clinical agencies
     - Social agencies (except in Mexico)
     - Specialized agencies

Phase 2
5. Development of improved responses
   - At national level
   - At local level
6. Monitoring and evaluation
   - At national level
   - At local level
7. Modification of responses
   - At national level
   - At local level

Surveys of agency clients

Surveys were carried out of selected clients attending community agencies. Lack of resources made it impossible to include every agency listed, but a number in each study area were selected for pilot surveys. The aim was to interview 100 new clients, aged 15 years or over, of each agency, or all new clients attending during a 1-month period if the
number was less than 100, and endeavour to obtain a representative sample of clients with alcohol-related problems. A new client was considered to be someone who had not contacted the agency within the previous 6 months.

A case report form was used to interview the clients, which contained questions to be asked if alcohol was thought to be involved in the events leading to their attendance at the agency. If the answers to the questions implied the existence of an alcohol-related problem, the client was interviewed in greater detail with questions similar to those asked in the general population survey, using a client interview form. The case report form enabled the presence and nature of alcohol involvement within the total caseloads of the selected agencies to be described. The client interview form described the drinking habits and characteristics of the clients found to have alcohol-related problems. They could then be compared with individuals in the general population with similar drinking habits, who were experiencing problems but who had not come into contact with an agency.

A police department in each community was included in the client survey. They completed a different type of case report form which provided information on the involvement of alcohol in police incidents; the characteristics of the persons involved; and the nature of the incidents themselves.

**Country studies**

The complex series of investigations described above was undertaken in each community during the first phase of the study. The information obtained was used during the second phase to improve community and national planning so that new or modified responses to alcohol-related problems could be introduced and the impact on the community monitored and evaluated. The components of the study are shown in Table 1.

In the following chapters the principal findings of the study are reviewed. It is important to recall that, although the findings are reported under country headings, the data are representative only of the communities studied.
2. Drinking practices, alcohol-related problems, and patterns of community response in the participating countries

Mexico

Background

In 1977, when the study commenced, Mexico was undergoing rapid socioeconomic and demographic change. The population had been over 48 million in 1970 and it was estimated would be over 65 million by 1980. The population growth rate was one of the highest in the world, 3.5% per year. This was the result of a very high birth rate and a declining mortality rate. In 1977 46% of the population was under 15 years of age. The majority were Spanish-speaking Roman Catholics. The literacy rate was 70%.

Between 1965 and 1975 the gross national product had quadrupled and the per capita income had nearly tripled. However, the distribution of wealth had remained uneven and migration from the rural to the urban areas had given rise to high levels of unemployment among the recently urbanized population.

Patterns and consequences of alcohol consumption

During the past 20 years there has been some increase in alcohol consumption. Between 1960 and 1981 the annual per capita consumption, in terms of absolute alcohol, rose by 80%, from 1.5 litres to 2.7 litres. By beverage type, the consumption of beer rose from 1 litre to 1.8 litres and spirits from 0.5 litres to 0.9 litres; relatively little wine is consumed in Mexico. In terms of the actual amount of per capita consumption of beer, this represents an increase from 22.9 litres in 1960 to 40 litres in 1981 (5). These figures relate to the consumption of commercially produced beverages; they do not take into account illicit production or the domestic production of pulque, an alcoholic beverage prepared from the juice of the maguey plant. Alcohol production is in
private hands but permission to produce has to be requested from the Department of Health and Welfare. It appears that commercially produced beer is supplanting the traditional beverage. In recent years the cost of alcoholic beverages has not risen as rapidly as that of food.

Previous surveys suggested that as many as 65% of adults, particularly the women, were abstainers. On the basis of the number of deaths from cirrhosis of the liver and of known alcoholics the alcoholism rate was estimated at 7% of the adult population. The recorded death rate from cirrhosis of the liver (20/100,000) remained constant between 1970 and 1976. Between 1970 and 1974, there was a 9% increase in the number of road accidents to which alcohol consumption made a significant contribution; approximately 20% of all accidents by 1974.

National responses to alcohol-related problems

When the study was first conceived, there were few planned preventive activities directed towards alcohol-related problems. Alcoholism was mainly looked upon as a disease, to be treated by clinicians in general or psychiatric hospitals. Priests played an important role, not only in providing moral guidance but in advising on drinking problems, and the Virgin of Guadalupe was often invoked as a source of help. Alcoholics Anonymous and the Mexican Association of Alcoholics gave help to "problem drinkers".

The Mexican Health Code, promulgated in 1979, recognizing that alcohol abuse constituted an important health hazard, fostered a national campaign against alcohol-related problems. It dictated that alcoholic beverage outlets should not be located close to schools, work places, sports facilities, or places where young people gathered. People under the age of 18 years were not to be served or employed in bars, nightclubs, or where pulque was served. Restrictions were placed on the content of advertising, which was not to glamorize the effects of alcohol.

There was no consistent educational policy in schools with regard to alcohol and its effects. There was no legislation relating to blood-alcohol level while driving, though anyone involved in an accident was liable to be medically examined. Drunken drivers could be imprisoned for up to 36 hours. If the offence was repeated within a year, the driving licence was suspended for 6 months.

In March 1981, after completion of the study, a national anti-alcohol council was established which was expected to coordinate national policy on alcohol and alcohol-related problems.

The Study Area: Tlalpan

Tlalpan is an extensive, fertile area in the Federal District, 20 km from Mexico City. The population was 130,000 in 1970, at which time 58% was under 20 years of age. Large differences in economic status existed: low-income families lived in the rural areas; families whose
conditions of life were precarious in the marginal areas of the town of Tlalpan; and families with a high income in the town itself. Within the area, an urban enclave with a population of 16,414 was chosen, which did not contain the exceptionally wealthy areas of Tlalpan but was considered more representative of urban Mexico. The rural community chosen was in the mountainous part of Tlalpan, on the road from Mexico City to Cuernavaca. In 1970 it had a population of 5,198.

The consumption of alcohol in the communities studied

No specific data existed on the drinking patterns in the chosen communities. Beer and spirits, principally tequila, were the most popular forms of alcoholic beverage in Tlalpan. A considerable amount of pulque was drunk in the rural areas. There were no distilleries or breweries in the study area.

Although the consumption of beer on the premises of the small shops that sold it was illegal, the local people often drank it there. Small drinking places, called pulquerías, sold only pulque. Only men were admitted but there was a small window at which women and minors could buy the drink to take home.

Cirrhosis of the liver was the third cause of death among all age groups (44 per 100,000). In the age group 45–65 it was the principal cause of death. This exceptionally high mortality rate from cirrhosis might have been partly attributable to the presence of a national institute of nutrition in Tlalpan, which drew patients with alimentary ailments from all over the country. The unusually large number of hospitals in the area included the San Rafael Community Mental Health Centre, which provided preventive and rehabilitative services through its psychiatric nursing and social workers.

Execution of the Study

A lack of up-to-date maps, population lists, and street-name indexes made it difficult to establish a sampling frame. This was overcome by the team members, who updated the existing information themselves. All the questionnaires were translated into Spanish and back-translated to check their validity. They were used for a pilot survey in the study area. The general population survey was carried out between July and September 1978. All adults aged 15 years and over were eligible for inclusion in the sample. Proportionately, men were selected in greater number than women, using a multi-stage sampling design. In the urban community 240 men and 114 women were interviewed and in the rural community 162 men and 110 women.

The survey of agency workers was carried out in early 1979. 76 workers at various levels, in 8 types of agency throughout the study area, were interviewed.
For the survey of agency clients, some changes in procedure proved necessary. In the emergency and general hospitals the questions aimed at determining the extent to which clients had alcohol-related problems were asked automatically with the general preliminary questions in the case report form without first determining whether alcohol was involved in the patient's attendance. At the psychiatric hospital only the questions regarding the extent of alcohol-related problems were asked, since the patients included in the survey had been selected because it was already thought they had alcohol-related problems. The questions on the extent of alcohol-related problems were asked selectively of the clients of the church organizations, since it was not intended to ask them the detailed questions contained in the client interview form. The survey proved difficult to conduct in some of the agencies, because of lack of space in which to work, the poor physical state of the clients, the rapid flow of cases, and the attitudes of both the staff and the clients.

**Principal Findings**

**Drinking practices**

Most of the respondents in the general population survey, 67%, said they had consumed some alcohol during the year prior to the interview. They were defined as “drinkers”. Drinking was most frequent among middle-aged men. Only 1% of the men under 20 years of age and none of the young women said they had a drink as often as once a week. The women of all ages were much more likely to be abstainers; 53% compared with 15% of the men.

Most “drinkers” said they drank less often than once a month but at least once a year. Only about 20% of the men and fewer than 10% of the women said they had a drink once a week or more often. Youths in the urban community seemed to drink more often than those in the rural community, but the opposite obtained for older men.

Among the men who said they had had a heavy drinking bout within the month preceding the interview, 34% had consumed more than 20 units of alcohol in the one day (Table 2).¹ The women and the young people drank less, and not as often.

Of the “drinkers”, 75% of the men and 25% of the women said they had been drunk at least once in the year preceding the interview. The responses suggested a society that drank rarely but, when they did, commonly drank to excess.

Beer was the most popular drink among the men, although 33% said they drank pulque or spirits and 6% said they purchased 96% alcohol from a pharmacy and flavoured it with fruit juice. Pulque was the drink favoured in the rural community; spirits were becoming popular in the

¹ Throughout this book, 1 unit of alcohol is taken to equal approximately 1cl of absolute alcohol, or approximately 10 g of alcohol. This is roughly equivalent to a single measure of spirits, 1 glass of wine or 1 glass (284 ml) of beer.
urban community. There was evidence that the pulque market was being eroded by commercially-produced spirits. Almost 50% of the men did their drinking in a private house, usually with male friends or relatives, rarely with their wives. Christmas was most often mentioned as a special occasion for drinking. Other special occasions were meetings with friends, mentioned more often by the men, and family celebrations, mentioned more often by the women. A local festival seemed to be a more important occasion for drinking in the rural community.

Cultural attitudes to drinking behaviour

Among the questions in the general population survey was a series that sought to clarify the reasons for drinking or being careful about drinking, and the quantities considered to be appropriate in a number of defined situations and roles. The aim was to see how alcohol consumption was defined, when it was considered to be appropriate, and the boundaries beyond which it was regarded as deviant.

Definitions of reasons for and against drinking

The reasons for drinking were most often those of sociability or celebration, the responses differing little between the men and the women (Table 3). Compared with the surveys in Europe and North America, the percentage of respondents who felt that getting “high” or drunk was an important reason for drinking was sizeable. The respondents largely agreed with the reasons for not drinking. Those who drank the most and the abstainers agreed with most of the reasons for not drinking, a trend that was also evident in the other countries taking part in the study. It seems that the heavy drinker shares the abstainer’s view of the hazards of drinking, presumably from first-hand experience, but this insight does not seem to influence his behaviour.
Table 3. Mexico (Tlaltenan): reasons for and against drinking selected by respondents who had had a drink in the year preceding the interview

<table>
<thead>
<tr>
<th>Reasons for drinking</th>
<th>Men</th>
<th>Women</th>
</tr>
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<tbody>
<tr>
<td>Drinking is a good way to celebrate</td>
<td>50</td>
<td>36</td>
</tr>
<tr>
<td>It is what most of my friends do when we get together</td>
<td>46</td>
<td>45</td>
</tr>
<tr>
<td>I like the feeling of getting “high” or drunk</td>
<td>42</td>
<td>30</td>
</tr>
<tr>
<td>I drink when I feel tense or nervous</td>
<td>20</td>
<td>28</td>
</tr>
<tr>
<td>Drinking helps me to forget about my worries and problems</td>
<td>18</td>
<td>19</td>
</tr>
<tr>
<td>Drinking gives me more confidence and makes me sure of myself</td>
<td>11</td>
<td>15</td>
</tr>
<tr>
<td>It is part of a good diet</td>
<td>21</td>
<td>10</td>
</tr>
<tr>
<td>I drink because there isn’t anything else to do</td>
<td>18</td>
<td>8</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Reasons for not drinking or being careful about drinking</th>
<th>Men</th>
<th>Women</th>
</tr>
</thead>
<tbody>
<tr>
<td>It costs too much when you need money for other things</td>
<td>95</td>
<td>92</td>
</tr>
<tr>
<td>Drinking is bad for your health</td>
<td>97</td>
<td>96</td>
</tr>
<tr>
<td>It may interfere with your job or work</td>
<td>91</td>
<td>93</td>
</tr>
<tr>
<td>Drinking can make you feel sick</td>
<td>90</td>
<td>82</td>
</tr>
<tr>
<td>Drinking can get you into trouble with the police or the authorities</td>
<td>80</td>
<td>85</td>
</tr>
<tr>
<td>Drinking leads to losing control over your life</td>
<td>88</td>
<td>88</td>
</tr>
<tr>
<td>Drinking often makes you do things you are sorry for later</td>
<td>80</td>
<td>80</td>
</tr>
<tr>
<td>My family or friends get upset when I drink</td>
<td>78</td>
<td>79</td>
</tr>
<tr>
<td>I am afraid of becoming an alcoholic</td>
<td>90</td>
<td>79</td>
</tr>
<tr>
<td>It goes against my religion</td>
<td>60</td>
<td>50</td>
</tr>
</tbody>
</table>

| No. of respondents                                                                | 401 | 223  |

Attitudes to drinking and drunkenness

The respondents in the general population survey were asked if they agreed or disagreed with 4 statements about drinking and 4 about drunkenness. Half the statements implied tolerance, such as “Having a drink is one of the pleasures of life” or “It does some people good to get drunk once in a while”; and half intolerance, such as “I would feel ashamed if anyone in my family got drunk” or “Drink often brings out the worst in people”. Approximately 60% of respondents agreed that having a drink with someone was “A way of being friendly”. This was the only statement implying tolerance to receive support from a majority of respondents, but most subscribed to all the statements implying intolerance. In general, therefore, the public attitude was inclined to be heavily against drinking.

Drinking norms

To obtain a picture of the drinking norms considered to be acceptable in men and women at different ages and of differing status, the respondents were asked a series of questions on what they thought was the most that should be consumed at one time by a public figure, a boy or girl aged about 16 years, a young man or woman aged about 21
years, a man or woman aged about 40 years, and a man or woman aged about 60 years. The extent to which it was considered acceptable in the various age and sex categories should drink at all, or drink until they felt the effect or got "high" differed considerably. Either would be the most tolerated in a man aged 40 years and the least in a girl aged 16 years; and much more acceptable in men then in women. For both men and women, getting "high" or drunk was much less acceptable than merely drinking. A striking finding was a near proscription on getting "high" for women of all ages. The ascribed norms in Mexico fitted the realities of drinking behaviour quite well. Though this may seem self-evident, it is noted, because in Scotland, for example, there was discrepancy between attitudes to drinking and drinking behaviour.

Women were much less tolerant than men of other people drinking, in particular young men aged about 21 years and men aged about 40 years. Differences between the rural and the urban communities were not substantial but the people in the rural community were significantly more tolerant than those in the urban community of conspicuous drinking in older men, a finding consistent with the heavier consumption noted earlier. However, people in the rural community were less tolerant than those in the urban community of drinking in a young woman aged 21 years, which perhaps reflects the traditional attitude to women.

Drinking situations

Each respondent was also questioned on what they regarded as the acceptable drinking behaviour of a person his or her own age and sex in 9 situations. Drinking and feeling the effects of alcohol were considered to be acceptable at a party, in a bar, or with friends at home; they were least acceptable when having to drive, during working hours, or in a parent spending time with small children. As with age and sex norms, drinking to feel the effects of alcohol was substantially less acceptable than drinking per se. In all the situations men were more tolerant than women. Respondents in the urban community proved more tolerant than those in the rural community of drinking at sports or recreational events and women in the urban community were more tolerant of drinking with friends after work. The differences possibly reflect the differences in lifestyle between the two communities.

Problems associated with drinking

Defining what is a "problem" in general, and a "drinking problem" in particular, is by no means simple, as it involves different values and the differing views of individual observers. What is considered a problem in one society may not necessarily be so considered in another. Similarly, what constitutes a problem in one person may not be regarded as a problem in another. Many "problem drinkers" feel their kill-joy spouses or overcritical employers cause the problems, rather than their own drinking habits. Thus reports on alcohol-related problems have to be somewhat arbitrary.
The "drinkers" were asked if they had experienced any of 14 types of problem associated with drinking during the year preceding the interview. The 14 problems were divided into 2 categories: those termed "personal consequences" and those termed "social problems" (Table 4).

<table>
<thead>
<tr>
<th>Table 4. Mexico (Tlalpan): percentages of &quot;drinkers&quot;* who experienced alcohol-related problems during the year preceding the interview</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
<tr>
<td><strong>Personal consequences</strong></td>
</tr>
<tr>
<td>Felt that I should cut down on my drinking or stop altogether</td>
</tr>
<tr>
<td>Have awakened the next day not being able to remember some of</td>
</tr>
<tr>
<td>the things I had done while drinking</td>
</tr>
<tr>
<td>Sometimes got drunk even when there was an important reason to</td>
</tr>
<tr>
<td>stay sober</td>
</tr>
<tr>
<td>Have had my hands shake a lot the morning after drinking</td>
</tr>
<tr>
<td>Have been told by a doctor or health worker that the amount I was drinking was having a bad effect of my health</td>
</tr>
<tr>
<td>Have taken a drink first thing when I got up in the morning</td>
</tr>
<tr>
<td>Stayed intoxicated for several days at a time</td>
</tr>
<tr>
<td><strong>Social problems</strong></td>
</tr>
<tr>
<td>Felt the effects of alcohol while on the job</td>
</tr>
<tr>
<td>Have been astounded of someting I did while drinking</td>
</tr>
<tr>
<td>Got into a fight because of my drinking</td>
</tr>
<tr>
<td>Been told to leave a place because of my drinking</td>
</tr>
<tr>
<td>Have been involved in an accident when I have been drinking</td>
</tr>
<tr>
<td>Have been involved in an accident at home when I have been drinking</td>
</tr>
<tr>
<td>Have been involved in an accident at work when I have been drinking</td>
</tr>
<tr>
<td><strong>No. of respondents</strong></td>
</tr>
</tbody>
</table>

* Aged 15 years and over.

All the "consequences" and "problems" were more common in the rural community. The levels, particularly those of the "personal consequences", seemed high, considering the apparently low alcohol consumption level.

Forty per cent of the men and 6% of the women said that, at some time during their lives, a family member, a friend, or an acquaintance had either commented on their drinking habits or suggested they should drink less. Considering that the frequency with which people drank was relatively low in Mexico, the number who had been approached in this way was high compared with Zambia. In addition, about 7% of the men said their drinking had caused difficulties at work and about 5% had had trouble with the police. Virtually none of the women had experienced these two consequences. The differences between the rural and the urban communities as far as these lifetime problems were concerned were not as substantial as they had been for the personal
consequences and social problems encountered during the year preceding the interview but more of the rural than the urban men said they had family problems and more of the urban men said they had work problems. The family problems most frequently reported among the men were “coming home drunk” (about 60%); “spending too much on drink” (32%); “being aggressive, fighting, arguing” (26%); and causing an “embarrassing incident in public” (20%).

Of the “drinkers” 8%, all men, had been in contact with a treatment agency because of an alcohol-related problem, about half of them with a general practitioner.

Agency views

Alcohol was involved in 40% of police incidents, most of which involved men in their late 20s. The extent to which alcohol was involved in the events that led to contacts with the hospitals or church organizations is summarized in Table 5. The figures serve to highlight the cost to the health and social welfare services of alcohol misuse. In many instances, the fact that alcohol was involved in an event was being overlooked by the staff, which points to the need for training in order to raise the level of awareness, something many of the staff themselves requested.

Table 5. Mexico (Tlalpan): Alcohol involvement in events leading to contact with the hospitals and church organizations

<table>
<thead>
<tr>
<th></th>
<th>Alcohol said to be involved</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>by the client</td>
</tr>
<tr>
<td></td>
<td>%</td>
</tr>
<tr>
<td><strong>Emergency hospital</strong></td>
<td></td>
</tr>
<tr>
<td>Men</td>
<td>40</td>
</tr>
<tr>
<td>Women</td>
<td>10</td>
</tr>
<tr>
<td><strong>General hospital</strong></td>
<td></td>
</tr>
<tr>
<td>First admissions: Men</td>
<td>32</td>
</tr>
<tr>
<td>Men</td>
<td>7</td>
</tr>
<tr>
<td>Women</td>
<td>30</td>
</tr>
<tr>
<td>Readmissions: Men</td>
<td>0</td>
</tr>
<tr>
<td>Women</td>
<td>70</td>
</tr>
<tr>
<td>Church organizations</td>
<td></td>
</tr>
<tr>
<td>Men</td>
<td>26</td>
</tr>
<tr>
<td>Women</td>
<td></td>
</tr>
</tbody>
</table>

*Respondents aged 15 years and over.

It has to be remembered, in judging alcohol-related incidents, that the victim is not always the drinker. A majority of the women who consulted a priest about alcohol-related problems were in fact talking about the drinking habits of their husbands, not their own.
The community response to alcohol-related problems

The community response was explored from 3 perspectives: the views of the respondents in the general population survey in regard to appropriate responses; the views of agency workers on appropriate management; and the views of the agency clients on the same issues.

General population

Attitudes to responses

Most respondents, 87% of the men and 92% of the women, believed there were effective ways of treating alcohol-related problems, but many would not know where to go for help. Many, particularly the women, felt it would be shameful to have to admit to having a drinking problem. When asked if they would like to have a treatment agency near where they lived, 50% said they would not. A more punitive approach was revealed in relation to treatment, with 64% of the women agreeing that a man who was always drunk should be punished.

Alcoholics Anonymous was most frequently referred to as a source of help (81%), with the hospital service next (60%), followed by a general practitioner (51%). A church organization would be called upon by 43% and a local healer, or curandera, by 23%. The church organizations were of much more significance as sources of help in Mexico than in Scotland or Zambia.

Responses to the public consequences of drinking

To explore attitudes to alcohol-related problems, the respondents were asked how serious they considered 4 public incidents occurring as a consequence of drinking to be, how frequently they had observed them, and how they thought they themselves, or society, should react. Two were personal but visible consequences of drinking: a man having fallen down in the street unable to get up; a woman staggering drunk. Two were domestic consequences: a man hitting his wife; a man spending so much on drink that there is not enough food for his family. All 4 were regarded as serious, and those involving men as commonplace. A drunken man hitting his wife was a situation known to 64% of respondents. It was felt that bystanders should help a drunken man who had fallen down but as the incidents caused through his drunkenness became more serious police intervention would become appropriate. Relatives were seen as sources of help and, interestingly, most respondents regarded all 4 consequences as meriting some form of treatment.

Intervention by the authorities, when there was not enough food for the family as a result of the father drinking, was thought to be less appropriate than intervention by relatives or referral for treatment. The differences in view between the men and the women, on how to deal with the 4 situations, were not substantial; nor, surprisingly, were there
substantial differences between the opinions of the rural and the urban communities.

Informal social responses

Aggressive behaviour was the most common social problem resulting from drinking. Almost 50% of the male “drinkers” said that, at some time, members of their families, usually their wives, had commented adversely on their drinking. In the year prior to the interview 37% had received such comments. Many of the women, particularly in the rural community, were anxious or angry about the drinking habits of their menfolk. Most said they were worried about their husbands; 40% were concerned about their fathers; and 33% about their teenage sons.

Of the “drinkers”, about 20% of the men and 3% of the women said they had talked to someone about their drinking habits; spouses, relatives, friends, and physicians were the most common confidantes, but a noteworthy minority had spoken to colleagues at work or to priests.

Agency workers

The views of the workers in the different agencies were influenced by their positions; for example, the staff of the emergency hospital were more likely to report trauma and the staff of the general hospital gastrointestinal conditions. All tended to view alcohol-related problems as most common among men of low socioeconomic status. The staff of the emergency hospital and the staff of the psychiatric hospital often mentioned trauma, convulsions, acute alcoholic confusion, and intoxication among young men as presenting the characteristics of “problem drinkers”. The staff of the general hospital were inclined to detect alcohol-related problems more among older men with hepatitis, pancreatitis, or malnutrition. Few of the staff interviewed had received training to assist them in recognizing the signs of alcohol misuse.

The police recognized the link between excessive drinking and crime but felt there was not much they could do about it. Alcoholics Anonymous was the agency best known to other agency staff but little use was made of referral channels. Most agency workers wished they could be trained to recognize and handle alcohol-related problems, although some, particularly those in busy casualty departments, felt that such training could not be accorded priority. In contrast to the attitudes of the staff in the forefront at non-specialized agencies, such as the hospitals, in Scotland, optimism was expressed with regard to the value of intervening to treat the alcohol-related problems of the clients who came to them.

Agency clients

Most agency clients were positive about the treatment they were receiving. They also said their families were highly antagonistic towards their alcohol-related problems.
Implications for the Community

The issues and conclusions emanating from the study in Tlalpan were examined at a series of local and national meetings in 1982. Such issues and conclusions were:

1. The "drinkers" were predominantly men, who drank infrequently but, when they did, commonly drank to excess, with a surprising number of problems in consequence.

2. While the abuse of alcohol is almost exclusively a male province, its harmful consequences cause the women much anxiety and they frequently complain angrily about their husbands' drunken behaviour.

3. The men and the women do not drink together; the women, apparently, neither consent to nor participate in the drinking, which often takes place in private homes.

4. The men in the rural community drink more and experience a significantly greater number of personally and socially damaging consequences.

5. Alcohol-related problems constitute from 30% to 70% of the workloads of the community agencies studied.

6. The public is highly aware of the existence of alcohol-related problems in the community and believes in the value of treatment. People with such problems, however, carry a stigma and often do not know where to go for help.

7. Since many of the male "drinkers" said they had experienced the effects of alcohol at work, a priority response might be the introduction of an alcohol-in-employment programme.

8. Although the agency workers are conscious that alcohol-related problems exist among their clients, they are, interestingly, less aware of problems in individual clients than the clients are themselves. They feel they need to be trained to recognize such problems. The very large number of problems dealt with by the police and the church organizations prove that community responses should not be regarded from a narrow, medical, perspective.

9. Many of the heavier drinkers had talked to someone about their problems. Such contacts could be important as bases on which to build effective responses.

Some of the issues are more susceptible to local responses than others: the rural community, for example, might explore why drinking is regarded there as likely to provoke problems, more than it is in the town. Training for the staff of the agencies most involved could be undertaken locally, but it would require support from national institutions.

To modify attitudes and behaviour is a difficult task, and the best means of doing so are not always evident. For example, many of the women are abstainers who are offended by the drinking habits of their menfolk. It is possible that if more of the women were to drink, they would be more tolerant of drinking in others. If more of the women
drank, would that encourage the men to drink more, or would a more permissive ambience cause others to adopt more relaxed, less explosive drinking patterns? There is no ready-made or obvious answer, but the issues raised call for sensitive discussion among those familiar with the community.

Scotland

Background

Scotland was chosen for the study as a developed country, heavily engaged in the production of an alcoholic beverage. It occupies about a third of the total area of the United Kingdom of Great Britain and Northern Ireland but has only 10% of the population. The population is relatively stable in number, being little affected by migration. In 1982 life expectancy at birth was 69.2 years for men and 75.2 years for women. The most common causes of death were heart disease (466 per 100,000 population), malignant neoplasms (294 per 100,000 population), and cerebrovascular diseases (135 per 100,000 population). About 25% of the population was 14 years of age or under and 15% was beyond retirement age (65 years for men and 60 years for women). The age structure of the population is strikingly different from that of the other two countries.

Scotland's name and economy are firmly associated with its national drink. The alcoholic beverage industry in Scotland employs 7% of the total workforce and 17.3% of persons engaged in the manufacturing industry as a whole. Between 1964 and 1973, whisky production increased by about 62% and beer production by 78%. More than 80% of the whisky is exported; in 1978 105 million proof gallons, contributing £661 million to the gross national product.

Patterns and consequences of alcohol consumption

Statistics for the total quantities of alcoholic beverages retained for local consumption are not available separately for Scotland. Consumption in the United Kingdom increased by 71% between 1950 and 1976. The per capita consumption of commercially-produced alcoholic beverages for the United Kingdom in 1976, in terms of absolute alcohol, was 8.4 litres, compared with 2.7 litres for Mexico in 1981 and 3.39 litres for Zambia in 1980.

The first national survey of drinking habits, which took place in 1972, indicated that 90% of the population drank, and that the men drank a great deal more than the women. In a typical week, 3% of the men who drank were responsible for drinking 30% of the total amount consumed. The heavier drinkers constituted 7% of all the men who drank, and as much as 15% of young, male manual workers aged 17–30
years. Beer was the most popular drink for men; women were more likely to choose spirits or fortified wine. The public house was the most popular drinking place for men (6). Smaller, more recent, surveys, while confirming this pattern, demonstrated a trend towards an increase in consumption by women. Considerable variation in self-reported drinking habits was noted between different towns.

The 1972 national survey did not consider the question of alcohol-related harm, but in a study in Clydebank in 1978 it was found that, among respondents aged over 15 years, 5% of the men and 1% of the women could be classed as "problem drinkers", and a further 5% of the men and 0.5% of the women as "alcoholics" (7).

Of male admissions to the general medical ward of a hospital in Glasgow, 20% were found to have alcohol-related problems (3) and a similar study among females showed that alcohol was an important factor contributing to their illnesses in 16% of patients (8). In a study in 1976 blood-alcohol levels in excess of 100 mg per 100 ml were observed in 42% of head injuries (9). Other studies pointed to alcohol involvement in cases of self-poisoning, in fire fatalities, and in industrial injuries. The Road Traffic Act of 1967 made it a criminal offence to drive with more than 80 mg of alcohol per 100 ml of blood. When the Act was first introduced, the number of road accidents and their resultant injuries decreased appreciably, but the initial beneficial effects have declined with the realization that the risk of detection is low. The number of convictions for drunken driving in Scotland in 1978 was 14704, an increase of 30% over the figure for 1977 and more than 100% since 1968. The number of prosecutions per 100,000 vehicles licensed in Scotland was almost double the average for the United Kingdom as a whole.

Between 1968 and 1978 there was a 27% increase in the number of "drunk and incapables" known to the police and a 67% rise in the number of charges of petty assault and breach of the peace, the majority of which were known to be alcohol-related.

Scotland has a mortality rate for cirrhosis of the liver of 6.5 per 100,000 population, which is lower than that of many other European countries, but double that of England and Wales. This type of information needs to be interpreted with caution, however, as diagnostic practices vary, drunkenness is regarded by the police and the courts with differing degrees of seriousness, and the services available to alcoholics are unevenly distributed.

National responses to alcohol-related problems

A report on community services for alcoholics in Scotland, published in 1976, has been useful in promoting coordination between the health, social work, and voluntary services. It recognized that the voluntary agencies and the social work departments had a responsibility to work with the health boards in planning and delivering a range of services for individuals with alcohol-related problems and their families (10).
The Scottish Council on Alcoholism is an autonomous voluntary organization active in encouraging the establishment of local councils on alcoholism and the initiation of alcohol-in-employment programmes, and in training voluntary counsellors throughout the country.

The principal statutory services in Scotland are the health boards and the social work departments, which are responsible for helping "problem drinkers" and their families. Under the National Health Service, all individuals resident in Scotland may register with a general medical practitioner who would be the first person to see with an alcohol-related health problem. Supporting these agencies are the psychiatric hospitals and a number of specialized units throughout the country for the treatment of alcohol-related problems. The social work teams have, to a varying extent, become aware of the existence of alcohol-related problems within their caseloads and have accepted some responsibility for responding to such problems, as well as for guiding their clients to the residential accommodation available in some areas for homeless "problem drinkers". A number of voluntary agencies, such as the local councils on alcoholism, Alcoholics Anonymous, Al-Anon, and the Church of Scotland organizations, provide counselling and services for the rehabilitation of "problem drinkers". A register of voluntary and statutory services for alcoholics, drawn up in 1978, contained the names of 60 specialized and almost twice as many non-specialized agencies concerned in some way for the welfare of individuals with alcohol-related problems.

Prevention

Approaches to prevention have been somewhat fragmentary. It is recognized that drinking habits may be influenced by the licensing laws, which are enacted separately in Scotland from those of England and Wales. The Scottish licensing laws were reviewed in 1973 and a modest relaxation of existing controls relating to the hours during which alcoholic beverages could be sold was introduced. The aim was to take away some of the pressure, felt in the public houses, to drink as much as possible before closing time. A consequence that was not anticipated was that, through regularly applying for special extensions, some licensees of public houses are able to keep their establishments open all day. Thus parts of Scotland, having had very restricted opening hours, have become the least restricted in the United Kingdom.

It is recognized, though mainly in official and specialist circles, that price influences consumption (11). There is no indication, however, of any awareness that a price increase might be used as a preventive, rather than a revenue-raising, measure.

In recent years, the Scottish Health Education Unit has contributed a great deal to the education of the public, having changed from a stance predominantly concerned with aiding the early recognition of alcoholism, to one that seeks to encourage sensible drinking habits and an awareness of the social hazards of abuse. Attempts are being made to
include education on alcohol and its effects in the school curricula, but this has not yet been achieved everywhere.

Research

For a decade, the authorities in Scotland have been active in organizing research activities. Meetings of research workers are held twice a year to review results. Nevertheless, alcoholism remains a major health problem and a number of priority areas for future research have been determined. The Scottish Home and Health Department provided funds for the general population survey which formed part of the community response study described here; its interest and stimulus undoubtedly contributed to the success of the study in Scotland.

The Study Area: Lothian

The Lothian Region was selected as the area for the study. It is one of Scotland's 12 administrative regions, situated at the eastern end of the central lowland belt. It contains the capital city, Edinburgh. The population in 1974 was 738,000. With approximately 435 persons per km², it was one of the most densely populated areas of Europe. Of the total labour force, 65% was employed in the service sector and 23% in manufacturing industries. Between 1964 and 1975 there was a significant increase in the number of women employed, especially in Edinburgh where at present almost half of the available jobs are for women. In 1977, 6.8% of the work force was unemployed, a figure that has since risen considerably.

The health and other services were similar to those available in other parts of Scotland. There were 416 general medical practitioners (1 to nearly every 1800 population), 5 general and 4 psychiatric hospitals, and 16 social work teams.

Before the study, no data on alcohol availability or drinking patterns existed specifically for Lothian. It was known that the mortality rate from cirrhosis of the liver was 5.8 per 100,000 population, about midway in the range for Scotland as a whole. It has since been shown that the total alcohol-related mortality rate in Scotland ranges from 6.7–34.3 per 100,000 population; 12.8 for Lothian (12).

An important reason for choosing Lothian was the presence of a number of workers interested in research into alcohol-related problems. It was also reasonably representative of urban Scotland and incorporated a semi-rural area. It would have been useful, for comparative purposes, to have also included an entirely rural community, but limited funds did not allow two widely separated areas to be chosen. In addition, there already existed an interest in joint planning in Lothian. The Health Board, the Social Work Department and the voluntary agencies in the area had committed themselves to a campaign which took place, with the formation in Lothian in 1980 of a committee on alcohol-related problems, at the same time as the study.
Execution of the Study

The following 3 methods were used to obtain the information required:

1. A general population survey, on the basis of a stratified probability sample of 608 men and 399 women, aged 17 years or over, living in Lothian. It was known that drinking and heavy drinking, as well as alcohol-related problems, were more common among the men than the women. More men were therefore included in the sample, in order to obtain a sufficiently large number of problems to be able to study the responses.

2. A survey of agency workers consisting of detailed, open-ended, interviews with 62 workers in 32 community agencies.

3. A survey of the clients of selected community agencies, who were interviewed with the case report form. If that presented evidence of an alcohol-related problem, the client was interviewed in greater depth, using the client interview form, in which the majority of questions were identical to those asked in the general population survey. It proved extremely difficult to obtain representative samples because of a number of procedural problems. This meant that there was little justification for the pooling of samples from the non-specialized agencies. Where they were pooled, it was for illustrative purposes only.

Principal Findings

Drinking practices

It was found that a majority of adults in Lothian drank. Only about 10% of the respondents in the general population survey had not had a drink in the year preceding the interview. The respondents could be divided into 3 broad categories:

1. Regular drinkers: who had consumed some form of alcoholic beverage during the week preceding the interview.

2. Occasional drinkers: who had not consumed any form of alcoholic beverage during the week preceding the interview, but had during the preceding year.

3. Abstainers: who had not consumed any form of alcoholic beverage during the year preceding the interview.

The distribution of the 3 broad categories, by sex and by age, is shown in Table 6. There were few abstainers, except among elderly, retired, people. Compared with sex and age, other demographic and socioeconomic variables were of little significance in categorizing the drinking patterns.

The drinking habit most frequently reported by the men was “once or twice a week”; and by the women, either “less than once a month but at least once a year” or “once or twice a week”. Of the women under 30 years of age, 32% drank once or twice a week and, of those over 50
years of age, 34% less than once a month but at least once a year. It is interesting that 18% of the women over 50 years of age claimed never to have drunk at all. If this is compared with the less than 3% of younger women who made a similar assertion, it seems that, even allowing for vagaries of memory, women now drink much more than they did in the past; they are not simply giving up drink as they get older.

The quantities of alcohol consumed during the week prior to the interview are shown in Table 7. The consumption levels are similar to those found in the 1972 survey (6), although in the current study the level is higher for the women. It seems, therefore, that there was little change in the consumption rate for men between 1972 and 1978 and a modest increase in the rate for women.

The men drank more often and more heavily than the women. Their average weekly consumption was 21.6 units of alcohol, three times that consumed by a regular woman drinker. The young men drank more often than the middle-aged men, the peak being 3 or 4 days a week during their 20s. It was probably no coincidence that the decline in frequency came during the period of maximum family responsibility; the decline in consumption was evident only in married men. The frequency tended to rise again after middle-age while the quantity consumed on each drinking day declined steadily with advancing years. The men of higher socioeconomic status drank more often during the course of a week but consumed less on each drinking day. Similarly, manual workers drank less often than non-manual workers but, when they did, drank more.

While, with the men, it was the amount consumed that varied according to socioeconomic status, with the women it was the frequency alone. The younger and more socially advantaged women drank the most heavily. In contrast to the men, the women preferred "shorter" drinks but drank them much more slowly. For men, 70% of the total
Table 7. Scotland (Lothian): quantities of alcohol consumed

<table>
<thead>
<tr>
<th></th>
<th>Number of units</th>
<th>17-29 %</th>
<th>30-49 %</th>
<th>50+ %</th>
<th>All %</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Men</strong></td>
<td>more than 51</td>
<td>13</td>
<td>7</td>
<td>6</td>
<td>9</td>
</tr>
<tr>
<td></td>
<td>21–50</td>
<td>25</td>
<td>20</td>
<td>10</td>
<td>18</td>
</tr>
<tr>
<td></td>
<td>11–20</td>
<td>19</td>
<td>20</td>
<td>17</td>
<td>19</td>
</tr>
<tr>
<td></td>
<td>6–10</td>
<td>11</td>
<td>16</td>
<td>14</td>
<td>14</td>
</tr>
<tr>
<td></td>
<td>1–5</td>
<td>16</td>
<td>22</td>
<td>21</td>
<td>20</td>
</tr>
<tr>
<td><strong>None in the week preceding the interview</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>None in the year preceding the interview</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>No. of respondents</strong></td>
<td></td>
<td>181</td>
<td>204</td>
<td>210</td>
<td>595</td>
</tr>
</tbody>
</table>

|                | more than 51   | 0       | 0       | 0     | 0     |
| Women          | 21–50          | 7       | 2       | 1     | 3     |
|                | 11–20          | 13      | 10      | 3     | 8     |
|                | 6–10           | 14      | 14      | 6     | 10    |
|                | 1–5            | 29      | 30      | 23    | 27    |
| **No. of respondents** | | 108 | 121 | 160 | 389 |

consumption was beer; they tended to change to whisky as they got older. It was interesting to note that 33% of the younger men spent more than 10 hours each week drinking. Indeed, in Scotland, it seems to be the major leisure pursuit.

The men did 70% of their drinking in the company of male friends in public houses, clubs, or hotels, whether they were married or not and whatever age they were. The women, in contrast, did nearly 50% of their drinking in domestic circumstances, mainly in their own homes with members of their families. The only women who regularly drank in public houses were those in the 17–29 year age group and it was more common for them to drink with friends.

Approximately 33% of the men said that the occasion on which they had drunk the greatest amount during the month preceding the interview had been a social one, or a regular drinking session. Christmas and Hogmanay (New Year’s Eve) were invariably mentioned as the occasions on which the greatest amounts had been drunk during the preceding year.
Cultural attitudes to drinking behaviour

Definitions of reasons for and against drinking

The reasons most often selected for drinking were those of sociability or celebration (Table 8). The men, particularly the heaviest drinkers, thought all the reasons listed were important. The most widely supported reasons for not drinking or being careful about drinking were the cost (more than 70%) and care for the health (60%). As in Mexico, the abstainers and the heaviest drinkers agreed with more of the reasons for caution.

Table 8. Scotland (Lothian): reasons for and against drinking selected by respondents who had had a drink in the year preceding the interview

<table>
<thead>
<tr>
<th>Reasons for drinking</th>
<th>Men %</th>
<th>Women %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Drinking is a good way to celebrate</td>
<td>54</td>
<td>46</td>
</tr>
<tr>
<td>I drink because there isn’t anything else to do</td>
<td>9</td>
<td>3</td>
</tr>
<tr>
<td>It is part of a good diet</td>
<td>10</td>
<td>4</td>
</tr>
<tr>
<td>I like the feeling of getting high or drunk</td>
<td>19</td>
<td>10</td>
</tr>
<tr>
<td>It is what most of my friends do when we get together</td>
<td>53</td>
<td>41</td>
</tr>
<tr>
<td>Drinking helps me to forget about my worries and problems</td>
<td>15</td>
<td>9</td>
</tr>
<tr>
<td>Drinking gives me more confidence and makes me sure of myself</td>
<td>20</td>
<td>17</td>
</tr>
<tr>
<td>I drink when I feel tense or nervous</td>
<td>14</td>
<td>11</td>
</tr>
</tbody>
</table>

| Reasons for not drinking or being careful about drinking                             |       |         |
| Drinking is bad for your health                                                     | 64    | 66      |
| It costs too much when you need the money for other things                          | 75    | 74      |
| My family and friends get upset when I drink                                       | 26    | 19      |
| It may interfere with your job or work                                              | 54    | 33      |
| It goes against my religion                                                         | 8     | 10      |
| I am afraid of becoming an alcoholic                                                | 20    | 19      |
| Drinking often makes you do things you are sorry for later                          | 33    | 24      |
| Drinking can make you feel sick                                                     | 49    | 46      |
| Drinking can get you into trouble with the police or the authorities                | 44    | 19      |
| Drinking leads to losing control over your life                                     | 39    | 34      |

| No. of respondents                                                                 | 608   | 399     |

Attitudes to drinking and drunkenness

The reaction to the same statements as were presented in Mexico (see page 14) reflected a somewhat ambivalent attitude to drinking, since most of the respondents said they agreed with most of the statements. The statements about drinking were much less categorical than those about drunkenness. This could explain the fact that fewer respondents agreed with the statements that implied intolerance of drunkenness than with those that implied tolerance of drinking.
Overall, the women were more against drinking and its consequences than the men, though the responses indicated that as women drank more they became more tolerant of drunkenness.

Age seemed to have little effect on attitudes to drinking but did on attitudes to drunkenness. Respondents in the youngest age group disapproved less of drunkenness than those in the oldest.

The respondents of higher socioeconomic status were more permissive with regard to drinking habits, but the male unskilled manual workers tended to be the most tolerant of drunkenness. In general, most respondents seemed tolerant of the habits that accorded with those of the socioeconomic group to which they themselves belonged and the greater the amount of alcohol consumed the more tolerant was the attitude to drinking and drunkenness. There was an abrupt change, however, when it came to respondents in the heaviest drinking category who, possibly speaking from personal experience, were more critical.

Drinking norms

To obtain a picture of the influence of age and sex on perceived drinking norms, the respondents were asked the same series of questions as in Mexico on what they thought was the most that should be consumed at one time by a public figure, a boy or girl aged about 16 years, a young man or woman aged about 21 years, a man or woman aged about 40 years, and a man or woman aged about 50 years. It was considered almost equally permissible for either a man or a woman over 21 years of age to drink. Most respondents, however, thought that 16-year-olds of either sex should not be allowed to drink. This suggests an abrupt change, on reaching the age of majority, from not being allowed to being allowed to drink. Such a view is, of course, quite out of keeping with reality, since it is known that drinking is common among early teenagers.

Respondents of all ages were significantly less tolerant of women drinking than of men. The women were consistently less tolerant of drinking to any degree in all age groups than the men. Individuals tended to be the most tolerant of drinking in those nearest to them in age but tolerance generally declined with advancing years. The women of higher social status were more tolerant of drinking among 16-year-olds than those of lower social status. As personal consumption increased, judgements on appropriate drinking behaviour in men and women of all ages became more tolerant.

Drinking situations

With regard to drinking behaviour in different situations, most respondents condoned some drinking, but not enough to feel the effects, at a party, in someone else's house, or at a bar with friends. It was largely proscribed in a parent spending time with small children. There was universal disapproval of drinking and driving, and drinking during
working hours. The contrast between the level of disapproval and the evident frequency with which the two rules are broken is interesting.

Problems associated with drinking

As in Mexico, the "drinkers" were asked if they had experienced any of 14 personal and social types of problem associated with drinking during the year preceding the interview (Table 9).

**Table 9. Scotland (Lothian): percentages of "drinkers"* who experienced alcohol-related problems during the year preceding the interview**

<table>
<thead>
<tr>
<th>Personal consequences</th>
<th>Men</th>
<th>Women</th>
</tr>
</thead>
<tbody>
<tr>
<td>Have awakened the next day not being able to remember some of the things I had done while drinking</td>
<td>25</td>
<td>7</td>
</tr>
<tr>
<td>Felt that I should cut down on my drinking or stop altogether</td>
<td>22</td>
<td>6</td>
</tr>
<tr>
<td>Have taken a drink first thing when I got up in the morning</td>
<td>7</td>
<td>1</td>
</tr>
<tr>
<td>Sometimes get drunk even when there is an important reason to stay sober</td>
<td>6</td>
<td>1</td>
</tr>
<tr>
<td>Have had my hands shake a lot the morning after drinking</td>
<td>6</td>
<td>1</td>
</tr>
<tr>
<td>Have been told by a doctor or health worker that the amount I was drinking was having a bad effect on my health</td>
<td>3</td>
<td>1</td>
</tr>
<tr>
<td>Stayed intoxicated for several days</td>
<td>2</td>
<td>0</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Social problems</th>
<th>Men</th>
<th>Women</th>
</tr>
</thead>
<tbody>
<tr>
<td>Felt the effects of alcohol while on the job</td>
<td>17</td>
<td>3</td>
</tr>
<tr>
<td>Have been ashamed of something I did while drinking</td>
<td>11</td>
<td>4</td>
</tr>
<tr>
<td>Got into a fight because of my drinking</td>
<td>5</td>
<td>0</td>
</tr>
<tr>
<td>Been told to leave a place because of my drinking</td>
<td>3</td>
<td>0</td>
</tr>
<tr>
<td>Have been involved in a road accident when I have been drinking</td>
<td>2</td>
<td>0</td>
</tr>
<tr>
<td>Have been involved in an accident at home when I have been drinking</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>Have been involved in an accident at work when I have been drinking</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>No. of respondents</th>
<th>Minimum</th>
<th>Maximum</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>579</td>
<td>582</td>
</tr>
<tr>
<td></td>
<td>360</td>
<td>362</td>
</tr>
</tbody>
</table>

*AGED 17 YEARS AND OVER.

Each type of problem was more common among the men. The one most frequently experienced, by 25% of the men and 7% of the women, was loss of memory after drinking; the figure for the men rose to 42% among the 17–29 year age group. Most problems were encountered more often as levels of consumption rose. Age, social class, and financial status influenced the number of different types of problem experienced at each level of consumption.

Even allowing for the influence, on the responses, of age and levels of consumption, it was evident that unemployment and alcohol-related problems were closely associated. Of the men who had been unemployed
at some stage during the year preceding the interview, 67% said they had experienced at least one problem, and 49% two or more.

Social class seemed to have little influence on "personal consequences", but resulting social problems were strongly influenced by class. This extremely interesting finding could be explained, in part, by the different patterns of drinking of the different social groups. Those in the higher social classes drank more frequently but somewhat less heavily, and heavy, episodic drinking is more likely to cause social problems. In addition, those with fewer financial resources are less protected against the socially harmful consequences of drinking. Further research is needed to gain an insight into the relationship between alcohol consumption, the consequent problems, and the social resources available to an individual.

At some time in their lives approximately 2% of the men and less than 4% of the women had been criticized for drinking, most commonly by parents or spouses. Only 2% of the men admitted to being criticized at work. Problems with the police had resulted from drinking for 8% of the men but none of the women.

Agency views

Unit for the Treatment of Alcoholism

This was the only agency in the entire study that specialized in treating individuals specifically for their alcohol-related problems. Expectations that its clients would be the heaviest drinkers were fully borne out. Of the 36 men and 13 women interviewed, 47% were married, 29% single, and 22% separated or divorced. It was a relatively stable group, 75% having lived in the area for at least 20 years and almost 50% not having experienced even 1 week of unemployment during the year preceding referral to the Unit. The men had consumed an average of 108 units of alcohol in the week prior to attendance at the Unit and the majority said they had experienced more than half the alcohol-related problems listed in the client interview form. In contrast to respondents in the general population survey, when asked why they drank 59% said they drank for what they termed "escape" or emotional reasons.

Non-specialized agencies

Attention was focused on the hospital casualty department, an area office of the Social Work Department, and the general psychiatric services serving Leith, a predominantly working class port area within the city of Edinburgh, the population of which had been 55,515 at the 1971 census. It quickly became clear that, because of insufficient resources, only a preliminary impression could be obtained of the ways in which alcohol-related problems manifested themselves in those

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1 Now called the Alcohol Problems Clinic.
settings. Also it was known that the clients who were interviewed, particularly at the office of the Social Work Department, could not be taken as representative of the various caseloads. This was because of procedural problems in conducting the interviews.

In the hospital casualty department, 89 patients were selected as a sample, in a way that made them representative of a total week's work. Alcohol seemed to have played a sufficient part in causing the admittance of 18 to warrant further investigation, during which 9 admitted having alcohol-related problems. At the psychiatric out-patient clinic 9 out of 40 clients, and at the office of the Social Work Department 11 out of 20, said they had significant alcohol-related problems. Most of those found by this means to have such problems were younger than the clients seen at the specialized unit. They were also more socially deprived. At the time they came into contact with the agency 65% were unemployed and 34% were living alone. The average amount of alcohol they consumed each week was 58 units, approximately half the average amount consumed by both the men and the women at the specialized unit. They said they got drunk quite often, 68 having done so at least once a week during the year preceding the interview. Again, more than half mentioned "escape" as being an important reason for drinking.

The police

All the incidents reported in Leith during 1 week were recorded. The number came to 240. There was no question of alcohol involvement in 54 and it was not possible to ascertain whether it was involved or not in 36. Of the remaining 150, alcohol was undoubtedly present in 61 and definitely not present in 89. The periodicity of the incidents that did not involve alcohol showed little variation throughout the week but the number of alcohol-related incidents increased towards the weekend and, each day, the greatest number occurred soon after the public houses had closed in the evening. The alcohol-related incidents were mostly minor. All the cases of disturbance of the peace were alcohol-related, as were 10 out of 14 of minor nuisance. Alcohol had played a part in 4 of the 6 incidents that involved physical violence.

The community response to alcohol-related problems

The community response was examined from the same 3 perspectives as in Mexico: those of the respondents in the general population survey, the agency workers, and the agency clients.

General population

Attitudes to responses

The reactions to the statements on attitudes to responses are shown in Table 10. Most respondents thought that referral for medical
Table 10. Scotland (Lothian): attitudes to responses

<table>
<thead>
<tr>
<th>Statement</th>
<th>Men %</th>
<th>Women %</th>
</tr>
</thead>
<tbody>
<tr>
<td>There are treatments that often succeed with people with alcohol problems</td>
<td>83</td>
<td>86</td>
</tr>
<tr>
<td>If you had a drinking problem in this community, everyone would soon know about it</td>
<td>75</td>
<td>78</td>
</tr>
<tr>
<td>If a man drinks and does not support his wife and children, the community should give them help</td>
<td>68</td>
<td>62</td>
</tr>
<tr>
<td>A man’s drinking is his own business and no concern of the community</td>
<td>49</td>
<td>51</td>
</tr>
<tr>
<td>If you had a problem with your drinking, you would not know where to get help</td>
<td>45</td>
<td>49</td>
</tr>
<tr>
<td>If you had a problem with your drinking you would be ashamed to tell anyone about it</td>
<td>44</td>
<td>54</td>
</tr>
<tr>
<td>You wouldn’t want a place where people with alcohol problems get treated to be near where you live</td>
<td>37</td>
<td>36</td>
</tr>
<tr>
<td>There is not much that community leaders or the Government can do about alcohol problems</td>
<td>36</td>
<td>36</td>
</tr>
<tr>
<td>If you asked for help with a drinking problem in this community, everyone would soon know about it</td>
<td>26</td>
<td>26</td>
</tr>
<tr>
<td>A man who is always drunk should be punished</td>
<td>17</td>
<td>18</td>
</tr>
</tbody>
</table>

No. of respondents 593 389

* Respondents aged 17 years and over.

treatment would be appropriate and effective. There was little support for punishing excessive drinkers. About half the respondents felt they would be ashamed to admit having an alcohol-related problem, evidence of a substantial lingering stigma associated with alcohol misuse. The view that a person’s drinking habits were his own business was strongly supported; they were regarded as areas of private life of no concern to the community, an institution, or even to the family. The difference in view between the men and the women was not substantial but there was some evidence that, for the women, shame would be a deterrent to seeking help. This view seemed particularly evident in the women who drank the most heavily and could play an important role in preventing them from seeking help. The younger and the more socially and educationally privileged respondents favoured intervention rather than a punitive approach to alcohol-related problems.

Alcoholics Anonymous was the agency best known to respondents, who were asked where they would recommend a relative or a friend with an alcohol-related problem to go for help. It was recommended by 55%, a general practitioner by 48%, and an alcoholism treatment agency by 28%.

Responses to the public consequences of drinking

As in Mexico, respondents were asked to comment on four hypothetical situations resulting from drinking (see page 18). All were
well known to the community. A man drinking so much that he deprived his family of food was regarded as the most serious. A majority of respondents thought that bystanders should try to help a man who had fallen down drunk in the street or a woman unsteady through drink. When respondents were asked whether neighbours should intervene in more serious situations, only about 25% felt it would be appropriate, seeing it more as the responsibility of the police or the authorities in general. It was the respondents of higher socioeconomic status who favoured intervention by neighbours or bystanders and, when necessary, the police. The younger women were more willing than the older ones to assign responsibility to relatives. The heavier drinkers were conspicuously unwilling to involve relatives, perhaps as a result of personal experience. Relatives were not rated very highly as sources of help, particularly in the case of a man hitting his wife. As anticipated, whereas in Mexico and Zambia relatives in particular were regarded as sources of help, in Scotland the inclination was to leave intervention to the authorities. The protagonists in all the incidents described were seen as suitable for treatment; further evidence of the community's preference for a medical response.

**Informal social responses**

The Scots proved much more reticent than the Mexicans about discussing their own alcohol-related problems. Only 3% of respondents (19 men and 5 women) said they had talked to someone, usually a spouse or a doctor. In most cases, either they had been told to reduce their intake or stop drinking or they had been given no advice. A further 2% (12 men and 4 women) said they had been concerned about having a problem but had never talked to anyone.

**Agency workers**

Randomly selected workers at different levels within such agencies as the police and the hospital casualty department were interviewed extensively, as well as members of primary health care teams, social workers, and a very small number of marriage counsellors, lawyers, pharmacists, and clergymen. It is not possible to summarize the information derived from this wealth of experience. The views of each agency on alcohol-related problems must inevitably be influenced by the characteristics of its own type of clientele, a fact often overlooked when endeavouring to assess the needs of what are grossly dissimilar groups of individuals. The information obtained has, therefore, proved invaluable as a basis of discussion at local level and in ascertaining the needs for training and for changes in service delivery and referral channels.

The overall impression was that workers in the non-specialized agencies were aware that persons with alcohol-related problems existed in their caseloads (notably the police); that they tended to regard alcohol-related problems as existing predominantly among the socially
deprived men; that they felt more should be done towards prevention, since to help the alcoholic was difficult; and that they would like support from specialist sources to be more easily accessible. Most, the police and workers in the hospital casualty department for example, felt that to respond to alcohol-related problems was not their main concern. Most wished for further training in regard to alcohol and its effects.

Workers in specialized agencies, such as Alcoholics Anonymous, the Edinburgh and District Council on Alcoholism and the Unit for the Treatment of Alcoholism, were much more optimistic about being able to help people with alcohol-related problems. Those at Alcoholics Anonymous seemed very confident, but the work of the agency was self-contained; it used the referral channels much less than the other agencies. Without exception, the specialized agency workers emphasized that motivation on the part of the client was essential to the success of intervention; yet “motivation” remained a nebulous concept, hard to define.

Agency clients

It has already been described, in relation to agency views, how insufficient resources enabled only a small number of clients to be interviewed. Those attending the Unit for the Treatment of Alcoholism and some non-specialized agencies were asked the same questions on attitudes to responses as the respondents in the general population survey. The clients of the specialized unit were inclined to be optimistic about the outcome of treatment, although ashamed of having problems, feeling that the community knew and also knew they had asked for help. The clients of the non-specialized agencies were more likely to feel that drunkenness should be punished and were not hopeful that treatment would be successful. Inconclusive as these views are, they illustrate the kind of resistance that needs to be overcome as a client is referred from one agency to another.

Implications for the Community

The findings of the study consolidated for the authorities a number of issues and observations on which to base their planning, some of which might be clarified through local initiative, while others will have to be considered at national level. The issues were discussed at a meeting of the principal workers in Lothian, and included:

(1) The drinking habits of the women are changing rapidly. This might have implications for prevention and treatment and an effect on the children’s perception of alcohol and its use.

(2) In general, people seem to be the most tolerant of the drinking habits in others most clearly reflecting their own;

(3) Abstinence is a characteristic of one of the least influential groups—elderly, poor women.
(4) An important challenge to health educators will be to lessen the disparity, evident from the answers of the respondents, between precept and practice.

(5) It is open to question whether the seemingly widely accepted norms and consistent attitudes expressed with regard to drinking could or should be changed.

(6) The harmful psychological effects of alcohol consumption are regarded as of very little importance; rather its contribution to conviviality is emphasized.

(7) What is the level at which the effects of alcohol consumption become harmful enough for the community to seek to intervene or respond?

(8) The future prospects for the relatively large number of young people with alcohol-related problems give cause for concern.

(9) Social deprivation, unemployment, and youth are all factors contributing to a high prevalence of alcohol-related problems;

(10) The community largely accepts alcoholism as being a disease, at a time when professional opinion in Scotland is changing from the medical concept.

(11) Among most of the people interviewed, during the general population survey and at the non-specialized agencies, a preference for treatment at specialized agencies was observed. This view does not accord with the concept of a “community alcohol team” favoured by the authorities in Lothian.

(12) The two issues mentioned above suggest discordance between the current views and expectations of the community in regard to appropriate responses, and the responses being promoted by specialists; there must be dialogue between members of the community and educators.

(13) What do specialized agency workers mean when they emphasize motivation on the part of the client as being fundamental to the outcome of intervention?

(14) What is the reason for the pessimism, with regard to being able to help people with alcohol-related problems, felt by non-specialized agency workers in the forefront, such as those in the hospital casualty department and the police?

(15) How can coordination be improved between all types of agency dealing with “problem drinkers”; and how can the support the non-specialized agencies need from specialist sources be provided?

(16) It is often not recognized that agencies differ markedly in their clientele. Different interpretations of such terms as “alcoholic” and “problem drinker” may confound attempts to communicate.

There are limits to the local community’s sphere of influence over matters that have a bearing on alcohol-related problems; for example, taxation, levels of funding, advertising regulations, and legislation, are mostly determined nationally. The meeting held in Lothian was therefore followed by a meeting at national level, to examine the interplay between national and local interests and plans.
Zambia

Background

Zambia was chosen for the study as a developing country with limited resources but firm commitment to preventing a further increase in the prevalence of alcohol-related problems. It is recognized there that developing countries must be cautious if a growth in alcohol consumption and misuse is not to place an impossible burden on the limited resources needed for national development. As is the case with many similar countries, the introduction of prevention and control measures has been hampered by a lack of the information necessary for planning.

In 1980 Zambia had a population of 5.7 million, representing an increase of about 43% in 12 years. At that time, 46.8% was under 15 years of age. A low density of 7 inhabitants per km² compared with an average of 13 for the African continent as a whole. In 1975 life expectancy at birth was 45.5 years, similar to that of the continent as a whole. The adult literacy rate was 43%. Various Christian religions are represented in the country and the indigenous apostolic churches have a considerable following. There is also a small number of Moslems. The country is undergoing rapid urbanization; in 1980 43% of the population was living in the towns. Nevertheless, the main occupation remains subsistence-level farming. The most common health problems are malnutrition, and respiratory and digestive disorders; the most common disease is malaria.

Patterns and consequences of alcohol consumption

Drinking has long been a traditional pastime in Zambia, as an integral part of village ritual and social life. In the past the number of situations in which drinking took place were probably controlled by custom and the fact that many of them were ceremonial. The colonial powers sought to control the drinking habits of the Africans; the role of alcohol in the politics of the colonial era has been ably reviewed (13). In 1930 an ordinance decreed that the Africans should drink only beer in municipal beer halls. It also provided local authorities with a monopoly over the brewing and sale of an opaque beer, the alcohol content of which was not to exceed 4%. In the 1950s the number of retail outlets in the Lusaka municipality was increased and plants to process better quality draught beer were acquired. The results of this initiative were phenomenal. In the first year alone sales rose by 252%. All the profits went into general revenue and were used to finance the municipality's share of the national social welfare costs. They were also used for capital expenditure programmes, such as road building, street lighting, and supplements to the housing budget.

Illicit brewing increased as dissatisfaction with the sordid conditions in the beer halls and the controls imposed there grew. For example, men
and women were officially segregated and often segregation was effected by allocating different times for each sex to drink. By the mid-50s Africans were allowed to buy European beer and wine, but spirits were still proscribed. At about the time of independence, in 1964, it became evident that socially aspiring Africans were attracted to imported alcoholic beverages, particularly spirits, perhaps thinking of them as emblems of their improving social status and newly acquired independence. Independence also meant that business was open to everyone and a profitable form of business was the sale of alcoholic beverages. There was therefore a sudden increase in the number of authorized liquor outlets.

There are, therefore, different layers of drinking patterns in Zambia: the traditional customs of the village culture; the artificially created habits of the colonial era; and the European styles acquired in recent years. Commercialization has influenced the traditional patterns; it is now possible for people in the accessible rural areas to drink at any time of the year, not solely when grain is available for brewing. The alcoholic content of village brews is often uncertain and the size of receptacles extremely variable, making it difficult to estimate the quantity of alcohol consumed.

Beer is by far the most widely consumed alcoholic beverage. Lager-type beers are made commercially by Zambia Breweries, and opaque beers by National Breweries. Both companies are government-owned. National Breweries has no depots because of the nature of its product which must be consumed within a few days. It is usually delivered to outlets in tankers and is never bottled. Following independence, the quantity of lager beer produced rose, but has levelled off in recent years at about 1 million hectolitres a year. Between 1968 and 1980 the annual amount of opaque beer produced fluctuated between 2.3 and 1.7 million hectolitres, the greatest amount produced having been in 1968 and the least in 1973. Spirits and wine form a very small part of the market and the quantities imported declined somewhat during the 1970s. Home-brewing, particularly in the rural areas, makes a substantial contribution to the alcoholic beverage production figure, but the exact amount produced is not known.

Calculated on the basis of the quantities of alcoholic beverage produced commercially or imported, the apparent per capita consumption of pure alcohol for that portion of the population aged 15 years and over was 4.12 litres in 1969, 3.58 litres in 1974, and 3.39 litres in 1980. Such estimates could, however, be very misleading. In an urban area such as Lusaka, where more accurate figures on the consumption of commercially produced alcoholic beverages are available, the per capita rate was more than twice as much.

Until the present study, no systematic survey of the drinking habits of the general population in Zambia had been carried out. In a study on psychiatric morbidity in patients attending health centres in 1969, 33% of the men and 64% of the women said they were abstainers (14). A study of alcohol and drug use carried out in 10 secondary schools in
1972 showed that 64% of the boys and 26% of the girls drank (15). A number of other studies have confirmed that more young people, particularly those who are receiving a better education, are drinking.

Very little statistical information is available on clinical conditions, such as cirrhosis of the liver, resulting from alcohol misuse. Of 740 autopsies performed over a period of 2 years at the Department of Forensic Medicine, University Teaching Hospital, Lusaka, 36% were deaths resulting from traffic accidents, of which 39% appeared to be alcohol-related (16). This figure contrasted with the police estimate that only 2% of traffic accidents over the same period could be attributed to alcohol. Between 1970 and 1980 there was little significant change in the number of "drunk and incapable" cases brought to the police courts; approximately 15,000 in 1970, 25,000 in 1974, and 19,000 in 1979.

Comments on the "end of the month syndrome"—that is, work absenteeism—often appear in the press, but precise information is difficult to obtain. It is suspected, and frequently stated, that wage earners neglect their families because they spend their money on drink but no data relating child malnutrition to the parents' consumption of alcohol are available. It has been claimed that 16% of the consumers' food budget in Zambia, an amount equivalent to that spent on beef, is spent on alcoholic beverages.

National responses to alcohol-related problems

The United National Independence Party has given considerable thought to means of pursuing a national alcohol policy. It recommended that beer production should remain at its current level, that the importation of spirits should be restricted, and that spirits should not be served at State, Central Committee or ministerial functions. It also recommended that the Party and the Government should embark on a vigorous educational campaign against illicit brewing and excessive drinking. A maximum blood-alcohol level of 50 mg per 100 ml was proposed for drivers and other recommendations related to improvements in the conditions at drinking places and the location of new premises away from the main roads and schools. The National Council on Alcoholism and Addictions, formed in 1966 to respond to alcohol-related problems, recommended the establishment of a national commission on alcoholism and excessive drinking. The draft bill, which would have given this commission wide-ranging powers, was never presented to the Cabinet. At the end of the 1960s, the National Council decided to suspend its activities. One of the recommendations resulting from the present study is that the National Council should be re-formed.

The health services grew in Zambia during the 1970s but at the end of the decade there was still room for improvement in most parts of the country. Emphasis had been placed on the use of health assistants, but as the numbers of health personnel remained low (80.5 per 100,000 population, compared with 101.2 for Africa as a whole, 349.6 for the
world, and 575.7 for Europe) prevention became of particular importance.

The Social Welfare Department of the Ministry of Labour and Social Services is concerned primarily with family and child welfare, juvenile delinquency, school and matrimonial problems, public assistance, and the problems of the handicapped. The professional manpower involved in this work is very small in number. There is no specific service for alcohol-related problems; severe cases can be referred to the only psychiatric hospital. Although Alcoholics Anonymous was active for a time in the north of the country, where the copper mines are situated, it has not really become established elsewhere.

The Study Areas: Lusaka and Mwaisompola

A rural community and 2 communities, one peri-urban and one suburban, within Lusaka, the capital, were chosen for the study. The population of Lusaka in 1980 was approximately 538,000.

The peri-urban community within Lusaka is 8 kilometres from the city centre and originated as a squatter area. In 1975 it was legally established as a settlement and later improvements were made under the Lusaka Housing Project. The population in 1980 was 39,498, of which 50% was under 15 years of age. The political and administrative community officials were the governing United National Independence Party's Branch Chairman and constituency officials.

The suburban community had a population of approximately 23,000, of which about 34% was under 15 years of age. Half the population had lived there for more than 10 years. It was therefore a more established community than the former squatter area.

The rural community is in one of the 7 districts of the Central Province. It covers an area of 5500 km² midway between Lusaka and Kabwe and is bounded by swamps to the west. It had an estimated population in 1980 of 37,000 of which approximately 50% was under 15 years of age. This represented a density of 6.1 persons per km² and a growth rate of 1.4% a year. The main occupation was farming. The community was served by a mobile health team and there were 7 rural health centres in the area. A 1975 survey found that more than 40% of the children examined were malnourished. Diarrhoea and anaemia were widespread, and schistosomiasis and malaria were common diseases. The main authorities were a rural council and various associated committees for the planning and execution of the development policies laid down by the Party and the Government.

Execution of the Study

The 3 following methods were used to obtain the information required:
2. PRACTICES, PROBLEMS, AND PATTERNS OF COMMUNITY RESPONSE

(1) A general population survey, carried out in October 1978. Samples of persons aged 15 years and over were obtained, using different methods in the rural and the urban communities. The number of men selected was not greater than the number of women. Altogether 1095 people were interviewed, 471 men and 624 women.

(2) A survey of agency workers, carried out in early 1979 in a variety of agencies, mostly in the suburban and peri-urban communities of Lusaka. A number of occupations were represented by the 51 workers interviewed.

(3) A survey of agency clients in Lusaka, at some local police stations, the hospital casualty department, local health centres, the psychiatric hospital and a psychiatric out-patient clinic, and the Social Welfare Office.

Several difficulties were encountered in carrying out the study in Zambia. The general population survey was particularly demanding on personnel and resources. Sampling proved difficult because of absence of the information needed to establish a frame. The interview form was translated into 5 vernacular languages but the interviewers were not accustomed to reading their own languages. It might have been preferable to have used the English version of the form, and to have allowed the interviewers to attempt to convey the intended meaning of the questions in the vernacular on the spot, having first made sure they understood them. Computer analysis of the data also proved difficult because of inadequate documentation on the software. Flooding and police and military operations also caused some disruption. The sampling of agency clients presented some problems because of local difficulties in regard to registration procedures. The crucial lesson learned was that, in data collection, expectations must not outweigh the available resources.

Principal Findings

Drinking practices

In each community the majority of the women said they were abstainers. Notable differences existed between the communities, however, in the proportions of abstainers among the men; there were many more abstainers in the urban communities than in the rural one. The men in the rural community also drank more often (Table 11). Replies to the questions regarding frequency of drinking did not seem to have been influenced by the fact that the survey was carried out in the month of October, when supplies of grain for home brewing would normally be low. Among the "drinkers", the men drank more often than the women and, in a pattern similar to that of Mexico, frequency increased with age, except in the oldest age group in the rural community where they drank the least often. The "drinkers" with no religious affiliations were likely to drink more frequently.
Table 11. Zambia (Lusaka and Mwacisompola): frequency of alcohol consumption*  

<table>
<thead>
<tr>
<th>Frequency</th>
<th>Peri-urban</th>
<th>Suburban</th>
<th>Rural</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Men</td>
<td>Women</td>
<td>Men</td>
<td>Women</td>
</tr>
<tr>
<td>At least once a week</td>
<td>40</td>
<td>11</td>
<td>32</td>
<td>11</td>
</tr>
<tr>
<td>Less than once a week</td>
<td>13</td>
<td>8</td>
<td>24</td>
<td>14</td>
</tr>
<tr>
<td>Not in the last year</td>
<td>5</td>
<td>3</td>
<td>1</td>
<td>4</td>
</tr>
<tr>
<td>A life-time abstainer</td>
<td>41</td>
<td>77</td>
<td>56</td>
<td>71</td>
</tr>
<tr>
<td>No. of respondents</td>
<td>165</td>
<td>206</td>
<td>151</td>
<td>223</td>
</tr>
</tbody>
</table>

* Although the general population survey sample was aged 15 years and over, analysis was confined to data obtained from respondents aged 18 years and over because of the low figures for those below that age.

On the day they had last had a drink prior to the interview 33% of the men and slightly less than 33% of the women "drinkers" had consumed 37 or more units of alcohol, equivalent to 13 or more bottles of local commercially brewed lager-type beer (mosi) (Table 12). The difference between the sexes in the quantities drunk did not appear to be as great as might have been expected, compared with Mexico and Scotland. The large number of women abstainers had, however, already been eliminated from the calculations, so that the actual number of women in the sample of those who drank large quantities was small. Out of the total sample, including the abstainers, about 33% of the men and 10% of the women got “high” at least once a week. Among the

Table 12. Zambia (Lusaka and Mwacisompola): quantity of alcohol consumed on the last drinking day prior to the interview*  

<table>
<thead>
<tr>
<th>Approximate quantity Units</th>
<th>Peri-urban</th>
<th>Suburban</th>
<th>Rural</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Men</td>
<td>Women</td>
<td>Men</td>
<td>Women</td>
</tr>
<tr>
<td>0-5</td>
<td>9</td>
<td>20</td>
<td>7</td>
<td>21</td>
</tr>
<tr>
<td>5-9</td>
<td>17</td>
<td>40</td>
<td>20</td>
<td>15</td>
</tr>
<tr>
<td>10-14</td>
<td>28</td>
<td>4</td>
<td>13</td>
<td>21</td>
</tr>
<tr>
<td>15-18</td>
<td>17</td>
<td>8</td>
<td>18</td>
<td>12</td>
</tr>
<tr>
<td>18 and over</td>
<td>30</td>
<td>28</td>
<td>42</td>
<td>32</td>
</tr>
<tr>
<td>No. of respondents</td>
<td>78</td>
<td>25</td>
<td>55</td>
<td>34</td>
</tr>
</tbody>
</table>

* Although the general population survey sample was aged 15 years and over, analysis was confined to data obtained from “drinkers” aged 18 years and over because of the low figures for those below that age.
"drinkers", the difference between the sexes was much smaller, 70% of the men and about 50% of the women reporting getting “high” with the same frequency. Many of the respondents gave the same answer to the question on frequency of drinking, the question on frequency of feeling the effects of alcohol, and the question on frequency of getting drunk, suggesting that either they tended to drink to get intoxicated or they were not able to differentiate between the questions.

As anticipated, commercially produced opaque beer (chibuku) was the most popular alcoholic beverage, with local lager (mosi) next. The consumption of spirits was negligible. Home-brewed beverages of uncertain alcoholic content were more commonly drunk in the rural community, chibuku in the peri-urban community, and mosi in the suburban community. People in the younger age groups drank mosi and in the older age groups chibuku, suggesting that mosi was seen as a modern beverage despite its greater cost. The better educated and the younger drinkers favoured European-style bars, whereas the lesser educated drank in taverns (beer halls) or private homes. Chibuku was drunk in the taverns, mosi in the bars, and home-brew in shebeens, which are illegal drinking places. There seemed to be little mixing of beverage types. Those who drank mosi consumed a lesser quantity at any one time than those who drank chibuku.

For about 40% of the men and 33% of the women, the last occasion on which they had had a drink had been at a tavern. The women, however, preferred to drink in a private home and the men at a public place, which meant that married couples tended not to drink together. The drinking companion of 56% of the men was another man and of 39% of the women another woman. About 20% of the men and 25% of the women said they had been alone on the last occasion they had had a drink.

In the rural community, drinking in greater amounts was usually associated with a special event, such as a wedding or another ceremony, whereas, in the urban communities, more was drunk on pay-day at the end of the month. Mosi was the favourite drink on those occasions, suggesting that, even in the rural community, a commercial brew had come to be considered the prestige drink for special occasions.

Cultural attitudes to drinking behaviour

Definitions of reasons for and against drinking

In common with the respondents in Mexico and Scotland celebration was most often selected as a reason for drinking but an unusually large number of respondents, 64% of the women and 53% of the men, also regarded drinking as a means of forgetting their problems. The reasons most commonly supported for not drinking were: cost, interference with work, and fear of trouble with the police; of acting in a manner that would later be regretted; and of losing control over one’s life.
Attitudes to drinking and drunkenness

In considering the same statements as were presented in Mexico (see page 14) respondents agreed with those that implied intolerance of drinking and drunkenness rather than those that implied tolerance. Again, the men were more tolerant than the women. Respondents in the rural community were more intolerant of drunkenness than respondents in the urban communities.

Drinking norms

Drinking seemed to be regarded as the prerogative of the middle-aged and elderly. Unlike in Mexico, where sex was the indicator to acceptable norms, in Zambia it was age. It was interesting that so few women drank, when it seemed more acceptable for them to drink than it was in Mexico. As in Scotland, there was a tendency for respondents to be most tolerant of drinking in those closest to them in age.

Drinking situations

Drinking and feeling the effects of alcohol were most likely to be considered acceptable at a party, in a bar, or with friends at home. The younger respondents were less likely to condone drinking or heavy drinking. This reaction was in marked contrast to that in Mexico and Scotland where the age gradient was quite the reverse. Drinking while driving was universally condemned.

Problems associated with drinking

All respondents were asked if they had experienced any of 14 types of problem associated with drinking during the year preceding the interview. The results are shown in Table 13.

More than 50% of the men who drank and about 40% of the women said they had felt they should try to drink less. In absolute terms, more of the men reported alcohol-related problems but, among the “drinkers”, the difference between the sexes was much less than in Mexico or Scotland. Differences between the urban and the rural communities were not significant.

The men and the less educated of both sexes had experienced more of the personal consequences. Social problems were experienced to a greater extent by the younger respondents. Those who got drunk once or twice a week had experienced more social problems than those who got drunk more often. This could have been because the habitual drinkers had learned to avoid situations that gave rise to such problems and had adapted themselves psychologically to coping with high blood-alcohol levels.

At some time during their lives 10% of respondents had been criticized for drinking by a family member or a friend. Difficulties at
Table 13. Zambia (Lusaka and Mwacisompola): percentages of respondents* who experienced alcohol-related problems during the year preceding the interview

<table>
<thead>
<tr>
<th>Personal consequences</th>
<th>Total community sample</th>
<th>&quot;Drinkers&quot;</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Suburban</td>
<td>Peri-urban</td>
</tr>
<tr>
<td>Felt that I should cut down on my drinking or stop altogether</td>
<td>36 9</td>
<td>19 10</td>
</tr>
<tr>
<td>Have awakened the next day not being able to remember some of the things I had done while drinking</td>
<td>17 5</td>
<td>11 4</td>
</tr>
<tr>
<td>Sometimes get drunk even when there is an important reason to stay sober</td>
<td>16 4</td>
<td>13 4</td>
</tr>
<tr>
<td>Have had hands shake a lot the morning after drinking</td>
<td>8 5</td>
<td>6 3</td>
</tr>
<tr>
<td>Have been told by a doctor or health worker that the amount I was drinking was having a bad effect on my health</td>
<td>6 2</td>
<td>3 3</td>
</tr>
<tr>
<td>Have taken a drink first thing when I got up in the morning</td>
<td>6 3</td>
<td>4 2</td>
</tr>
<tr>
<td>Stayed intoxicated for several days</td>
<td>6 5</td>
<td>3 1</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Social problems</th>
<th>Total community sample</th>
<th>&quot;Drinkers&quot;</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Suburban</td>
<td>Peri-urban</td>
</tr>
<tr>
<td>Felt the effects of alcohol while on job</td>
<td>18 6</td>
<td>12 8</td>
</tr>
<tr>
<td>Have been ashamed of something I did while drinking</td>
<td>13 5</td>
<td>7 4</td>
</tr>
<tr>
<td>Got into a fight because of my drinking</td>
<td>4 2</td>
<td>4 3</td>
</tr>
<tr>
<td>Have been told to leave a place because of my drinking</td>
<td>4 1</td>
<td>3 1</td>
</tr>
<tr>
<td>Have been involved in a road accident when I have been drinking</td>
<td>6 1</td>
<td>1 1</td>
</tr>
<tr>
<td>Have been involved in an accident at home when I have been drinking</td>
<td>2 1</td>
<td>1 1</td>
</tr>
</tbody>
</table>

No. of respondents                                                                   | 165 205 | 151 223 | 155 196 | 471 624 | 251 152 |

* Aged 15 years and over.
work had been experienced by 2% and 1% said they had had trouble with the authorities or the police. Perhaps surprisingly, these consequences had been experienced more or less equally by the men and the women.

Agency views

Approximately 33% of police incidents were thought to have involved alcohol, with assault as the most common offence.

At the hospital casualty department, approximately 10% of the men interviewed thought the alcohol they had consumed had contributed to their being there. The staff was more likely than the patients to consider that there was alcohol involvement. Only 2% of the clients attending the health centres showed sufficient evidence of alcohol-related problems to qualify for further interview. Virtually none of them were attending for that reason. Seventeen clients were interviewed at the Social Welfare office. Approximately 33%, said they had alcohol-related problems but the number was too small for any conclusion to be drawn.

More than 50% of the men and almost 50% of the women interviewed at the hospital casualty department had been sent there by the police. Relatives were also frequently responsible for sending them there and, for 12% of the men, employers.

The community response to alcohol-related problems

The community response was examined from the points of view of the respondents in the general population survey and the agency workers.

General population

Attitudes to responses

Only 33% of respondents felt there were forms of treatment available that could succeed for people with alcohol-related problems. Opinion was divided on the relevance of punishment. It was widely agreed that, if someone in the community had a drinking problem the rest would soon know of it, as they would if someone were to seek help for such a problem. More of the women than the men said they would be ashamed to admit having an alcohol-related problem but in most respects the attitudes of both sexes were similar. There was little agreement on the places where treatment might be sought, numerous health, social work, and political sources having been mentioned.

Responses to the public consequences of drinking

The same 4 hypothetical situations resulting from drinking as were presented in Mexico were described to respondents (see page 18); each
was regarded as serious. About 50% regarded them as quite common occurrences, the respondents in the urban communities assessing them as both common and serious. In contrast to the respondents in Scotland, many of those in Zambia felt it appropriate for relatives to intervene in every situation. Intervention from the treatment system or the police was seldom mentioned. A majority felt that if a man's drinking habits meant that his family was deprived of food, he should be reported to the authorities. The respondents in the urban communities favored intervention by outside authorities more than those in the rural community.

*Informal social responses*

At some time, members of their families, or friends of 33% of the men and 20% of the women had expressed concern about their drinking habits. One of their parents or their wives were most frequently mentioned by the men as having done this. In the suburban community concern was likely to be expressed by a spouse or an acquaintance and in the rural community by a parent. Most family members had wanted them to reduce their intake or stop drinking.

Of the men 7% and of the women 3% said they had talked to someone about an alcohol-related problem of their own, mostly to relatives but also to spouses or friends. About 5% of the men and 1% of the women said they had been treated for an alcohol-related problem at some time in their lives.

*Agency workers*

The workers at the various agencies could not give clear estimates of the extent to which alcohol misuse contributed to the problems they encountered. They placed dealing with alcohol-related problems about midway along their spectrums of priority. Most felt that such problems were more common among the lower income groups.

*Implications for the Community*

As in Mexico and Scotland, a number of issues emanated from the study in Zambia, some of which could be addressed locally. Such issues included:

1. Relatively few Zambians drink; those who do appear to make little distinction between drinking and getting drunk; they are either regular heavy drinkers or virtual abstainers.
2. There are considerable differences between the urban and the rural communities. The rural community has more “drinkers”, who get drunk more often, start to drink at an earlier age, drink a home-brewed beverage, spend more time drinking, and can find more reasons for drinking. Its members are more tolerant of drinking and drunkenness in
others, and, should an individual have an alcohol-related problem, more in favour of intervention from the community. There are not, however, more members with alcohol-related problems, possibly because of their tendency to drink beverages of lower alcoholic content.

(3) The drinking habits in the rural community are, nevertheless, changing as the more expensive commercially brewed alcoholic beverages are introduced. The possible effect on nutritional status and on the family budget will have to be considered.

(4) As in Mexico and Scotland, the police assume a very important role. They seem to be feared, and yet they deal with a large number of alcohol-related problems, directly and by referring them to other agencies. There is, however, little evidence of coordination between the different agencies.

(5) At present most members of the community do not understand the concept of alcoholism. They do not regard alcohol-related problems as being possibly medical in nature and are not sanguine about the benefits of treatment. The community agency workers, however, like those in Mexico but unlike those in Scotland, are optimistic about the value of treatment. This may be the result of education having increased their perception of social problems and the means of solving them.

These and many other issues were reviewed at a national conference held in Kalumba in 1982, composed of participants from many backgrounds. The Government was asked to establish a drinks and drugs commission and to revive the National Council on Alcoholism and Addictions. It was agreed that industrial alcohol programmes should be established; Government and public institutions, and the Ministries of Health, Home Affairs, Education and Culture, Finance, and Labour and Social Services, were all given tasks to accomplish which, if achieved, should prevent an increase in the number of people with alcohol-related problems in Zambia.
3. Reflections on the outcome of the study and the implications for future action

The completion of the first phase of the community response study merged with the second phase, which commenced after meetings had been held within each country to discuss the implications of what was being found. Each community then proceeded to implement and evaluate the changes recommended as a result of the experience it had gained. A description of the second phase is published elsewhere (7). This chapter aims to consolidate and reflect on the experience gained during the first phase. The methods applied have been set down in guidelines for investigating alcohol-related problems and developing appropriate responses, which should be of value to others who wish to pursue similar studies (77).

The study demonstrated how coordinated international research activities, on the basis of which appropriate community responses can be determined, can be planned and carried out within the limits of available national resources. The introduction of sophisticated techniques may not only prove irrelevant in the long run, but creates a mistaken impression that little can be achieved without substantial resources and, when they cannot be sustained on the withdrawal of international support, a sense of frustration and helplessness.

Among the questions that come to mind, now that the data have been collated, are what has been learnt and what is its relevance to local, national, and international policy on the use of alcohol? The unique data yielded relate to 3 very different types of country and should prove to be an invaluable source of information for further studies. The primary aim was to ensure that the research activities were consistently relevant and linked to action for improving the community response in each area.

Methods Adopted

The conscious attempt to obtain background information on alcohol consumption and responses to alcohol-related problems at local and
national levels proved extremely fruitful and could be undertaken as a preliminary task in any country. Gaps were quickly revealed where information was lacking or where data had been collected in such a way as to make it difficult to extract the information required: for example, the difficulty experienced in extracting the Scottish consumption and production figures from the United Kingdom statistics. The time spent on elucidating known information is well worthwhile and should receive adequate support.

A major part of the resources, manpower, time, and energy invested was devoted to the near-identical general population surveys of the 3 study areas. In future it may prove wise to devote less time and fewer resources to a general population survey, at the expense of the other components of the study and of community response planning activities. However, the result was a unique set of data, and cross-national surveys are one of the few ways of providing information that can be compared with reasonable confidence. The methodology of research through surveys is much better developed in industrialized countries and, as the study progressed, the complexities involved in coordinating method and design across national and cultural boundaries became increasingly evident.

It was of particular importance that the research methods should be comparable. Translation of the interview forms into Spanish in Mexico and the vernacular languages in Zambia, careful testing, and translation back into English, helped to overcome some of the obvious difficulties encountered in trying to reach equivalence among the 3 study areas. Methods of coding and data production and analysis also had to be comparable. To achieve this, the coordinating skills of a project manager were vital to a successful outcome.

It was essential to use methodology that is easy to apply in a developing country, since to have promoted sophisticated analytical techniques, dependent on technology not available in the country, would have been pointless. The communities in the study areas had to "own" the research, that is not only the questions asked and the data obtained but also the means to continue to analyse and use the data.

Some problems were encountered with sampling in the 3 countries. It was often difficult to decide who should be selected for inclusion in the general population sample. The interviewers employed varied in training, age, sex, and skill. For example, in Scotland a professional interviewing agency was employed and most of the interviewers were middle-aged women; young men dressed in uniform conducted the interviews in the rural community in Zambia. In Mexico the interviews were often regarded as a special occasion, with the rest of the household looking on; whereas in Scotland they were usually held in private. Such variables must have affected the responses.

The communities studied could not claim to be representative of their countries and generalization from their experience should be undertaken with caution. In Mexico and Zambia, particularly the former, the upper social classes were under-represented. Although those that were left out
constituted a very small group, to have included them might have had some significance, in view of the belief that the elite are often heavy drinkers and are important models for others (18). In that regard, it was noteworthy that none of the communities studied were tolerant of drinking in their leaders; in Zambia 62% of respondents said they did not think a public figure should drink.

In all 3 countries, the urban communities were over-represented and it was debatable whether the rural areas of Lothian in Scotland were sufficiently rural; they certainly were not representative of the remote areas of the country. It could be argued that to generalize, from the data obtained, on the cultures and situations in the countries concerned would be unscientific. Attempts to generalize from the information obtained on communities within each country could be similarly criticized. However, planning could be inhibited by such a philosophy, since it leads to restrictive scepticism. Some of the differences between the countries were so great that they could not be overlooked; for example, in the number of abstainers. On the other hand, some of the similarities were so striking that it would have been obtuse to have ignored them; for example, the predominance of men among the "drinkers". Another similarity was the fact that, in all 3 countries, the police seemed to devote a major part of their time to dealing with alcohol-related problems.

The Validity of the Findings

It was possible to approach the question of validity in a number of different ways. There was the evidence from previous similar studies. In Scotland, a body of survey data already existed with which the data from the present study were compared; the broad trends observed were very similar. In Mexico and Zambia, reliance was placed more on ethnographic information but, again, there was considerable agreement between that information and the findings of the present study. The social statistics assembled as background information also provided some clues in regard to alcohol consumption and alcohol-related problems in each community. For example, the background information seemed, in most cases, to strengthen the validity of the general population survey findings that beer was the most popular beverage in all 3 countries. It was also possible to compare the views of the 3 groups of people taking part in the study—the general population, the agency workers, and the agency clients—which again were in agreement within each country. Finally, tests conducted on the general population survey data of all 3 countries confirmed the internal consistency of the answers obtained.

As has already been mentioned, the time spent on the general population surveys probably detracted from that available for the surveys of agency workers and agency clients. Quite apart from time, the surveys of agency clients presented formidable difficulties, because of the differing organizational patterns of the agencies. The surveys of agency
workers proved very useful in helping to develop community responses and were cheap but effective means of quickly gleaning the views of key informants with knowledge of the local health and social systems. The most important shortcoming of the survey of agency workers was that it was not a good basis for generalization. A key informant might not be talking of the real situation in the community but perpetuating an inaccurate stereotype view; some means of comparing the views of each agency with reality seemed essential. The data obtained from the agencies were not valuable for comparative studies because the institutional framework of each agency was markedly different and the samples selected were small and somewhat idiosyncratic. The experience of selected workers in agencies dealing directly with alcohol-related problems was, of course, invaluable as a basis for local action.

**Cross-cultural Issues**

The primary concern has been to focus on the relevance of the study to the situation in each country. However, from a cross-cultural perspective the findings raise fascinating issues for further analysis and research.

One of the most striking is related to the data on per capita alcohol consumption, which are misleading unless viewed in the context of the known number of abstainers and prevailing drinking patterns. The patterns of heavy drinking or no drinking at all in Mexico and Zambia gave rise to numerous personal and social alcohol-related problems among those who did drink. In Scotland almost everyone drank but mostly in moderation, apparently resulting in few problems. If the abstainers in Mexico and Zambia were to commence to drink in the same pattern as the drinkers, the problem rate could become phenomenal. This poses some crucial questions for educators. For example, what kind of education related to alcohol and its consumption is appropriate for a country where 50% of the population are abstainers; is it possible to disassociate drinking from drunkenness in the minds of the community? Another question is, should controls be imposed on the marketing and advertising of alcoholic beverages.

In all the communities studied, the women were either abstainers or drank less than the men. They were also much less tolerant of women drinking. In Mexico and Zambia sex was an important determinant of drinking behaviour. In Scotland age was a crucial determinant and there only were the heaviest drinkers young adults. Young people drinking was tolerated to a much greater extent in Scotland. The drinking behaviour of the younger Scottish woman had undergone rapid change; so much so that the mother who drinks will be a model for the next generation. It seems reasonable to assume that this will remain the established pattern and it is interesting to speculate what would be the consequences of a similar change throughout the world.

In each country, if problems resulted from alcohol consumption it was mostly family members who suffered and expressed anxiety. It could
have been that the conflict was most acute where the women were abstainers; certainly many of the women in Mexico were anxious and angry about their husbands' drinking habits. In no community did the men habitually drink with the women; and in all 3 countries it was traditional, in drinking places, to separate the men from the women, in certain communities by legislation. It is not known what effect this separation of the sexes has on drinking behaviour. It is, however, a situation that could be changed, for instance by redesigning the drinking places.

The Scottish public seemed largely to take the view, not necessarily shared by the workers at the specialized agencies, that specialist intervention was required for alcohol-related problems. In Mexico and Zambia, where few specialized agencies exist, a much wider range of sources of help was mentioned, the Church and native healers prominent among them. The Scots were remarkably reticent in consulting anyone about their problems (only 3% said they had), whereas the Mexicans and the Zambians sought help much more freely, usually from members of their families. This greater frankness could be a force in strengthening informal community responses.

The differences between the rural and the urban communities were, as anticipated, more evident in Mexico and Zambia. Contrary to recent experience in European countries with strong temperance traditions, however, the men in the rural communities of Mexico and Zambia drank and got drunk more often than those in the urban communities. In the rural community in Zambia, the men were much more tolerant of drinking in others (it could be that they would prove more tolerant of many other potentially harmful aspects of life). This suggests that further study of the drinking patterns in the rural communities of developing countries would yield valuable information.

In Mexico there was a greater number of alcohol-related problems in the rural community than in the urban community. In Zambia alcohol-related problems were more common in the peri-urban community than in the rural community, in spite of the heavier consumption and the greater frequency of drunkenness in the rural community. The data do not support the hypothesis that urbanization increases the prevalence of alcohol-related problems. The relationship seems to be a complex one requiring further study.

Implications for Planning

The findings make it clear that responsibility for the community response to alcohol-related problems must rest with a wide range of agencies. Some recognize this responsibility; others do not, at present, understand the role they could assume. There are also marked contrasts, among the different agencies, in the levels of optimism regarding the outcome of intervention; the agency workers in Scotland were pessimistic in regard to intervention from any agency other than a specialized one, while those in Mexico were generally optimistic. The
general population in Zambia, more than in Mexico or Scotland, recognised how important it was for relatives, bystanders, and others to react to the manifestations of alcohol-related problems in their midst; in Scotland the tendency, in considering responses to the public consequences of drinking, was to relegate responsibility to the authorities.

A producer of an alcoholic beverage, surveying a new market, might regard the large number of abstainers, for example in Mexico, as ripe for exploitation. If the abstainers in Mexico were to start to drink, would they do so in moderation, or would they adopt the style, already predominant, of occasional bouts of heavy drinking resulting in a great number of reported alcohol-related problems? It could be postulated, from the existing pattern of alcohol consumption, that as more Mexicans drank the number of medical and social alcohol-related problems would reach an unprecedented level. However, as more drank, particularly the women, they might become more tolerant and less inclined to see a problem in every drinking bout. How to approach the future is a major challenge for planners and educators, since little is known about how to encourage people to drink less heavily or how to change cultural alcohol consumption patterns. All that can be said at present is that an increase in alcohol consumption must give cause for concern; there is no evidence, from the present study, that it would bring about widespread moderation in drinking.

A public education programme designed for one community may not be equally suitable for another. Similarly, governments should beware of trying to impose the ideas and use the materials conceived for another country. An effective education programme must, if it is to retain credibility, relate to the needs of the community it serves.

The findings and conclusions of the study refer to the status of all 3 countries at the time the study was carried out. The situation is, however, a dynamic one, affected by socioeconomic considerations other than alcohol consumption, related to national economy and culture. The point at which increasing per capita consumption could level off and reach a steady state is not known. There is little evidence that it will stabilize, although in some industrialized countries it has arrived at a plateau (19).

The authorities in each country have to decide what measures they are going to introduce in order to respond to the increasing levels of alcohol consumption. It is evident that in Scotland the extent of the local response will be limited, partly because the Regions depend on the Government for revenues and partly because certain measures that might influence prevention, such as taxation, and regulations governing alcohol production and most advertising, are determined nationally. To ensure that a response is in keeping with the needs of the community, however, some aspects can only be pursued locally; for example, those requiring knowledge of the attitudes of the local agency workers. The authorities in Lothian are much more conscious, as a result of the study, of the pessimism with regard to the outcome of intervention existing among some non-specialized agency workers, and will ensure that
community action is focused appropriately. The fact that in all 3
countries, but particularly in Zambia, the police emerged as an
important source of information makes their participation in planning
and future educational activities essential. At the outset of the study
planning was further advanced in some respects in Scotland than in
Mexico and Zambia, because an infrastructure of agencies used to
working together already existed. Hopefully, the establishment of teams
of research workers and mechanisms for coordinating their activities
with those of the agencies involved will provide a sound basis for
planning in each country. That steps are being taken towards this aim is
evident from the local and national meetings held as a result of the
study.

In each community there were issues that needed to be addressed by
personnel of different disciplines meeting together. Some of the
personnel were familiar with each others' interests; some may have felt
at first that they had little in common. They included local politicians,
village headmen, clergymen, magistrates, law enforcement officers,
educators, and staff of the licensing authorities, the health and social
work services, voluntary agencies, and trade and tourist organizations.
They had a common concern for the prevention and control of problems
related to alcohol and its misuse although differing priorities may have
led them to conflicting conclusions. Such meetings have already been
held in the communities studied and the data have been used. The
changes that ensued were monitored and their effect assessed during the
second phase of the study.

National multidisciplinary meetings have been similarly organized.
Though tensions may exist between trade, employment, revenue raising
and law enforcement agencies, and the welfare and health services,
cooperation is essential in order to formulate national strategies for
dealing with alcohol-related problems. Increasing consumption must be
contained and yet competing interests related to the sale and
consumption of alcohol satisfied.

Coherent responses to alcohol-related problems require adequate
data bases. Efforts to improve statistics or assemble more information
must not become ends in themselves or substitutes for action; there is
plenty of evidence of that to be found in national archives and record
offices. The study served to elucidate the means by which a community
may obtain useful information on the extent and nature of alcohol-
related problems among its members, and the professional and public
attitudes to alcohol use. It would be naive to suppose that information
alone is enough to launch a national campaign. The communities
themselves and the national authorities must summon the will to
embark, and ensure that the necessary funds, an essential ingredient, are
committed.
References


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