

**FACTORS CONTRIBUTING TO ALCOHOL ABUSE AND PERCEIVED HEALTH EFFECTS
AMONG THE YOUTH AT MAKHADO MUNICIPALITY, SOUTH AFRICA**

BY

Mudau Mbavhalelo Delco

**A Mini Dissertation Submitted In Partial Fulfillment Of The Requirements For The Degree
Of Master Of Public Health (MPH) At The University Of Venda**

SUPERVISOR: DR. T.G TSHITANGANO

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DECLARATION

I, Mudau Mbavhalelo Delco (11580217), declare that the mini-dissertation titled “**Factors contributing to alcohol abuse and perceived health effects among the youth of a rural area at Makhado Municipality, South Africa**”, hereby submitted for the degree, Master of Public Health (MPH) at the University of Venda has not been submitted before by me at this or any other University, and that it is my own work in design and in execution. All the sources that I have quoted and cited have been indicated, acknowledged and referenced.

Signature:

Date:

DEDICATION

I dedicate this mini-dissertation to my wife, Mrs. Karabo Carol Mudau, my children Mpho Shaun Mudau and Munangwa Pearl Mudau and my late grandmother Muthelo Maria Mudau. You have given me support, courage and believed in me. If it was not for you, I would not made it. Your courage and support made me reach my destiny. I can say I have made it because of you. I love you and God bless you. Siregu, may your soul continue to rest in peace.

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ABSTRACT

Lately, the abuse of alcohol amongst youth has become a global problem, resulting in individual, social and economic implications. Alcohol abuse is the third leading risk factor for poor health, causing disease and death in people aged 15-49 years, which is economically the most productive group. The aim of the study was to investigate the factors contributing to alcohol abuse and perceived health effects among the youth of a rural area at Makhado Municipality, South Africa. The study adopted a quantitative approach, using a descriptive cross-sectional survey. Data was collected using a questionnaire consisting of six sections; namely, demographic information of the respondents, the rate of alcohol abuse, socio-economic factors contributing to alcohol abuse, psychological factors contributing to alcohol abuse among the youth, environmental factors responsible for alcohol abuse and perceived health effects of alcohol abuse. The survey population comprised of youth aged 16-35 years. A sample of 255 participants were chosen using systematic sampling technique. The data was captured using Microsoft Excel and analyzed using the Statistical Package for Social Sciences (SPSS) software version 26.

Two Hundred and fifty five (255) questionnaires were distributed to respondents and they were all completed. The findings indicate that the majority of the respondents were males (60.4%), whilst females constituted 39.6 %. Furthermore, 84 (32.9%) were in the age bracket 21-25 years; 70 (27.5%) were in the age bracket 26-30, 63 (24.7%) were in the age brackets 31-36 while 38 (14.9%) were in the age bracket 16-20. The results indicated that environment and alcohol initiation age have a significant association ($P\text{-value} = 0.009$). There was positive relationship as most of the respondents (45%) started drinking alcohol at the age of 16 years because in each village there are more than three (3) (45%) alcohol outlets). Nthabala village including the local social workers should consider these factors when designing intervention strategies to minimize alcohol abuse in the area.

Key Words: Abuse, Alcohol, Effects, Factors, Health, Nthabalala, Youth.

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LIST OF ACRONYMS

WHO	World Health Organization
DALY	Disability-Adjust Life Years
APC	Adult Per Capita
DBE	Department of Basic Education
USA	United States of America
HIV	Human Immunodeficiency Virus
AIDS	Acquired Immune Deficiency Syndrome
TB	Tuberculosis
NDMP	National Drug Master Plan
NCD	Non-Communicable Disease
SPSS	Statistical Package for Social Sciences

CHAPTER ONE

INTRODUCTION AND BACKGROUND OF THE STUDY

1.1 Introduction

Alcohol is a psychoactive substance with dependence-producing properties. The consumption of alcohol and problems related to alcohol vary widely around the world. However, the burden of disease and death remains significant in most countries. The harmful use of alcohol ranks among the top five risk factors for disease, disability and death throughout the world. Alcohol is a causal factor in more than 200 diseases and injury conditions (WHO, 2014). This section covers the background of the study, problem statement, rationale, significance, purpose, objectives and definition of terms.

1.2 Background of the study

The abuse of alcohol is a global problem, particularly by the youth, resulting in individual, social and economic implications. Globally, alcohol abuse is the third leading risk factor for poor health and is the number one risk factor causing disease and death in people aged 15-49 years, which is economically the most productive group (Marara, Rath, Sharma, Bosman, & Srinivas, 2016). In addition Esser & Jenigan (2018) and WHO (2014), indicated that, in 2012 alcohol consumption was responsible for 3.3 million deaths globally, or nearly 6% of all deaths, and 5.1% of disability-adjusted life years (126).

Various factors have been put forward as contributing to substance use and abuse. In the case of alcohol and drug use, the contributing factors include the environment, peer pressure and communal drinking among teenagers, as well as the availability of drugs (Banyard, 2010). In addition, Simango (2014) mentioned that most disadvantaged communities, ignorance, the falling price of certain kinds of alcohol products (such as malt beer and brandy), relative to the consumer price index, chemical dependence on alcohol, poor social conditions and boredom, lack of social control to deal with those who misuse substances, and social attitudes in general, have been linked to increased substance abuse.

The findings of a study by Department of Social Development (2013) revealed that the availability of taverns and shebeens within reach of school premises plays a significant role in the engagement of learners in drug use.

However, the Alcohol Policy Youth Network (APYN) project conducted in European Union found that, alcohol is causing health disaster such as addiction, chronic diseases and the death of the young people. Harmful alcohol consumption is a driving factor in the steady rise of chronic diseases. It can also be linked to more than 60 different types of diseases and conditions, and is related to around 120 000 premature deaths per year in Europeans aged 15-64 years (Jan Peloza, Liutkute, Galkus, Kokole, van Dalen, & Drobne, 2016).

Moreover, the study titled National Framework to Prevent and Minimise Alcohol-related Harms among Individuals, Families and Communities, conducted by the Australia Department of Health (2018), found that Australia is regularly reported or casually referred to as having an “alcohol culture”, where not consuming alcohol is viewed as being “unAustralian”. There are many Australians for whom this perception or cultural norm contributes to increased risk of serious harm and development of harmful drinking patterns. In addition, the Foundation for Alcohol Research and Education (FARE) (2016), in their annual polls, also indicates that the vast majority of those surveyed were concerned about alcohol, with 78% indicating that Australia has a problem with excessive drinking or alcohol abuse; 73% believing that alcohol-related problems in Australia will get worse or remain the same over the next five to ten years and 78% believing that more needs to be done to reduce the harm caused by alcohol.

Despite the high levels of alcohol consumption in other countries, Marara et al (2016), have argued that India’s consumption of alcohol is still low, when compared to the rest of the world. This is because only 32% of Indians consume alcohol, out of which 4-13% are daily consumers. However, the recent consumption levels of alcohol have increased due to liberalized social values. As a result, India is now one of the key markets for the global spirits industry and alcohol is the most commonly used intoxicating substance in the country. The percentage of the drinking population aged below 21 years has also increased from 2% to more than 14% in the past 15 years. In addition, people drink at an earlier age than before, and the mean age of initiation has dropped from 19 to 13 years over the past two decades.

Osei-Bonsu, Appiah, Norman, Asalu, Kweku, Ahiabor, et al (2017) in their cross-sectional study conducted in Ghana, indicated that in Africa, the rate of alcohol consumption is not different from the rest of the world because alcohol and other illicit drugs are easily accessible to the youth. Furthermore, they found that the use of alcohol is prevalent among the youth between the ages of 15-34 years in Ghana, with Volta Region recording the highest prevalence among males, which

constitutes 42%, and among females. The highest prevalence of alcohol consumption was in the Upper West Region, with a prevalent rate of 37%. However, Ferreira-Borges, Parry & Babor (2017) argued that low consumption levels can also be found in the countries of North Africa and sub-Saharan Africa, such as Niger, Senegal or Guinea.

Alcohol consumption and alcohol-attributable burden of disease in Africa are expected to rise in the near future, yet increasing alcohol-related harm receives little attention from policymakers and from the population in general. Even where new legislation is proposed, it is rarely enacted into law. Being at the center of social and cultural activities in many countries, alcohol's negative role in society and contribution to countries' burden of disease are rarely questioned (Ferreira-Borges et al, 2017).

According to WHO (2014) the danger of alcohol-use and abuse costs was estimated at about 125 billion euros in the European Union for 2003; 21 billion pounds in 2009 in the United Kingdom of Great Britain and Northern Ireland, and 233.5 billion dollars in 2006 in the United States of America. Such economic costs related to alcohol represent 1.3% to 3.3% of the gross domestic product. Even when intangible costs are omitted, these costs are still substantial, not only in comparison to the gross domestic product, but also in relation to the costs associated with other risk factors.

Vellios, & Van Walbeek (2018), mentioned that South Africa (SA) has the highest per capita alcohol consumption (in terms of pure litres of alcohol) by individuals aged ≥ 15 years. Moreover, provincial alcohol consumption prevalence amongst youth varies greatly, with the Western Cape at 44.2%, Gauteng at 40.2%, Free State at 40.9% and North West at 50.8%, reporting the highest rates. Limpopo and the Western Cape were the only provinces where more female learners than male learners had used alcohol in their lifetime. Gauteng and Western Cape reported a significantly greater proportion of past month drinkers than of the past month binge drinkers, which suggests that there was a large proportion of youth in these provinces who had drunk alcohol during the month before, but whose drinking did not constitute binge drinking (Department of Social Development, 2014-2016).

The findings from the study conducted in Limpopo Province by Provincial Department of Social Development (DSD) and University Of Limpopo (2013) showed that the youth smoke tobacco, drink alcohol and use hardcore drugs. The most commonly used alcohol is bottled wine (32%),

home-brewed beer (30%), and commercially brewed beer (greater than 4% Alc/Vol) used by 54.8% of the youth.

The impact of alcohol abuse among the youth has gained attention globally, including in South Africa, which led to the formulation of policies and laws to reduce alcohol abuse. In order to reduce alcohol related harms, South Africa has developed several alcohol policies. In 2010 the Cabinet of South Africa established the Inter-Ministerial Committee (IMC) under the chairperson of the Minister of Social Development, to urgently devise and implement strategies and programmes to reduce alcohol-related harm (WHO, 2014). Furthermore, Setlalentoa, Ryke & Strydom (2015) note that the Prevention of and Treatment for Substance Abuse Act no. 70 of 2008 was also developed to deal with the prevention of and treatment for substance abuse, such as alcohol and the associated harm. It emphasized that the prevention programmes need to be on-going and not once-off.

To reduce the harmful use of alcohol, it is also important to regulate the availability of liquor. In turn, to reduce the availability of alcohol, it is important to regulate the days and hours when liquor sales should be permitted. Furthermore, to regulate accessibility of alcohol at public events or any liquor outlet, the licensees, manager or any person dispensing liquor at the premises must take steps to ensure verification of age of any person, by requesting identity document, passport or driver's license, in order to verify the person's age (National Liquor Policy Review, 2016)

The Revised National Drug Master Plan (2013-2017) (NDMP) complements the work of the Inter-Ministerial Committee on Alcohol and Drug Abuse, by guiding and monitoring the actions of government departments to reduce the demand for and supply of drugs and the harm associated with their use and abuse. The commonly recognised strategies applied in the NDMP 2013 – 2017 are the following: demand reduction, supply reduction and a localised version of harm reduction. The Department of Social Development has also developed a programme called Ke-Moja (No Thanks, I am fine without drugs) that they conduct at schools for learners as a prevention strategy for the reduction of alcohol abuse.

1.3 Problem Statement

Despite the availability of the aforesaid interventions, policies and regulations to fight alcohol abuse in South Africa, most youth still entertain themselves by drinking alcohol. As a resident of Nthabalala Location, the researcher observed that youth at Nthabalala Location spend much of their time at local taverns drinking alcohol, while some wake up to go and drink home-brewed beer all day long. This was confirmed in the study conducted by Limpopo Department of Social Development and University of Limpopo (2013), which found that the most commonly abused substances in Makhado municipality include cannabis (49%), inhalants (39%), bottled wine (32%), home-brewed beer (30%), and commercially brewed beer (greater than 4% Alc/Vol), used by 54.8% of the youth. The concern is that alcohol use contributes to both communicable diseases, such as the transmission of HIV infections, tuberculosis and noncommunicable diseases, as well as cancer and liver cirrhosis. This corresponds to 5.9% of all deaths, or one in every twenty deaths in the world (7.6% for men, 4.0% for women) (WHO, 2014). It is not yet clear what could be the reason why youth abuse alcohol, while the consequences of alcohol abuser are well known. This study emanated to investigate such reasons.

1.4 Rational for the study

The seriousness of alcohol abuse among the youth has led to several studies conducted in South Africa, particularly in Limpopo Province and Vhembe District, focusing on the prevalence of substance abuse among the youth. However, there is no known study conducted in the rural areas of Makhado Municipality regarding the factors contributing to alcohol abuse among the youth. Though it is good to understand the extent of the problem, it is better to identify the factors associated with it in order to establish a pointer of appropriate intervention strategies.

1.5 Significance of the study

The findings of the study might assist government departments, such as the Department of Health, Education, Social Development, SAPS, SANCO, Nthabalala Tribal Authority, Policy makers and community members to come up with an adequate intervention on how to reduce the high level of alcohol abuse among the youth. It will also help in strengthening the laws that deal with alcohol and improving the existence programmes addressing substance abuse.

1.6 Purpose of the study

The purpose of this study was to investigate the factors contributing to alcohol abuse and the perceived health effects among the youth of a rural area at Makhado Municipality, South Africa.

1.7 Objectives of the study

- To assess the rate of alcohol abuse among the youth at these areas
- To assess socio-economic factors contributing to alcohol abuse among the youth in these areas.
- To explain the psychological factors contributing to alcohol abuse among the youth in these areas.
- To describe the environmental factors responsible for alcohol abuse by the youth.
- To explore the perceived health effects of alcohol abuse.

1.8 Definition Of Terms

Rate of alcohol abuse- A measure, quantity, or frequency, typically one measured against another quantity or measure result (Oxford Dictionary, 2015). In this study a rate of alcohol abuse means the amount of alcohol being consumed by the youth and how often they consume alcohol.

Factors refers to circumstances, facts or influences that contribute to a result (Curl, and Wilson, 2015). In this study factors means environmental, socio-economic and psychosocial factors contributing to alcohol abuse among the youth.

Abuse is the use of drugs, legal or illegal with some regulating or patterns that results in person's experience a patterns of negative life consequences resulting from other substance abuse (Johnson, 2004). In this study abuse means an excessive use of alcohol beverages, to an extent that it controls an individual's behaviour and results in negative life consequence.

Youth refers to any persons between the age of 14-35 years (National Youth Development Agency Act 54 of 2008). For the purpose of this study, youth is any person between the age of 16-35.

Alcohol is a range of drinks containing ethyl alcohol produced by fermentation of fruits, vegetables or grains. Examples of alcohol are booze, beer, lager, wine, spirits (Cohen, 1994:17).

Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity (WHO, 1948).

Rual areas means in relation to, or characteristic of the countryside rather than the town result (Oxford Dictionary, 2015). In this study, rural areas means areas which fall under the Nthabalala Location, such as Mathuli, Ramulumo, Ramatshila, Vari, Magobo, Mpofu, Maduwa and Tshathogwe.

CHAPTER TWO

LITERATURE REVIEW

2.1. Introduction

This chapter critically analyzes and presents the data-based literature on the factors contributing to alcohol abuse among the youth. This is followed by a discussion of alcohol abuse from a global perspective. Thereafter, alcohol abuse is discussed from a South African perspective, with specific focus on the contributing factors and the perceived health effects of alcohol.

2.1.1 Global perspective on alcohol abuse

The abuse of alcohol by people, especially youth, has become a prominent public health problem nationally and internationally. The harmfulness of alcohol use has gained the attention of everyone as a major factor for non-communicable diseases, infectious diseases and injury, as well as disability and mortality caused by accidents, violence and crime (Hassan, 2013). According to WHO (2014), the danger of alcohol-use and abuse costs in 2003 was estimated at 125 billion euros by the European Union, 21 billion pounds in 2009 in the United Kingdom of Great Britain and Northern Ireland, and 233.5 billion dollars in 2006 in the United States of America. Such economic costs related to alcohol represent 1.3% to 3.3% of the gross domestic product. Even when intangible costs are excluded, these costs are substantial, not only in comparison to the gross domestic product, but also in relation to the costs associated with other risk factors.

Despite the cost incurred by the economy, the harmful use of alcohol also results in 2.5 million deaths every year, worldwide. It has been indicated that 320 000 young people between the age of 15 and 29 die from alcohol-related causes, representing 9% of all deaths in that age group (WHO, 2011). Furthermore, the global per capita ingestion of alcoholic drinks in 2005 amounted to 6.13 litres of pure alcohol consumed by each person aged 15 years or older. A large percentage of this ingestion (28.6% or 1.76 litres) for each person was homebrewed and illegally produced alcohol inclusive of unrecorded alcohol. The drinking of homebrewed or illegally produced alcohol may be linked to an increased risk of harm because of unknown and potentially dangerous impurities or contaminants in these drinks (WHO, 2011).

2.1.2 Alcohol abuse in South Africa

According to the study published by Saggie (2012) in the South African Medical Journal, South Africa is a hard-drinking country. It is reckoned that South Africans consume in excess of 5 billion litres of alcohol every year. This figure is likely to be higher still if sorghum beer is included, and equates to 9-10 litres of pure alcohol per person. South Africa's adult per capita of 9.5 is above the world average of 6.13, inclusive the regional average for Africa of 6.2. In comparison, the average for the Americas is 8.7; the average for the South-East Asia region is 2.2, and the average for the Western Pacific region of 6.3. However, it is below the European regions' Adult Per Capita is 12.2 (Fieldgate, Jeffrey, Madinane, Ebrahim and Soobyah, 2013).

The consumption of unrecorded alcohol is a significant issue in South Africa, as it is all over the world and poses a difficult dimension for measuring the true nature of global alcohol consumption. This sector of consumption accounts for 26½% of total adult consumption in South Africa, compared to 29% worldwide. Unrecorded liquor is usually cheaper than mass or factory-produced products. The latter is often brewed in rural areas and is consumed mostly by the poorer segments of society. (Fieldgate et al, 2013). The consumption of homemade or illegally produced alcohol may be associated with an increased risk of harm because of unknown and potentially dangerous impurities or contaminants in these beverages (WHO, 2011).

Using the data from the study conducted in 2000, Morojele, Parry, Brook and Kekwaletswe, (2013) estimated that 33,699 deaths were related to alcohol among South Africans. A large amount of the alcohol-related deaths were due to injury, especially among the younger age groups between 15-29 years. Furthermore, alcohol is expected to be the contributory factor to 7.0% of all Disability-Adjust Life Years. Of all the alcohol-related DALYs, 63% were due to deliberate and unintended injuries; 39% were due to interpersonal violence; 14.3% to road traffic accidents; 6.0% to other unintentional injuries, while 3.7% was due to self-inflicted violence.

According to Lategan, Preez and Pentz (2017), in a global scale, it appears that hazardous and harmful drinking patterns, such as drinking to intoxication and binge drinking, are on the rise among adolescents and young adults. South Africa faces similar challenges, where young adults were identified as having the highest levels of binge, hazardous, and harmful drinking patterns. Consequently, drinking among young adults is of great concern to the South African public health community and drastic policy changes (such as a ban on alcohol advertising and a zero limit for

drinking and driving) are being proposed to address this drinking problem (Germishuys 2015; South African

In the Republic of South Africa the estimates for the combined tangible and intangible costs of harmful use of alcohol to the economy has reached nearly 300 billion rand or 10–12% of the 2009 gross domestic product (WHO, 2014).

2.1.3 Commonly consumed alcoholic beverages globally

Geographical differences exist among the type of alcohol people consume. These include beer, wine, spirits or other alcoholic beverages. Beer includes malt beers, while wine includes wine made from grapes, and spirits include all distilled beverages. Other beverages includes one or several other alcoholic beverages, such as fermented beverages made from sorghum, maize, millet, rice, or cider, fruit wine and fortified wine. Spirits are the commonly consumed beverages in terms of litres of pure alcohol in Asian and eastern countries (WHO, 2011).

WHO (2011) reported that wine constitutes the largest proportion of alcohol consumed in some European countries and the South American wine growing countries of Argentina and Chile. The traditional European differences in beverage preference, where northern Europeans once preferred beer while southern Europeans drank more wine, are diminishing. Today, in Spain the commonly consumed alcoholic beverage in litres of pure alcohol is beer, while in Sweden it is wine. Beer and spirits are commonly consumed in sub-Saharan Africa, which has generally low alcohol use levels. In the rest of the world – including most of the Western Hemisphere, northern Europe, many African countries and Australia – the commonly consumed beverage in terms of litres of pure alcohol is beer.

2.2 Contributing factors to alcohol abuse

Various factors have been put forward as contributing to substance use and abuse. In the case of alcohol and drug use, the likely contributing factors include the environment, peer pressure and communal drinking among teenagers, as well as the availability of drugs (Banyard, 2002). In addition Simango (2014) mentioned that most disadvantaged communities, ignorance, the falling price of certain kinds of alcohol products (such as malt beer and brandy), relative to the consumer price index, chemical dependence on alcohol, poor social conditions and boredom, lack of social control to deal with those who misuse substances, and social attitudes in general, have been linked to increased substance abuse. In addition, Klingemann (2011) stated that alcohol can be

said to be a contributory cause of many types of negative social conditions for both individuals and society, but rarely acts alone in determining them. In such circumstances alcohol is often said to increase the risk of negative consequences.

2.2.1 The rate of alcohol abuse

According to Settertobulte, Jensen and Hurrelmann (2015), in most countries, more than 50% of 11-year-old children have already tried alcoholic drinks at least once. As might be expected, the proportion of those who have never drunk falls steadily in subsequent age groups. Therefore, only a few countries have more than 10% of 15-year-old adolescents with no previous alcohol experience. Norway, Israel and Switzerland have the most abstainers in all age groups. However, here, too, the proportions fall with increasing age. Pledger, Martin and Cumming (2016) found that in New Zealand seventy-nine percent of adults aged 15+ years had drunk alcohol in the previous 12 months. This equates to around 2,833,000 adults. Eighty-four percent of males, compared with 76% of females, reported having done so. The survey further revealed that a greater percentage of people living in the least deprived areas (84%) reported having drunk alcohol in the previous year, compared to those living in the most deprived areas (71%). People living in the most deprived areas were 0.9 times less likely to have drunk alcohol in the past year compared to those living in the least deprived areas, after adjusting for age, sex and ethnic differences.

In 2012/13 most adults had consumed alcohol in the past 12 months, typically doing so in their home or in another's home. Most drinkers made a point of eating always or most of the time when they drank alcohol. A third of drinkers drank alcohol regularly: at least three to four times a week. Half of the drinkers had drunk to intoxication at least once in the past 12 months, with a much smaller percentage reporting drinking to intoxication at least weekly. Furthermore, drinkers reported a range of risky behaviours while drinking. Drinking and driving was most commonly reported, with one in six drinkers who drove in the previous year having driven while under the influence of alcohol.

2.2.2 Socio-economic factors contributing to alcohol abuse

2.2.2.1. Poverty

Poverty plays a role in increasing the possibility of later substance-use, mostly in circumstances of extreme economic deprivation, which co-occurs with childhood behaviour problems. Children and adolescents from low socio-economic families and communities are at high risk of engaging

in substance use (Morojele et al 2013). Furthermore, WHO (2014) concurs with the statement and adds that people with lower socioeconomic status seem to be more susceptible to real problems and consequences of alcohol consumption.

Living through poverty and hardship becomes a continuous assault on the sense of identity and self-worth of whole communities that eventually can lead to the deadening of feelings of hope and sense of possibilities for the future. These are ideal conditions for the likelihood of the use and dependency on alcohol and drugs. This is because it is a way to escape the harsh realities of a life of poverty and struggle (Nicholas, Rautenbach and Maistry, 2010).

2.2.2.2 Employment vs Unemployment

A study by Nyatuoro (2012) on environmental and demographical factors influencing drug and substance abuse, found that both men and women who were employed, household heads, and between the ages of 25 and 34 reported risky drinking since they had greater access to money which enabled them to purchase alcohol. The study further substance abuse among both men and women in South African primary care clinic patients showed that, age range 18-25+, which being employed was cited as a reason for abuse as it made it possible for individuals to buy alcohol and other drugs.

A study by WHO (2011) has also shown that unemployment and heavy drinking tend to go together. The causative effect can work both ways: heavy drinkers have a higher risk of losing their jobs, but becoming unemployed, which often leads to increased drinking. Moreover, both alcohol abuse and unemployment may be caused by a third factor, which may explain why some people are both heavy drinkers and unemployed. Klingemann (2011) concurred with WHO after finding out that many studies have shown that unemployment and heavy drinking tend to go together. The causative effect can work both ways: heavy drinkers have a higher risk of losing their jobs, on the other hand, becoming unemployed often leads to increased drinking.

Dom, Samochowiec, Evans-Lacko, Wahlbeck, Van Hal, McDaid (2016), reported the negative effects of alcohol consumption during economic crisis periods, most frequently associated with unemployment. In Italy, during economic fluctuations, alcohol consumption increased. A Spanish study comparing the pre-and post-crisis years (2006 and 2010), a rise in alcohol dependence and related disorders was found, especially among those who experienced severe economic losses,

such as the unemployed. The economy of the country thus plays a significant role in the behaviour of an individual.

2.2.2.3. Advertisement and media influences

More often, the media makes drinking seem nice and fun. Thus advertising may comprises of items with alcohol brand names, and alcohol companies may sponsor popular events or give free products to young people. However, evidence suggests that alcohol advertising may influence the beliefs and behaviors of young people, causing them to drink illegally (Hanes, 2012). In addition Pettigrew and Donovan, (2013), in their report, indicated that beer marketers are the main sponsors of the most popular sporting codes in Australia, and elsewhere, including South. For example, South Africa have Calling Black label Cup. This marketing obviously reaches children, youth and everyone.

Like tobacco advertising, the advertising of alcoholic beverages has an effect on young people's behaviour. The orientation of advertising messages towards an adolescent lifestyle, including that of young women, appears to be partly responsible for the increasing consumption that is being seen and for the differences in rates of consumption between girls and boys (WHO, 2001).

2.2.2.4 Powerlessness

Nicholas, Rautenbach, and Maistry (2010), in their study, identified powerlessness as another cause of substance abuse. It is a condition in which individuals cannot direct the course of their own lives because of societal conditions and/or power dynamics that place them in devalued positions in society. Where the individual experiences powerlessness, it also makes him/her vulnerable to external influences as ways of coping. Individuals who experience a feeling of powerlessness tend to drink heavily and develop a drinking problem.

2.3.1 Psychological factors contributing to alcohol abuse

2.3.1.1 Stress and life events

According to Nicholas et al, (2010) persons would drink in order to relieve stress and anxiety, and would seek out occasions where drinking would occur and would consume more than their companions. Stress can produce disturbing emotions, impair motor functioning and negatively affect ongoing behaviour. This risk occurs when the stressor that individuals experience in their lives exceed their ability to cope with them in constructive ways. Thus, individuals who experience

stressors for extended periods of time are commonly referred to as vulnerable or at risk. These individuals may be vulnerable to the use and abuse of substances as a means of coping.

A study by Carter, Filoche and Mckenzie (2017), found that for some young people, reasons for drinking imply a more complex picture. Their reasons include drinking to forget about things, to feel more confident and to relax. However, for some older youth, drinking has been cited as a means to cope with stress. Anthenelli and Grandison (2012), have linked alcohol abuse and stress, and found that in the tension-reduction hypothesis, stress was seen to increase anxiety, and in response, alcohol was consumed to reduce the anxiety. The National Institute on Alcohol Abuse and Alcoholism (2012) also associated stress and alcohol abuse. One way that people may choose to cope with stress is turning to alcohol. Drinking may lead to positive feelings and relaxation, at least in the short term.

However, Carter, Filoche and Mckhenzie (2017) argue that reasons for drinking appear to be related to how the young person is drinking – where social reasons (such as enjoy a party) appear to be associated with moderate alcohol use, premeditative drinking (e.g. to get drunk) with risky drinking, and coping motives (for example, reduce stress) with alcohol-related problems. Nicholas, Rautenbach and Maistry (2010), have identified powerlessness as another cause of substance abuse. Where the individual experiences powerlessness, it also makes him/her vulnerable to external influences as ways of coping. Individuals who experience a feeling of powerlessness tend to drink heavily and develop a drinking problem.

2.4.1. Environmental factors contributing to alcohol abuse

Our environment or surroundings can either help or harm us. The environment can affect us negatively, stunting growth and making us at risk for negative influences, especially those like discrimination and oppression. Environmental factors such as disorganized families can contribute to the development of most of the problems a person may face, substance abuse being only one of them. Living in poverty negatively impacts on people's ability to realize their career/economic, education, social and psychological potential (Nicholas et al, 2010).

Literature from Settertobulte, Jensen and Hurrelmann (2015), studied the influence of friends and found that as adolescents grow older, the family becomes less important for the socialization process, while the influence of a person's group of friends increases. This is part of the normal

process of growing up away from parents. In this phase, young people aged between 12 and 24 years typically come together in more or less fixed groups, in which adult behaviour is practiced.

2.4.1.1 Peer pressure

A review of studies of youth between the ages of 16-20 shows that young people are engaged in alcohol use due to developmental tasks such as self-exploration and attachment with peers (Newbury-Birch, 2008). In addition, Morojele, Parry, Brook, and Kekwaletswe (2013), found that peer substance use is a factor that encourages young people to engage in substance abuse. Many young people frequently report their first use of alcohol and other drugs with friends and peers, mostly for recreational purposes. Bezuidenhout, (2008), stated that peer groups act according to subgroups, giving the individual a chance to manifest behaviour that is uncontrolled by the external environment.

Pettigrew and Donovan (2013), indicated that peer pressure to consume alcohol in an obvious sense that appears weak. However, peers who drink gather together as non-drinking youth do. In other words, peer drinking serves to operate as a passive facilitator because it increases the exposure to alcohol, the opportunity for consumption and normalize the behaviour.

According to WHO (2011), as adolescents grow older, the family becomes less important for the socialization process, while the influence of a person's group of friends increases. This is part of the normal process of growing away from parents. During this stage, young people between 12 and 18 years old typically come together in more or less fixed groups, in which adult behaviour is practiced. Belonging to a special group of people is expressed by using symbols. Special patterns of behaviour and attitudes are taken as symbols of a subcultural identity the young people feel committed to (for example, a real Punk has to be drun). These behaviour patterns are often risk behaviours, like alcohol misuse.

2.4.1.2 Family influence

The study conducted by the Department of Basic Education (2013), reported that parents who use drug expose the adolescent to increased danger for alcohol and other drugs use. In South Africa, parental drinking and marijuana use has been found to be related to adolescents' use of illegal drugs. The maltreatment of offspring, such as sexual abuse, physical abuse and neglect, may also lead to childhood psychopathology and later to problem drinking (WHO, 2014). Furthermore, Hassan (2013), argued that parenting practices, especially support and control,

have been associated with an increase of adolescent engaging in drinking, delinquency, and other problem behaviors.

According to the study by WHO (2011), in most cases, the introduction to alcohol consumption takes place in the family, mainly at family events such, as birthdays, marriages and anniversaries. However, children's continuation of alcohol consumption is also dependent on a number of family factors, both risk factors and those with a protective effect. Studies on the influence of the family have shown that this generally has an effect already in childhood and, with a certain degree of latency, determines affinity towards alcohol in adolescence. The research carried out to date has mainly looked at genetic factors, parents' behaviour models, style of upbringing and communication patterns in the family.

2.4.1.3 Availability of alcohol

The findings of a study by the Department of Social Development (2013), revealed that the availability of taverns and shebeens within reach of school premises plays a significant role in the engagement of learners in drug use. Furthermore, learners cannot only access alcohol but dagga too, as some use school breaks to smoke dagga in the school's toilets. The accessibility of low alcohol drinks also increases the chance for many people to consume alcohol (Bezuidenhout, 2008).

Lax control of availability and selling of alcoholic drinks increases higher consumption of alcohol (Petronyte et al, (2007). The increasing tendency of selling alcohol from outlets without valid and necessary licence is making it hard for the control and regulation of such sales inclusive of the sales to person under the age of 18. (National Drug Master Plan, 2013-2017). Although there is a law that governs the sales alcoholic drinks, their availability on the open and black markets stimulates alcohol use and makes them easily accessible (Petronyte et al, 2007, Bezuidenhout, 2008).

Mafa and Ananias (2019), revealed that there is a small percentage of young people who drink traditional beer and some who drink all sorts of alcohol they can access. It was found that it is easier for participants to access traditionally brewed alcohol, as it is available close to their places of residences and was cheaper than commercially brewed alcohol.

Petronytė, Zaborskis, and Veryga (2016), confirmed that local taverns contribute to youth alcohol abuse. The survey revealed that the relationships between drinking behaviour and density of alcohol outlets are complex. Previous research has shown a positive relationship between alcohol outlet density (clustering) and increased local levels of alcohol consumption (WHO, 2018). According to Otieno (2016), the availability of drug peddlers, selling Miraa, tobacco, alcohol and marijuana cheaply in shops encourage students to engage in drug abuse.

Pledger et al (2016), found that greater alcohol outlet density has been associated with increased alcohol consumption. A study by Settertobulte, Jensen and Hurrelmann (2015) argued that where alcohol can only be obtained in a few places, its availability is limited and less is therefore drunk. A study by Wood and Bellis (2017) suggested that reducing the availability of alcohol through restricting the density of alcohol outlets can be effective in reducing alcohol related harm. Furthermore, the effect of staying near alcohol outlets contributes to alcohol abuse by youth due to accessibility. This was confirmed by the survey conducted in New Zealand by Pledger et al (2016). The survey found that the majority of New Zealanders live in an environment where 85% live within two minutes' drive to an alcohol outlet, 66% live within two minutes of an alcohol on-licence outlets (bars, clubs, restaurants and cafés), and 67% live within two minutes of an off-licence alcohol outlet (bottle stores and supermarkets).

2.5.1. The effects of alcohol abuse

The dangerous use of alcohol is one of the world's leading health risks. It is a causal factor in more than 60 major types of diseases and injuries and results in approximately 2.5 million deaths each year. If we take into consideration the beneficial impact of low-risk alcohol use on morbidity and mortality in some diseases and in some population groups, the total number of deaths related to alcohol consumption was estimated to be 2.25 million in 2004 (WHO, 2009). This accounts for more deaths than caused by HIV/AIDS or tuberculosis. Thus, 4% of all deaths worldwide are attributable to alcohol. The harmful use of alcohol is especially fatal for younger age groups and alcohol is the world's leading risk factor for death among males aged 15–59. (WHO, 2011)

2.5.1.1 Injuries and mortality

According to WHO (2011), alcohol related deaths were 3.8% nationwide in 2004. From this statistics, men constituted 6.2% while women constituted 1.1%. Furthermore, South Africa, Cape Town, Port Elizabeth and Durban between 1999 and 2001, up to two-thirds of patients admitted with injuries to trauma units had taken some alcohol. The report further found that 139 patients

were young people below the age of 20 and 27% tested positive for breath alcohol levels (Department of Basic Education, 2013). In addition Morojele et al, (2013) found that the estimated number of alcohol-attributable deaths in South Africa was 33,699 and a large proportion was due to injury, specifically amongst youth between the age of 15-29 years.

WHO (2017), stated that 3.8% of all global death were attributable to alcohol; 6,2% for men and 1,1% for women. However, Wood and Bellis (2017), stated that higher rates of alcohol-related mortality have been reported among lower social economic status/education level groups in many EU countries. Thus, only 3.6% of alcohol users worldwide are alcohol dependent, a condition implying a degree of addiction that makes it difficult for them to abstain or reduce their drinking in spite of it increasingly doing serious harm. An evidence-based literature review reported that for most injury types, alcohol's involvement in the injury is likely to be a matter of an increased rather than certainty. The association of alcohol and injury may just reflect alcohol use being more common among those incurring injuries.

2.5.1.2 Diseases

Alcohol is a contributory factor in sixty types of diseases and injuries and a component cause in 200 others. Alcohol-related diseases include cancer, liver cirrhosis, and as for heart disease it takes time to develop. Alcohol-related deaths are estimated to be at 4%, greater than the deaths caused by HIV/AIDS, tuberculosis or violence. The long-lasting effects of alcohol misuse are hardly seen among young people (Newbury-Birch et al, 2008, WHO, 2011). Bezuidenhout, (2008) added that individuals who excessively use alcohol are reducing the life span by 10 years because alcohol causes the human brain to age prematurely. He further mentioned that abusing alcohol destroys the vitamin B complex in the body, weakening the body's resistance to infections.

The major diseases linked to alcohol are the following: neuropsychiatric diseases, gastrointestinal diseases (such as liver cirrhosis and pancreatitis), cancer, intentional injuries (through violence and suicide), unintentional injuries (such as road traffic accidents and drowning), cardiovascular diseases, foetal alcohol syndrome and pre-term complications as well as diabetes mellitus (Fieldgate et al, 2013). According to WHO (2014), alcohol is linked to the incidence of diseases and the course of disease. Alcohol has also been identified as a component cause for over 200 ICD-10 disease codes. Alcohol-attributable DALYs were for neuropsychiatric disorders which consists of 88% DALYs due to alcohol use disorders and 12% DALYs due to epilepsy and unipolar depressive disorder. The statement also supported a study by Carvaja and Lerma-Cabrera

(2015), which revealed that recently, drinking alcohol has been related to the incidence of infectious diseases such as tuberculosis and HIV/AIDS.

2.5.1.3 Violence

The Department of Basic Education, (2013) reported a solid connection between crime and substance use. The excessive use of alcohol and drug have been associated with homicide, intimate partner violence, rape and abuse of children. The continual use of alcohol and other drug may also motivate users to commit crime in search of money, to buy them. The information collected from 1080 arrestees in Cape Town, Durban and Johannesburg in 2004 showed that 45% had tested positive for at least one substance. Research has shown that most of the crimes committed are due to the psychopharmacological effects of substances ingested by the perpetrator, such as alcohol, certain stimulants, and hallucinogens (Simango, 2014).

According to Klingemann (2011), It is generally believed that when high-risk activities and socially disruptive behaviour are connected with drinking, they are judged less critically than the equivalent sober behaviour. Alcohol and domestic violence are linked to spouse/partner and family structures. The partners of alcohol abusers also pay a heavy price. They are at serious risk of violence, as marital violence is clearly more common among problem drinkers. The family is also liable to split or break up, as several studies on the causes of divorce have shown.

2.5.1.4 Crime, domestic violence and unsafe sexual activity

Jacobs, Steyn And Labadarios (2013), conducted a study on the mind the gap: Observations in the absence of guidelines for alcohol abstinence among expectant women in South Africa stated that associations between alcohol abuse and child abuse have also been reported. According to the South African Police Services (SAPS) Crime Report 2010–2011, 65% of social contact crimes, such as murder, attempted murder, rape and assault, are a result of alcohol and, to a lesser extent, drug abuse.

However, the literature from Carvaja and Lerma-Cabrera (2015), differs with the findings of the study. It nonetheless, revealed the impact of of underage drinking related to unsafe sexual activity. Underage alcohol use has been associated with risky sexual behavior (unwanted, unintended and unprotected sexual activity) and multiple sex partners. For example, 32% of adolescents who started drinking at 13 reported having unplanned sex because of drinking, and 10% reported having unprotected sex because of drinking. Such behavior increases the risk of unplanned

pregnancy and sexually-transmitted infections. Also, young people who drink are more likely to carry out or be victim of physical or sexual assault (Carvaja and Lerma-Cabrera, 2015)

2.3 Current Alcohol Policy In South Africa

2.3.1 The National Drug Master Plan

The National Drug Master Plan was designed to bring together government departments and other stakeholders in the field of substance abuse, to combat the use and abuse of and dependence on dependence-forming substances and related problems. The overall objectives of NDMP is to:

- Ensure coordination of efforts to reduce the demand, supply and harm caused by substance abuse;
- Ensure effective and efficient services for the combating substances of abuse through the elimination of drug trafficking and related crimes
- Strengthen mechanism for implementing cost-effective interventions to empower vulnerable groups
- Promote national, regional and international cooperation to reduce the supply of drugs and other substances of abuse.

2.3.2 The prevention of and Treatment for substance abuse Act no.70 of 2008

Prevention of and Treatment for Substance Abuse Act no. 70 of 2008 was also developed to deal with the prevention of and treatment for substance abuse, such as alcohol and the associated harm. It emphasized that prevention programmes need to be on-going and not once-off.

2.3.3 National Liquor Act no.59 of 2003

The national Liquor Act was developed to:

- reduce the socio-economic and other costs of alcohol abuse by;
- set essential national norms and standards in the liquor industry
- regulate the manufacture and wholesale distribution of liquor

The act further stipulates that a person must not manufacture or distribute liquor, except to the extent that the person is permitted to do so in terms of this Act. It also states that no person is permitted to to manufacture, sell or supply any substance under the name of any liquor or methylated spirits, if that substance is not liquor or methylated spirits, respectively as defined in this act.

CHAPTER THREE

RESEARCH METHODOLOGY

3.1 Study design

The study used a cross-sectional descriptive quantitative design. A survey was used to investigate the factors contributing to alcohol abuse among the youth in Nthabalala Location. Van Rensburg (2013) described cross-sectional descriptive design as the one that researchers use to collect data from a defined population, to describe its current status or condition at one point in time. A cross-sectional study was used in this study because data was collected from the participants at one point in time and because it is cost-effective. A descriptive study is a study aimed at giving specific details of a situation, social environment or relationship (Van Rensburg, 2013). A descriptive study is effective because it attempts to describe and interpret a phenomenon. The study described the demographic characteristics of alcohol abusers's income, age and gender.

A survey can be defined as a systematic collection of specific information, obtained through asking a sample of respondents the same question at a particular point in time. A survey involves investigating a large number of people who are geographically spread out over a wide geographical area. The researcher met with participants in their villages and households. Respondents were asked to fill in a questionnaire in the presence of the the researcher.

3.2 Study setting

This study was conducted at Nthabalala Area. Nthabalala Area is a rural area located 20 km north of Elim and 40 km North West of Louis Trichardt. Nthabalala Area is under the leadership of Thovhele Nthabalala in Makhado Municipality, Vhembe District, Limpopo Province of South Africa. The area is inhabited by mainly Venda people, although there are also few Tsonga people. The area consists of fourteen (14) villages, namely, Masethe, Ramaru, Manyima, Kanana, Mathuli, Mpofu, Maduwa, Ramatshila, Ramulomo, Magobo, Tshathogwe, Vari, Munzhedzi, andMaila. These villages have 189, 69, 281, 760, 165, 195, 162, 448, 167, 635, 240, 2128 and 1700 households respectively. The total number of households are estimated at 7270. The area has only 2 primary health care clinics, situated at Masethe and Magobo villages. There are also 15 taverns, and 11 schools in this area. Agriculture is the most common occupation for supporting the families while some depend on social grants, such as the Child Support Grant. The majority of elderly persons sell homebrew beer (mahafhe) as a source of income.

The educational level of the community is described as poor because there are many of school drop-outs, high crime rates, unemployment and lack of recreational facilities.

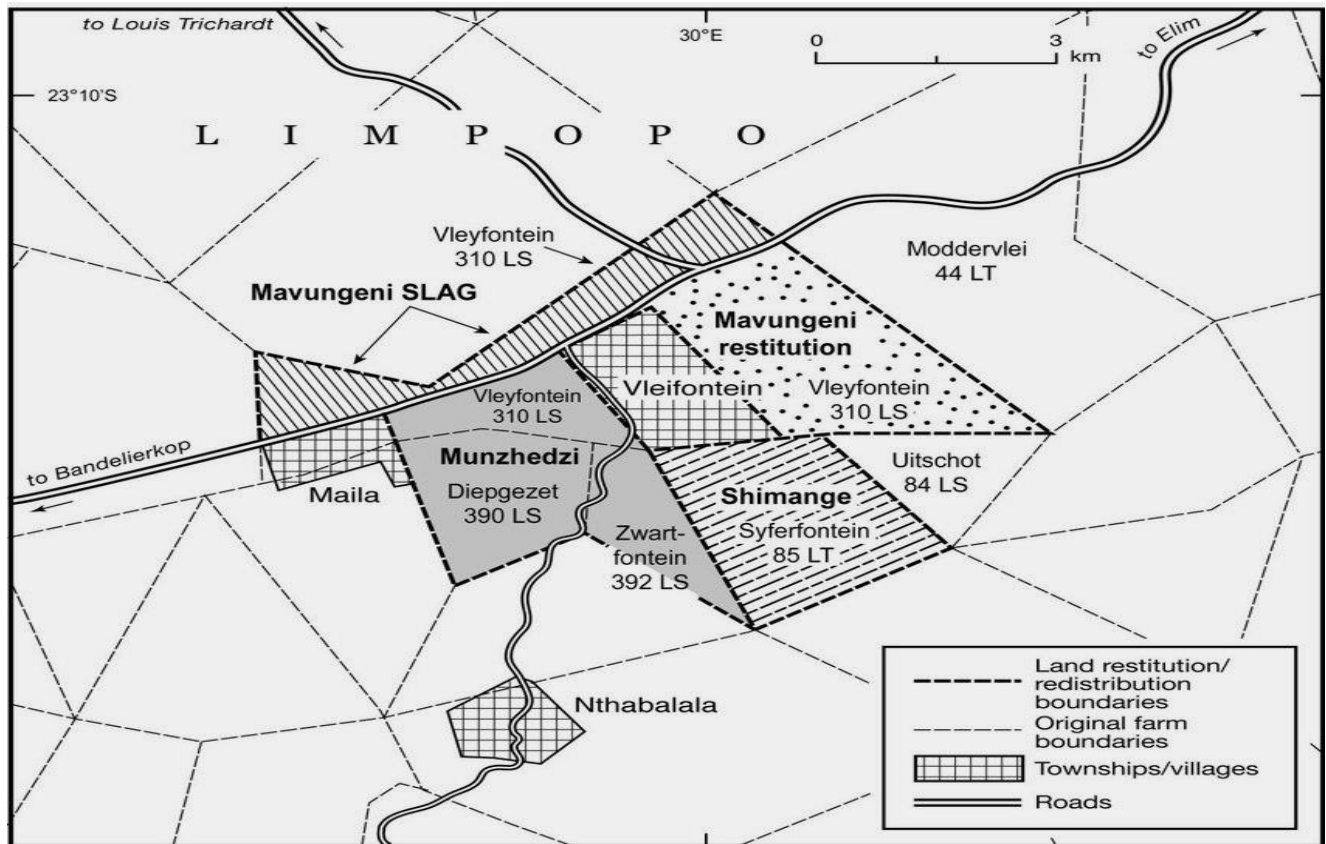


Figure 2.1: A map showing Nthabalala area (Makhado Municipality)

3.3 Study population and sampling

3.3.1 Population

Hewstone, Stroebe & Jonas (2015) define a population as the entire groups of people or objects that are of interest to the researcher. In addition De Vos, Strydom, Fouché & Delport (2013) defined population as a set of individuals, subjects, events or elements or objects that possess or meet the same criteria for inclusion in the study. The study population were male and female youths age of 16-35 years. In the case of a child, a guardian was given a consent form to sign on behalf of the child. The population were youth who were residents of the villages falling within Nthabalala Area. There are 14 villages within the Area of which consists of 2266 youth (see table 1).

Table 3.1: Population frame

Villages	Total Number of Youth	
Village 1: Masethe	75	$75/2266 \times 100 = (3.30\%)$
Village 2: Ramaru	21	$21/2266 \times 100 = (0.92\%)$
Village 3: Manyima	153	$153/2266 \times 100 = (6.75\%)$
Village 4: Kanana	320	$320/2266 \times 100 = (14.12\%)$
Village 5: Magobo	52	$52/2266 \times 100 = (2.29\%)$
Village 6: Maila	410	$410/2266 \times 100 = (18.09\%)$
Village 7: Mathuli	40	$40/2266 \times 100 = (1.76\%)$
Village 8: Munzhedzi	650	$650/2266 \times 100 = (28.68\%)$
Village 9: Ramatshila	73	$73/2266 \times 100 = (3.22\%)$
Village 10: Ramulumo	104	$104/2266 \times 100 = (4.58\%)$
Village 11: Tshathogwe	120	$120/2266 \times 100 = (5.29\%)$
Village 12: Vari	103	$103/2266 \times 100 = (4.54\%)$
Village 13: Maduwa	85	$85/2266 \times 100 = (3.75\%)$
Village 14: Mpofu	60	$60/2266 \times 100 = (2.64\%)$
TOTAL	2266	(100%)

3.3.2 Sampling

Considering the number of villages, time and budget constraints, only eight (8) villages with a total number of 637 youth; and which are close to each other, the researcher observed that they have more than one tavern and there is a high number of people selling home-brewed beers. The eight villages purposively selected were Mpofu, Maduwa, Vari, Tshathogwe, Ramulomo, Ramatshila, Magobo and Mathuli.

3.3.2.1 Sample size

The sample size was calculated using Slovin's (1960), formula as cited by Guilford and Frucher (1973), where N is the total number of population, n is the sample size and e is the level of error, in this study level of error is 0.5:

$$\frac{n}{1+N(e)^2} = N$$

$$\begin{aligned} n &= \frac{637}{1 + 637(0.05)^2} \\ n &= 637 / (1 + 637 \times (0.05)^2) \\ &= 637 / (1 + 1.5) \\ &= 637 / 2.5 \\ \text{Sample size (n)} &= 255 \end{aligned}$$

3.3.2.2 Sample frame

A propotional sample size was also be calculated using the Slovin's formular per selected village (see Table 2). This means that from village 1, only 21 youth participated.

Table 3.2: Propotional sample size per village.

Villages	Total No. of sample in each village	Percentage (%)
Village 1: Magobo	255/637 x 52 = 21	8.02 %
Village 2: Mathuli	255/637 x 40 = 16	6.27%
Village 3: Ramatshila	255/637 x 73 = 29	11.37%
Village 4: Ramulumo	255/637 x 104 = 42	16.47%
Village 5: Tshathogwe	255/637 x 120 = 48	18.82%
Village 6: Vari	255/637 x 103 = 41	16.07%
Village 7: Maduwa	255/637 x 85 = 34	13.33%
Village 8: Mpofu	255/637 x 60 = 24	9.41%
TOTAL	255	100%

The systematic sampling technique was used to select households until the total sample size was reached. Thus, the total number of households in a village were divided by the sample size, to find the ; the K value; that is, $K = 637 / 255$. This gives the value of 02, meaning that in all villages every 02nd household was selected for the study. The first house was chosen randomly by the researcher, and then other households were chosen at every 02nd interval. In each selected household, one youth representative was selected to participate in the study. In case of refusal, the next household was chosen for the study and from that household the researcher started counting up to the 02nd household again. Even though the sample size was 255, the sample size was increased by 45 to make provision to cover for non-responses, constituting a sample size of 300.

3.2.3 Inclusion

Youth between 16-36 years who abused alcohol and were residents of the eight (8) villages were sampled for the study. All youth residing in other villages were excluded even if they fell within the Nthabalala Area.

3.4 Data Collection Instrument

The researcher used a self-administered questionnaire to collect data because it keeps the participants anonymous, as participants were encouraged not to write their personal details on the questionnaire. Questionnaires allow the respondents to be more honest by providing anonymity. The questionnaire consisted of 6 sections; namely, **Section A:** Demographic information of respondents, **Section B:** Rate of alcohol abuse, **Section C:** Socio-economic factors which contribute to alcohol abuse, **Section D:** Psychological factors which contribute to alcohol abuse, **Section E:** Environmental factors which contribute to alcohol abuse **Section F:** Perceived health effects. The questionnaire contained closed ended questions and gave the participants an option to choose from two alternatives, yes or no. The questionnaire was constructed in English based on various literature reviews but the researcher translated it into Tshivenda.

3.5 Pre-test

The pre-test was done using volunteers in a youths in a neighbouring village to Nthabalala Area, as they shared some common features of being rural areas. Atleast 10% of the population size was sampled (37 or 38 households) of youths were selected randomly. The aim of the pre-test

was to modify some aspects of the questionnaire and making it understandable to the participants.

3.6 Validity and reliability

The researcher ensured validity and reliability when developing the instrument. Polit & Beck (2012), defined validity as a term describing a measure that accurately reflects the concept it is intended to measure. Reliability is defined as the dependability or consistency of the measure of a variable (Neuman, 2011).

3.6.1 Validity

This study ensured validity by means of content validity. Van Rensburg (2013), defined content validity as the extent to which the study confirms the existence of a cause-effect relationship. The content validity of the questionnaire was determined by expert judgment, as the instrument was scrutinized by the supervisors of the study, to assess the appropriateness of the content of the questions and to determine the questions that needed to be amended, so as to achieve the objectives of the study. Face validity was done by arranging the order of the questions according to the objectives of the study.

3.6.2 Reliability

The correlation coefficient of the instrument was tested using the test re-test method of reliability testing. The instrument was administered to 10% of the sample size of 255 participants, to measure accuracy and consistency of the questionnaire, to check if it produced the same results over time. The aim of administering the test on two occasions was to avoid participants memorizing the answers they gave the first time. The correlation-coefficient should be close to 1, to show the reliability of the instrument. If the correlation coefficient is less than 0.5, the instrument is to be modified because there will be no relationship between the instrument and what it intends to measure.

3.7 Plan for data collection

Data was collected by distributing questionnaires among participants, who were each given a chance to respond confidentially and independently in English or in the language that the participants understood, which is Tshivenda. However, the researcher was around to clarify and assist with completing the questionnaires among those who were illiterate. The questionnaires

were distributed to all the youth who abused alcohol. Questionnaires were given to those who volunteered to participate in the study. The researcher ensured a high response rate by handing out the questionnaires and then collecting them after completion. The participants were also provided with an envelope to put the questionnaires in and then drop them in a box for the researcher to collect.

3.8 Plan for data management and analysis

The completed questionnaires were checked thoroughly to ensure that every question had been filled out correctly and there were no gaps when a participant submitted them. The questionnaires were numbered and coded for ease of handling. Data from structured questionnaires were entered, checked, cleaned and analysed using the Statistical Package for the Social Science version 26. Descriptive statistics which contain the following were used to analyse data: Mean, Standard Deviation and frequencies. The chi-square test was used to categorise variables in case of any relationship. Data was presented using graphs and tables.

3.9 Ethical considerations

According to Monette, Sullivan, & Dejong (2011) ethics in research are guidelines that regulate acceptable behaviors between the researcher and the participants. Duploy (2009) states that ethics are the study of standards of conduct and value, and in research how those impact on both the researcher and research subject.

3.9.1 Permission to conduct research

The researcher's proposal were presented to the Higher Degree Committee of the School of Health Sciences at the University of Venda for recommendation for ethical clearance by the University Research and Ethics Committee. The Ethical Certificate Clearance was submitted to the Chief Thovhele Nthabalala and his headmen for permission to conduct the study (Appendix D). Permission was also from the University Higher Degree Committee.

3.9.2 Informed consent

Every participant was informed that participation in the study is voluntarily and there would be no any participation incentives would be given. Participants were also informed that they had a right to withdraw at any stage or decline to respond to whichever questions they felt uncomfortable

with. In case of a child below the age of 18, a guardian was given the consent form to sign on behalf of the child. Consent forms (appendix E and F) were distributed to each of the participants.

3.9.3 Confidentiality

Confidentiality means that individual identities of participants will not be linked to the information they provide and will not be divulged (LoBiondo-Wood & Harber 2014)

The information that was obtained from the participants was treated as confidential. The instrument was constructed in such a way that names or any form of identity did not appear on the instrument or any document where data would be store. The researcher also made sure that the information provided by participants was protected and unavailable to anyone other than the researcher and the supervisor.

3.9.4 No harm to participants

No harm to participants is the requirement that there might be physical or psychological danger as a result of participation in the study (Nicholas, Rautenbanch & Maistry, 2010). In addition, Akinsola (2015) states that freedom from harm implies that the researcher should protect the study participants from any form of harm or injury, whether physical, psychological or emotional.

The researcher protected the study participants from harm any forms of harm such as humiliation, physical discomfort, embarrassment, by not deceiving or lying to them. The reseacher also kept the participants' information confidential, to avoid humiliation and ensured that they were comfortable throughout the study process.

3.9.5 Voluntary participation

According to Neuman (2011), voluntary participation is an ethical principle that people should never participate in research unless they have explicitly and freely agree to participate.

The researcher did not force the participants to participate in the study by means of bribery or promising them something in return. The researcher also explained to the participants that their participation was voluntarily and they could withdraw from participating any time they felt they did not want to be part of the study anymore.

3.10 Scope and limitations of the study

The limitations of the study are challenges or obstacles that might be encountered in the study. The participants, especially those who were alcohol abusers, could refuse to participate in the study unless they were compensated. Some of the youth might not participate because they knew the researcher and they may suppose that the researcher would not keep their information confidential or he might be judgemental. Some might refuse to participate because the researcher is from the same area, and they might suppose that their participation would help researcher become successful in his education.

3.11 Plan for dissemination and implementation of results

The results of the study will be published in the international and national journals. The results will also be distributed to the library and presented in international conferences.

3.12 Conclusion

In this section the research design and study design, study setting or area of study, study population and sampling, measurement instrument, pre-test of the instrument, validity and reliability, plan for data collection, data analysis and ethical considerations were discussed.

CHAPTER FOUR

DATA ANALYSIS, PRESENTATION AND INTERPRETATION

4.1 Introduction

The purpose of this chapter is to presents the results of the sudy and interpretation of the findings based on the analysed data. It comprises of the six sections from the questionnaire; namely: demographic information, rate of alcohol abuse, socio-economic factors, enviornmental factors and perceived health effects of alcohol abuse. The results are presented statistically in the form of frequencies and percentages.

4.2 Demographic Information

A total of 255 participants agreed to take part in the study. Table 4.1 shows the demographic data of the respondents from the eight villages. The findings show that the majority of the participants were males (60.4%), whilst females were at (39.6 %). Regarding age, 14.9% of the respondents were below the age of 20, whilst 32.9% were in the age range 21-25 years. Most of the participants (47 or 18.4%) were from Tshathogwe village whilst, the fewest (16 or 6.3%) were from Mathuli village. One hundred and ninety (74.5%) respondents were single, followed by fifty-two (20.4%) respondents who were married, whilst the remainder (1.2%) were widowed. It also shows that 118 (46.3%) were still attending school, while 47 (18.4) had dropped-out of school. Another 4 (1.6%) were attending primary school, 63 (24.7) were at secondary level, 73 (28.6%) were staying with their single mother, whilst 56 (22.0%) were staying with both parents.

Table 4.1 Demographic information of the participants (N=255)

Variables	Frequency (N)	Percentage (%)
Gender N =255		
Male	154	60.4%
Female	101	39.6%
Age range N =255	255	100%
16-20	38	14.9%
21-25	84	32.9%
26-30	70	27.5%
31-35	63	24.7%

Village N =255		
Mathuli	16	6.3%
Magobo	21	8.2%
Tshathogwe	47	18.4%
Ramatshila	29	11.4%
Ramulumo	42	16.5%
Vari	41	16.1%
Maduwa	35	13.7%
Mpofu	24	9.4%
Marital status N =255		
Married	52	20.4%
Single	190	74.5%
Divorced	10	3.9%
Widowed	3	1.2%
Attending school N =255		
Yes	118	46.3%
No	90	35.3%
Dropped-out	47	18.4%
Type of schools N =255		
Primary	4	1.6%
Secondary	63	24.7%
Tertiary	48	18.8%
Dropped-out	140	54.9%
Family type		
Mum and Dad	56	22.0%
Single Mum	73	28.6%
Single Dad	10	3.9%
Foster parents	12	4.7%
Aunt/Uncle	13	5.1%
Grandparent(s)	33	12.9%
Siblings	13	5.1%
Wife	28	11.0%
Husband	17	6.7%

4.3 Rate of alcohol abuse

4.3.1 Do you take alcohol?

In order to ensure that all sampled participants were alcohol abusers, participants were asked if they really drank alcohol. Figure 4.1 below shows that 255 (100%) agreed that they took alcohol.

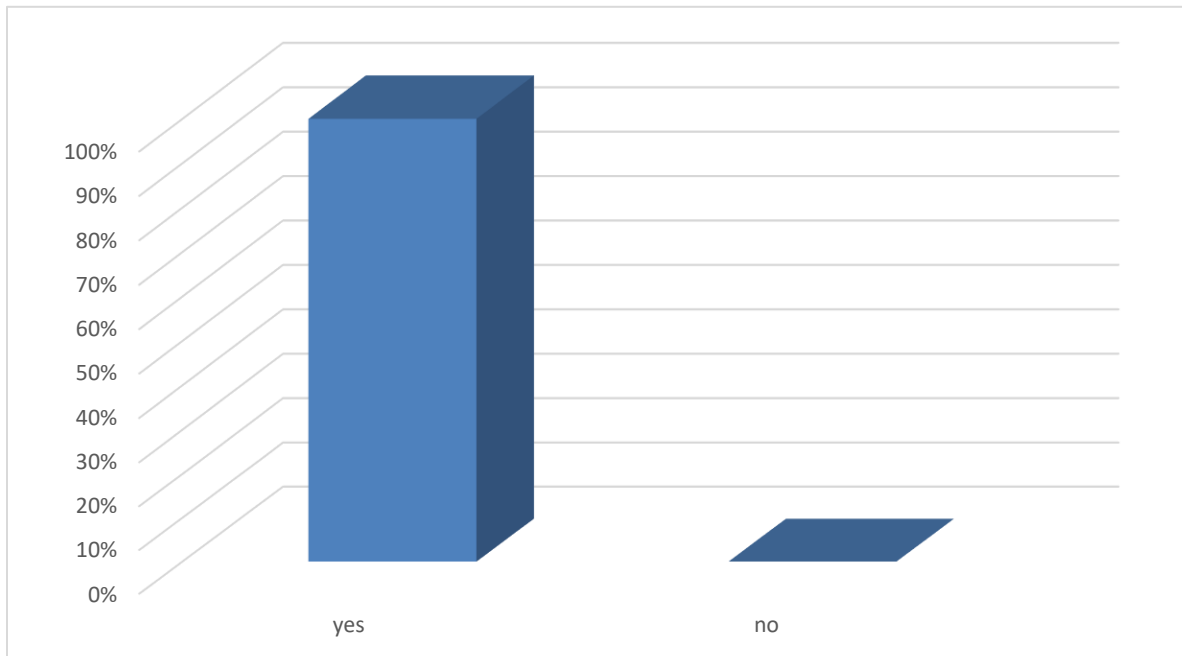


Figure 1: Alcohol abusers (N=255)

4.3.2 How long have you been drinking.

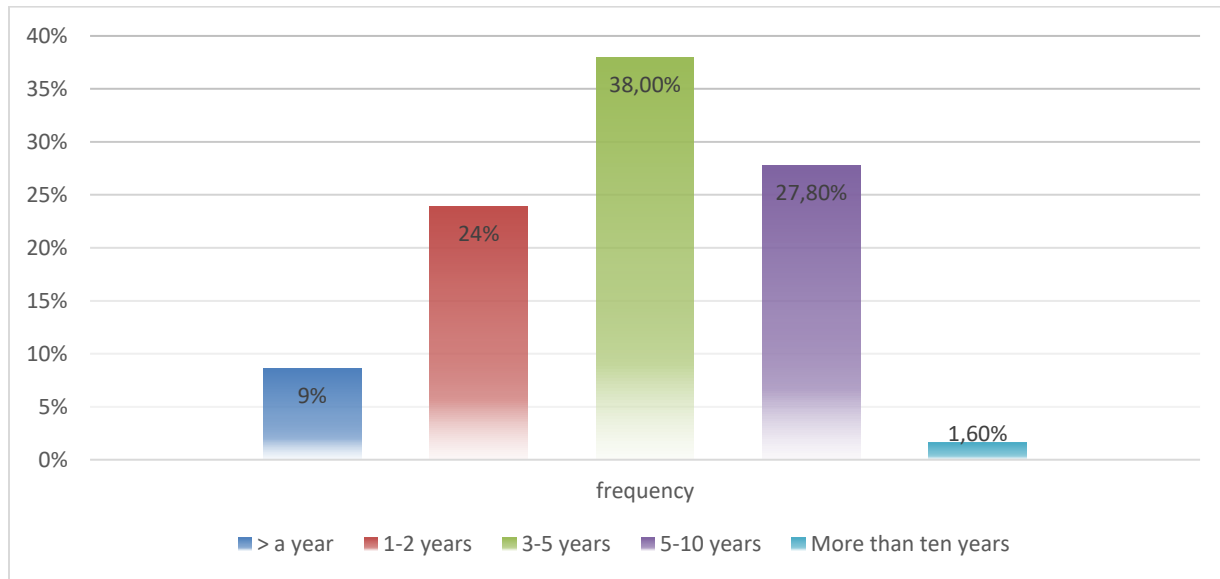


Figure 2 Years of drinking (N=255)

Figure 4.2 illustrates the years for which participants had been taking alcohol. Many of the participants (38%) had been drinking for more than three years, followed by some (27.8%) who had been drinking for more than five years. The lowest group (1.6%) had been drinking for more than 10 years.

4.3.3 Distribution of respondents by age of first intake of alcohol

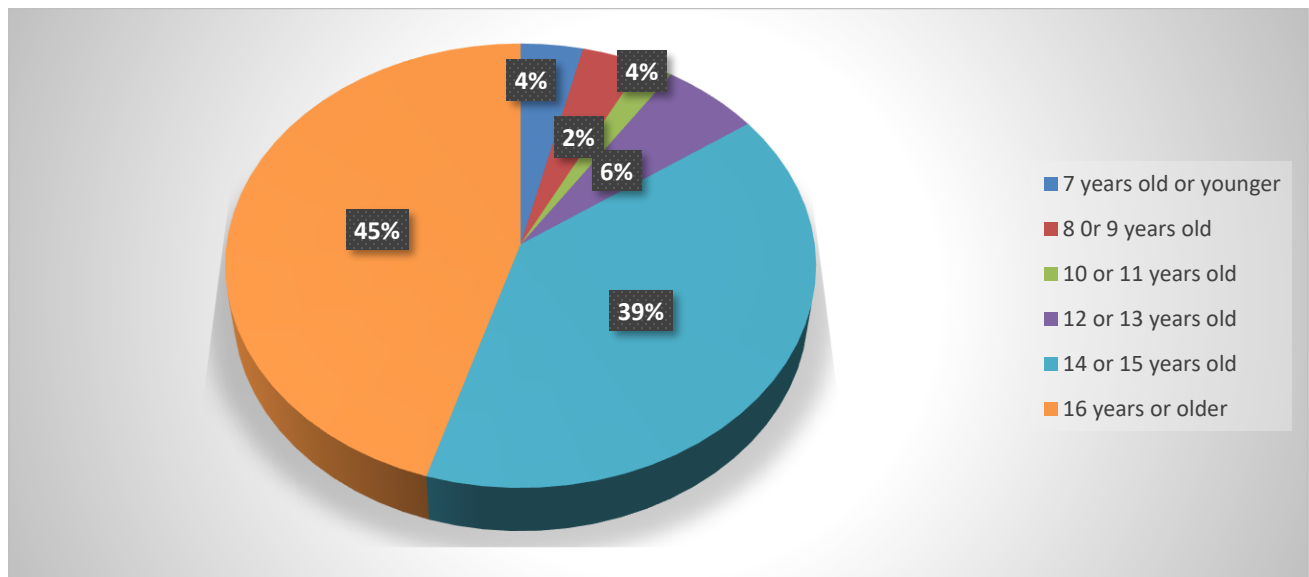


Figure 3 Age of first intake (N=255)

Respondents were asked to state the ages at which they started taking alcohol. The pie chart above shows the age at which participants started taking alcohol. The findings showed that almost half (45%) of the participants started drinking alcohol after sixteen years of age, whilst 39% started drinking alcohol at the age of 14 or 15 years. The study further revealed that very few (2%) of the participants started drinking alcohol at the age of 10 or 11 years.

4.3.4 Distribution of respondents by number of drinks participants drank per day

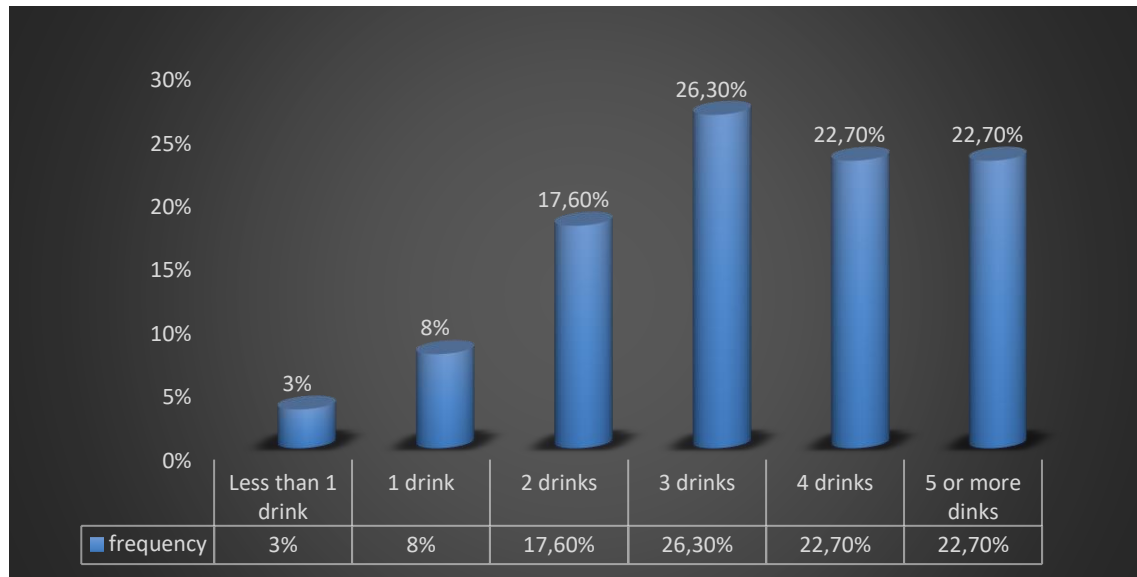


Figure 4 Number of drinks participants drank per day (N=255)

Respondents were asked how many drinks they took per day. Figure 4.4 shows different percentages of the respondents on the number of drinks consumed per day. The findings shows that about a third of the participants (26%) take 3-drinks a day, followed by 22.7% who take 4-drinks and 5 or more drinks a day, respectively. About half (45%) mentioned that they took more than 5-drinks a day.

4.3.5 How often do you drink alcohol

Table 4.2 Number of days when participants take alcohol (N=255)

Days spend drinking alcohol	Frequency (f)	Percentage (%)
Daily	137	53.7
Once a week	77	30.2
Weekly	7	2.7
Monthly	8	3.1
Other	26	10.2
Total	255	100.0

The results in Table 2 indicate that, the majority of participants (53.7%) took alcohol on a daily basis, followed by a third (30.2%) which took alcohol once a week. The other participants (10.2%) mentioned that they only drank alcohol occasionally, when there was an event, such as birthday parties or other events where they could get free alcohol.

4.3.6 Have you ever increased your drinking because the amount you used to drink did not give you the same effect?

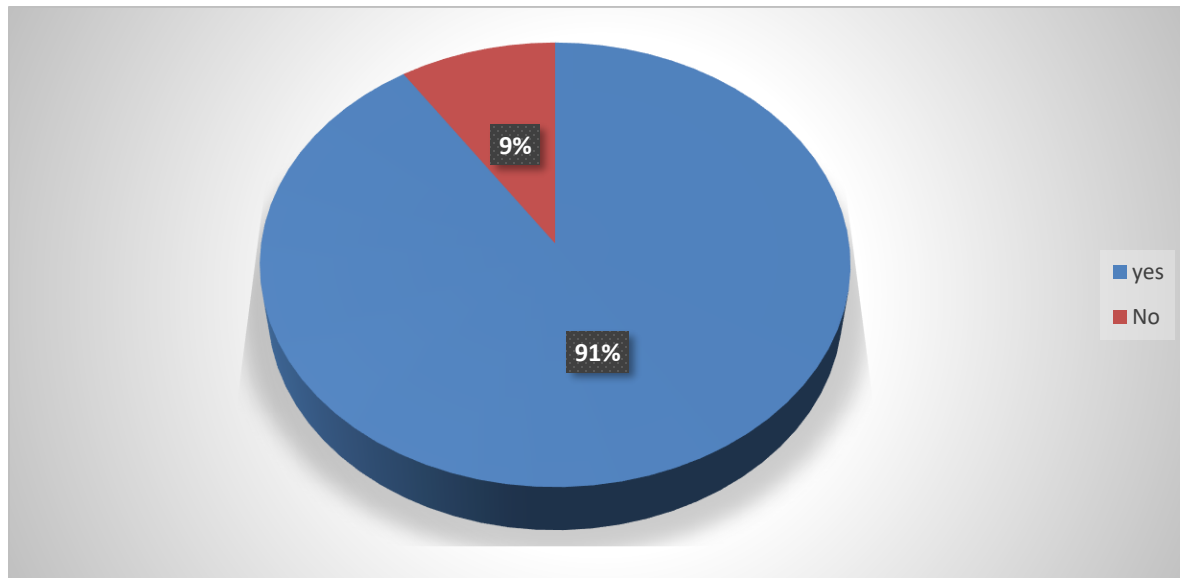


Figure 5 Distribution of respondents by checking if they had ever increased their alcohol intake because the amount of alcohol they used to take did not give them the same effects (N=255)

The results in Figure 4.5 indicate that most of the participants (91%) agreed that they had increased the drinking because the amount of alcohol they used to drink before did not give them the same effects, while the remainder (9%) disagreed that they had ever increased the amount of liquor.

4.4 Socio-economic factors

The findings in Figure 4.6 below regarding employment status shows that the about half of the participants (46%) were students, followed by a third (36%) who were unemployed, 6% were self employed, while the remainder were employed.

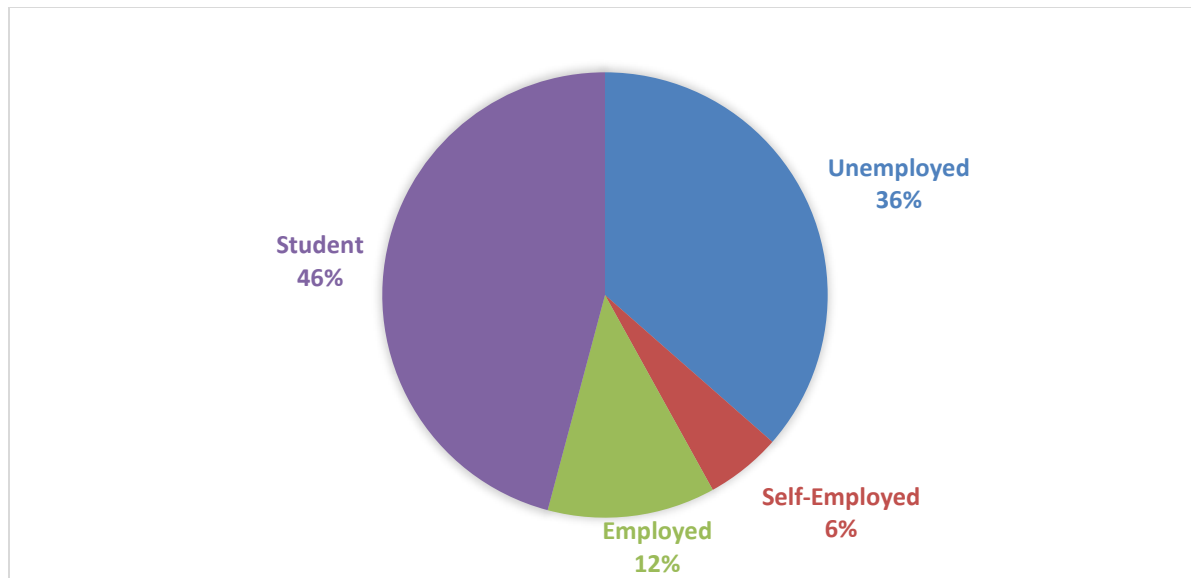


Figure 6 Employment status (N=255)

4.4.1 If employed, where do you work?

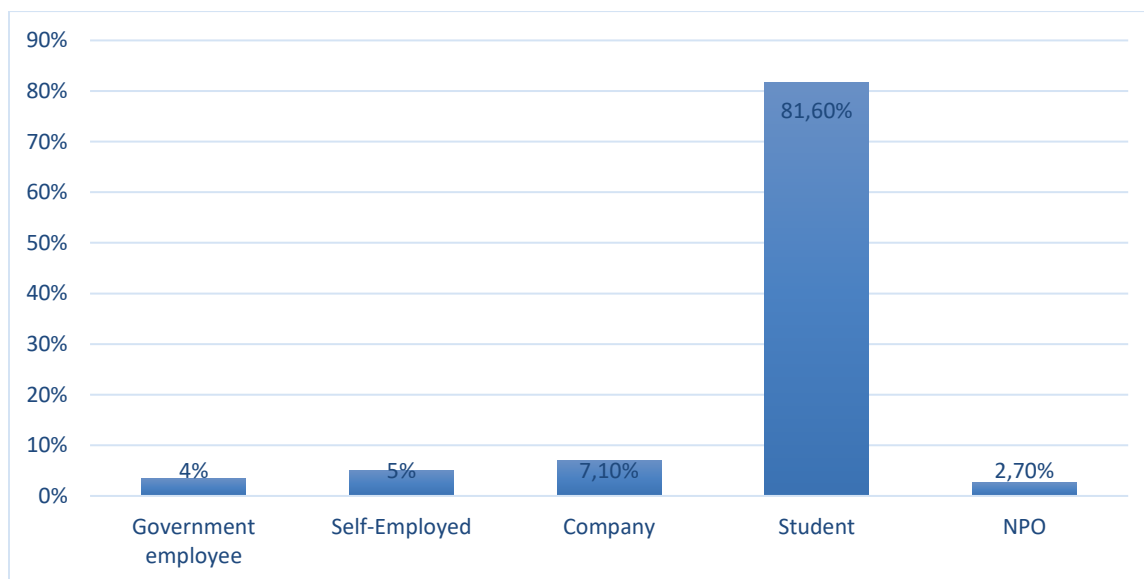


Figure 7: Occupation type (N=255)

It is evident from the data shown in Figure 4.7 that the majority of participants (81.6%) were not working as they were still students at secondary and tertiary levels. However there were very few participants (7.10%) who were working at companies; hence the fewest participants (2.7%) mentioned that they were working at NPOs.

4.4.2 if unemployed, have you ever worked before?

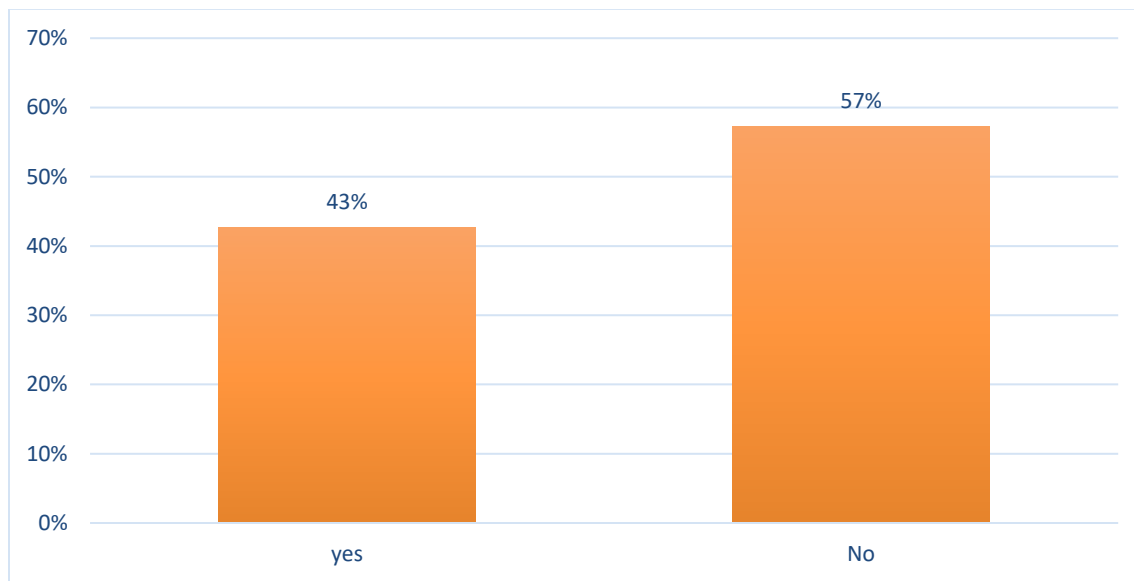


Figure 8: Have you ever worked before? (N=255)

It is evident from the data shown in Figure 4.8 that out of the 250 participants, just over half (57%) disagreed that they had worked before, while the remainder (43%) agreed that they had worked before.

4.4.3 If you have worked before, what happened to you job?

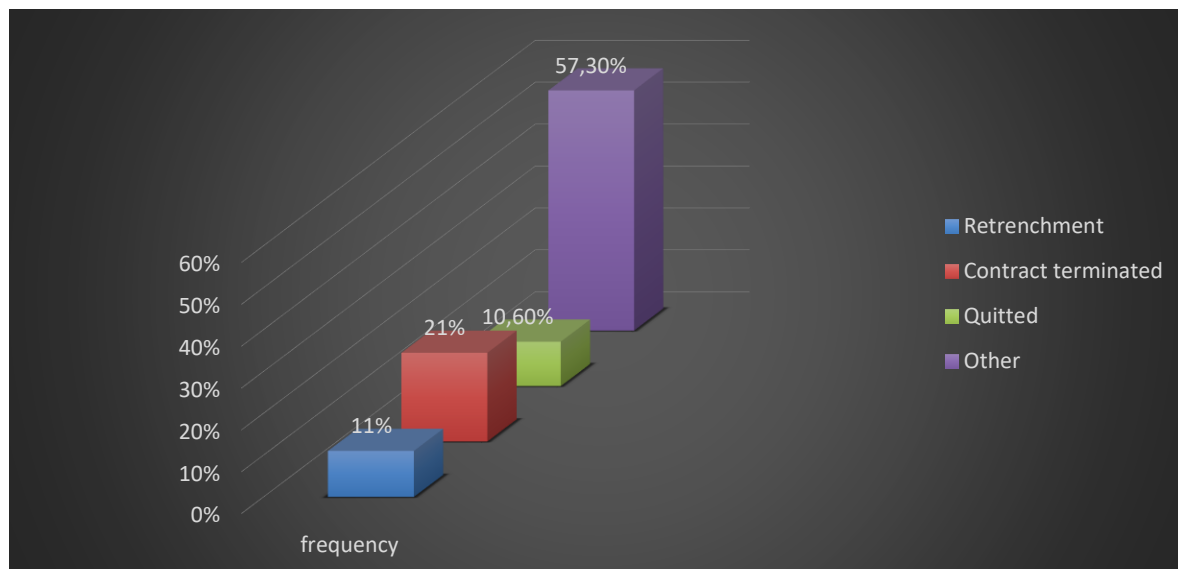


Figure 9: What happened to you job? (N=255)

The findings in Figure 4.9 above indicate that the majority of participants (other-57.3%) indicated that they were still students and had never worked, followed by 21% of the participants, whose contracts had been terminated, while 11.0% of the participants said they were retrenched. The findings further illustrate that even though some participants' contracts had been terminated there were few participants (10.6%) who just quit their work.

4.4.4 Household gross monthly income

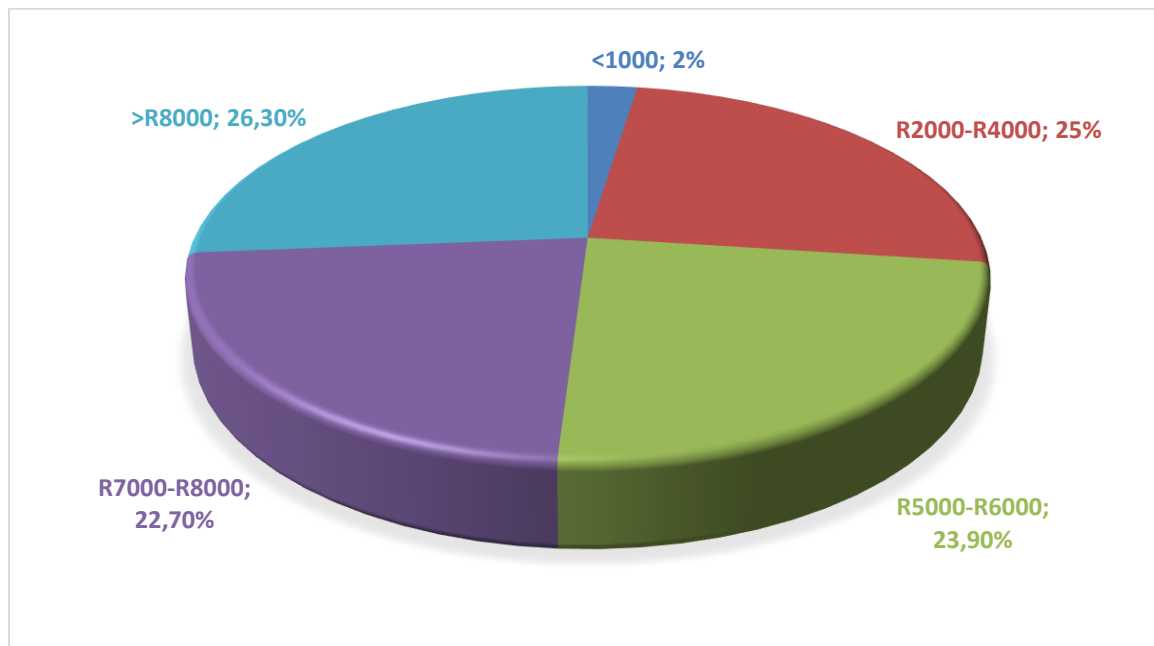


Figure 10: Household gross monthly income (N=255)

The findings in Figure 4.10 shows the gross monthly income of the participants, where one fifth of the participants (26.3%) earn more than R8000,00 per month, followed by 23.9% whose gross monthly income was R2000-R4000. The findings further indicate that only 2% earned gross monthly income of below R1000,00. The explanation for the finding is that the majority of participants (73.7%) had gross monthly income of less than R8000,00 as compared to 26.3% whose gross monthly income was more than R8000,00. However, most of the participants were employed.

4.4.5 Money saved for entertainment

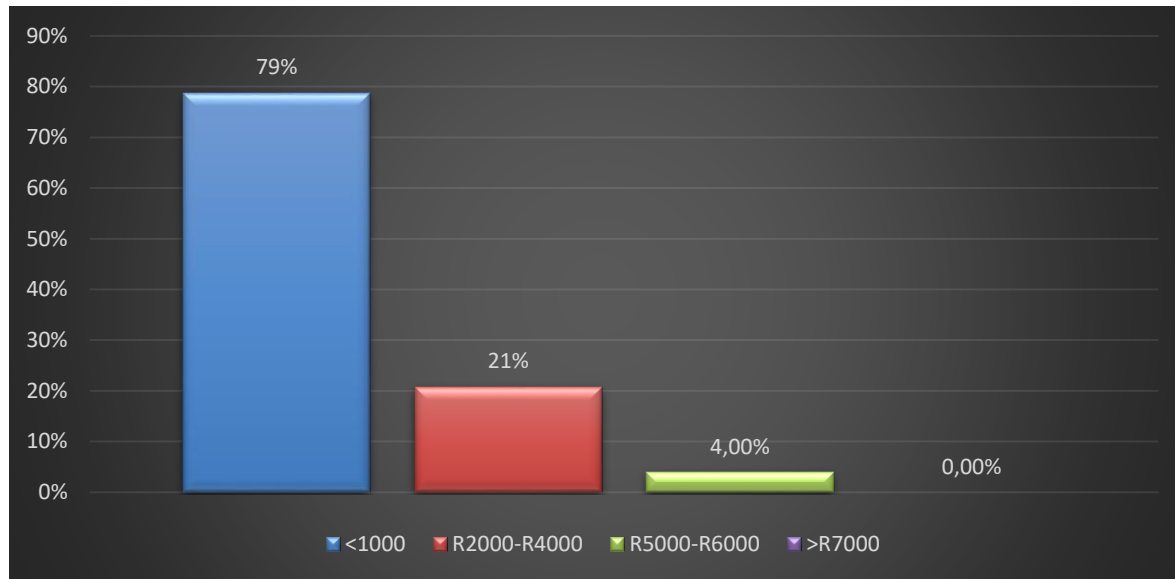


Figure 11: Money saved for entertainment (N=255)

It is evident from the data in Figure 4.11 about the money saved on a monthly basis for entertainment, that the majority of participants (100%) saved less than R6000 on a monthly basis for entertainment. The findings further show that most of the participants (79%) saved less than R1000,00 for entertainment, followed by 21% who saved R2000-R4000 for entertainment. However, very few participants (4.0%) saved between R5000-R6000 for entertainment on a monthly basis. No participant(s) saved more than R7000,00 for entertainment monthly.

4.4.6 Affordable alcohol beverages

Table 4.3 Affordable alcohol beverages (N=255)

Alcohol Beverages	Frequency (f)	Percentage (%)
Beer	172	67.5
Wine	25	9.8
Spirits	5	2.0
Mahafhe	53	20.8
Total	255	100.0

The findings in Table 3 indicate the most affordable alcohol beverages for participants. The findings further reveal that the majority of participants (67.5) indicated that beer is the most affordable alcohol beverage, while some (20.8%) mentioned Mahafhe (homemade traditional

beer) as their affordable alcohol beverage. Very few participants (2.0%) mentioned spirits as their affordable alcohol beverage.

4.4.7 How often do you drink your affordable alcohol?

Table 4.4 Number of days participants drink their affordable alcohol? (N=255)

Days spend drinking alcohol	Frequency (f)	Percentage (%)
Daily	137	53.7
Once a week	77	30.2
Weekly	7	2.7
Monthly	8	3.1
Other	26	10.2
Total	255	100.0

The findings in Table 4 shows that the majority of participants 137 (53.7%) mentioned that they drink their affordable alcohol beverage on a daily basis, followed by 77 (30.2%) who said they drank their affordable alcohol once a week. The study findings further show that 26 (10.2%) indicated that they drink occasionally.

4.4.8 Persons whom the respondents spend most their time with

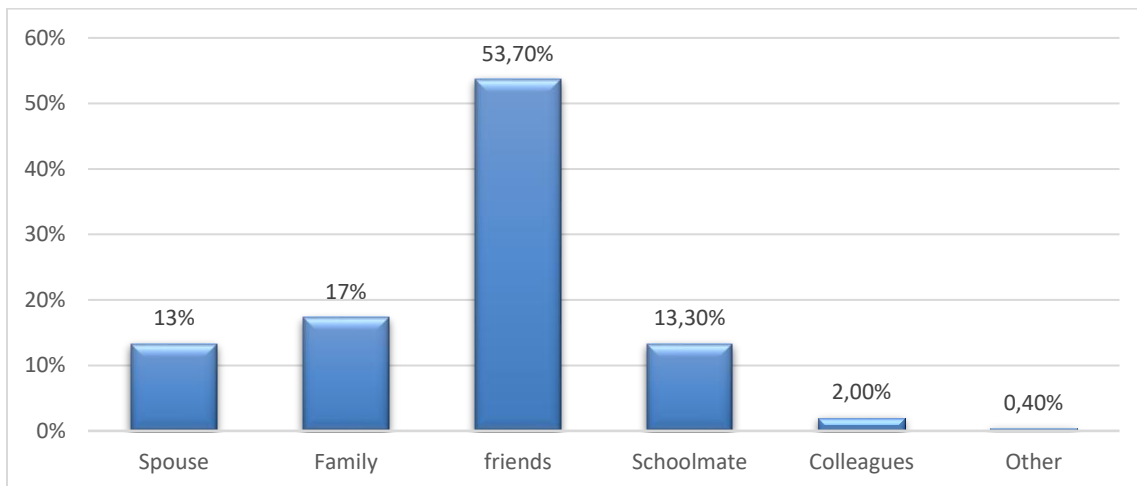


Figure 12: Persons whom the respondents spend most their time with (N=255)

It is evident from the data shown in Figure 4.12 that the majority of participants (53.7%) spent most of their time with their companions. Moreover, 17 % of the participants mentioned that they spend most of their time with family hence 13,3% and 13% participants said that they spent most

of the time with schoolmates and spouses, respectively. However, one (1) participant (0.4%) mentioned that he spent most of his time just chilling alone.

4.4.9 Do the people participants spend most of their time with drink alcohol?

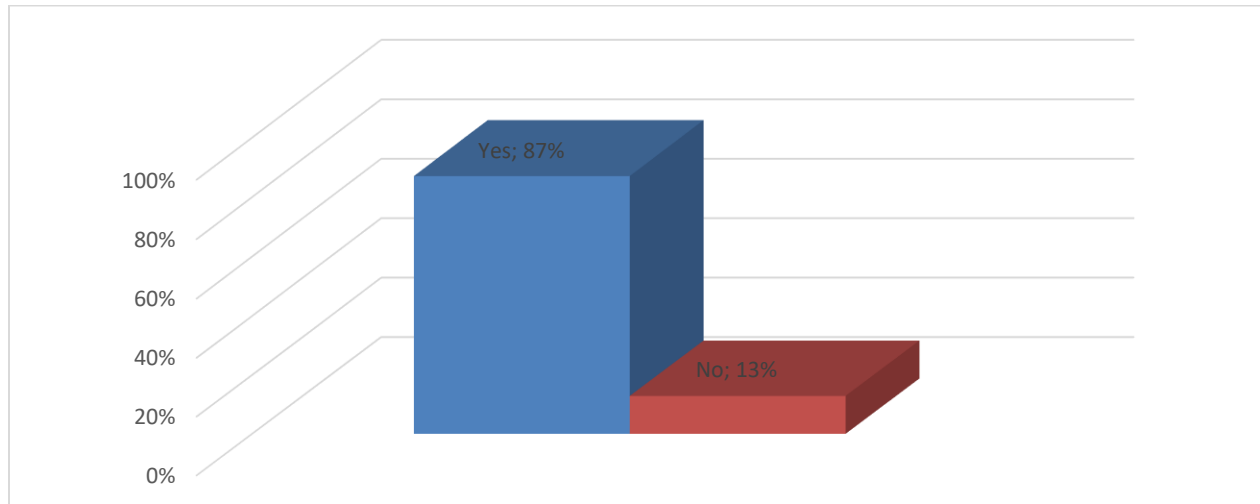


Figure 13: Do the people participants spend most of their time with drink alcohol (N=255)

The findings in Figure 4.13 indicates that out of the 255 participants, (222 or 87%) agreed that people whom they spend most of their time with drink alcohol, while few (33 or 13%) mentioned that people they spent most of their time with did not drink alcohol.

4.4.10 What participants do with their leisure time

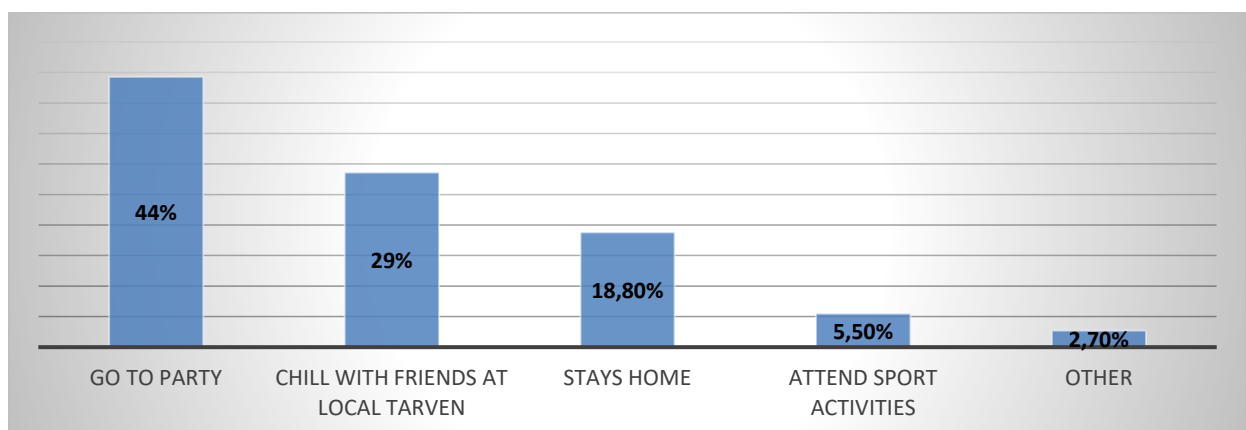


Figure 14 Distribution of respondents by what they do with their leisure time (N=255)

It is evident from the data in Figure 4.14 that the majority of participants (44%) spend their leisure time attending parties, followed by a third (29%) who relax during their leisure time; they relaxed with their friends at local taverns. The findings further show that (other-2.7%) spent their leisure time studying and performing odd jobs.

4.5 Psychological factors

4.5.1 What participants do to relieve stress

Table 4.5 Ways to relieve stress (N=255)

Ways to relieve stress	Frequency (f)	Percentage (%)
Sleep	38	14.9
Drink alcohol	191	74.9
Talk to someone	25	9.8
Other	1	0.4
Total	255	100.0

The findings in Table 5 show that the majority of participants 191 (74.9%) drink alcohol when they are stressed to relieve the stress. The findings further shows that 38 (14.9%) of the participants sleep when they are stressed, as a way of relieving the stress. However, only one (1) participant (other-0.4%) mentioned that she just kept quiet when she was stressed.

4.5.2 Do family expectations make participants drink alcohol?

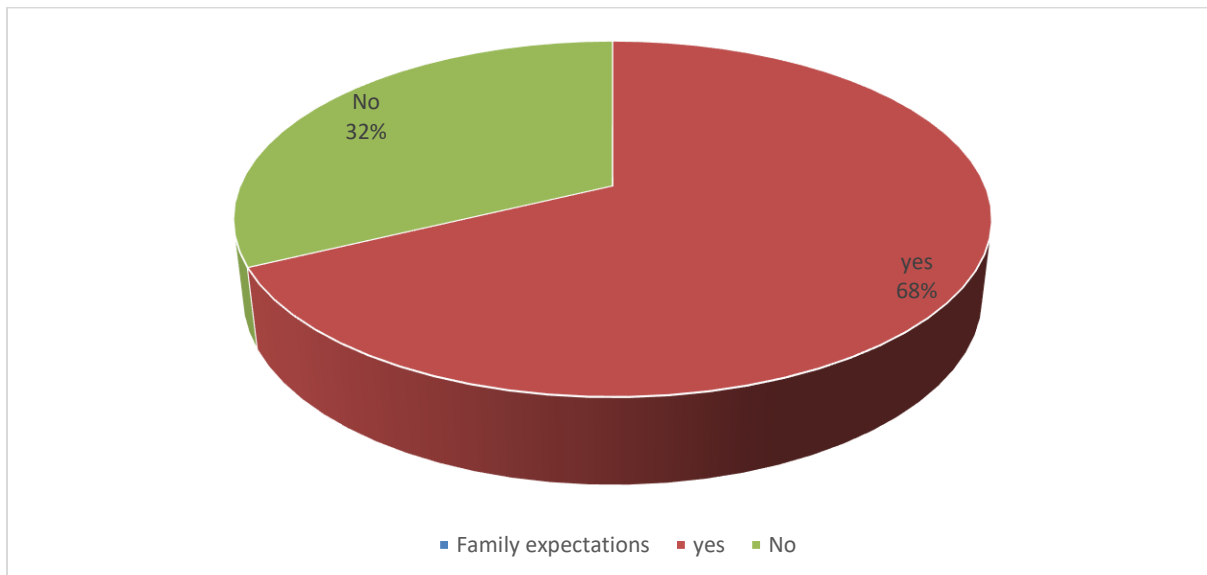


Figure 4:15 family expectations make participants drink alcohol (N=255)

It is evident shown from the data on Figure 15 that the majority of participants (68%) agreed that high family expectations made them drink alcohol, while 32% disagreed that high family expectations made them drink alcohol.

4.5.3 Do participants sometimes drink alcohol in order to experience the feeling of power?

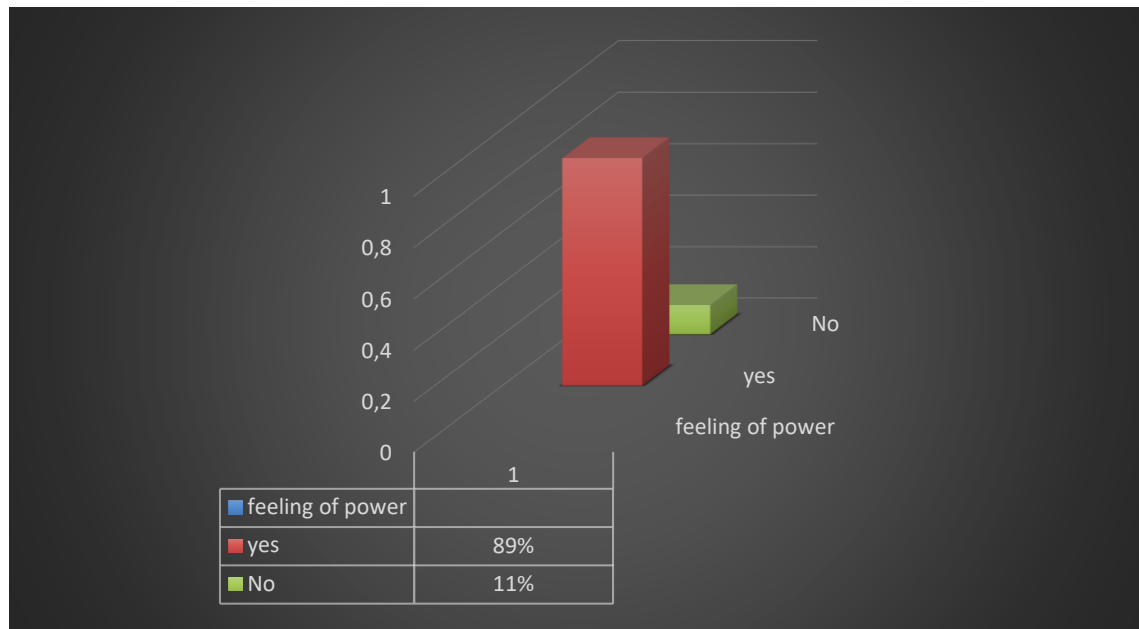


Figure 16 Do participants sometimes drink alcohol in order to experience the feeling of power? N=255

The findings in Figure 16 shows that the majority of participants (89%) agreed that they sometimes drank alcohol in order to experience the feeling of power, while fewer (11%) disagreed that they drink alcohol in order to experience a feeling of power.

4.5.4 Does too much school/work related stress makes participants drink alcohol?

Table 4.6 Too much school work/work-related stress make participants drink alcohol (N=255)

	Frequency (F)	Percentage (%)
Yes	184	72.2
No	71	27.8
Total	255	100.0

The findings on Table 6 revealed that majority of participants 184 (72.2%) have magnificently agreed that indeed school/work related stress makes them drink alcohol, while the lesser number of participants 71 (27.8) have disagreed that school/work related stress makes them drink alcohol.

4.6 Environmental factors

4.6.1 Sources of alcohol beverages

Table 4.7 Sources of alcohol (N=255)

Sources of alcohol	Frequency (f)	Percentage (%)
Home	16	6.3
Friends	56	22.0
Party	62	24.3
Local tarven	81	31.8
Home breweries	36	14.1
Other	4	1.6
Total	255	100.0

The findings in Table 7 indicate that many participants (31%) agreed that alcohol came from the local tavern, while some said parties, (24.3%) and friends (22.0%), Home (6.3%) and others (1.6%) were reported by the remainder.

4.6.2 Number of taverns/shebeen/home breweries selling alcohol beverages

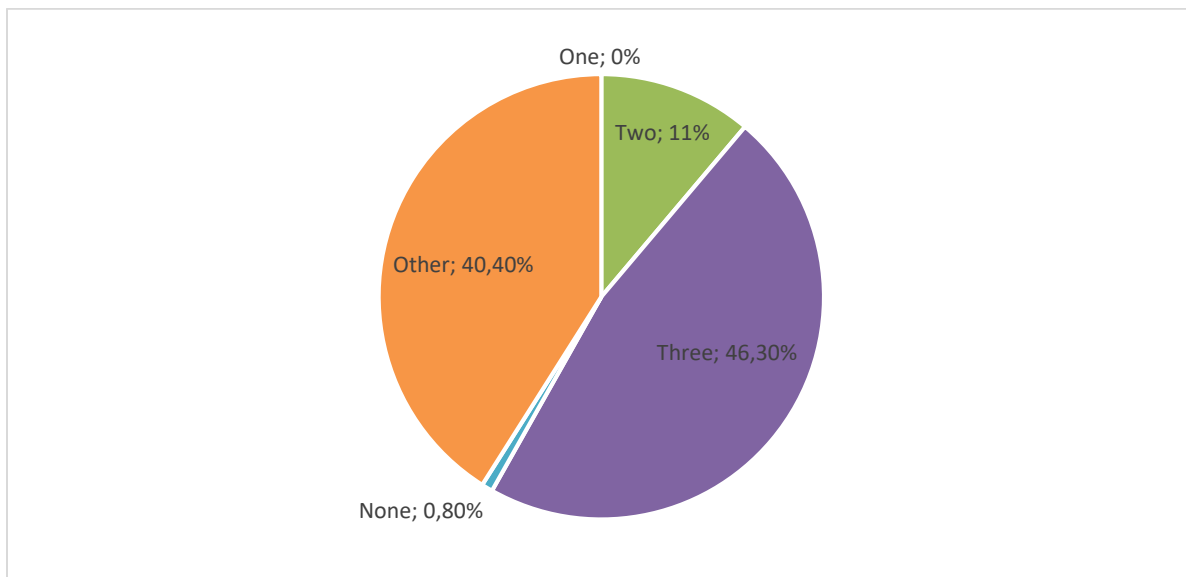


Figure 17: Taverns/shebeen/home breweries selling alcohol beverages (N=255)

It is evident shown from data in Figure 17 that the majority of participants (46.3%) indicate that there are three (3) taverns/shebeens/home breweries in their villages, followed by other (40.4%), who mentioned that there were four (4) and five (5) areas where they could buy alcohol in their village. The findings further revealed that no (0%) agreed that there is only one home brewery/shebeen/tavern in their village.

4.6.3 Alcohol accessibility

Table 4.8 Alcohol accessibility (N=255)

Alcohol accessible	Frequency (F)	Percentage (%)
Not easy	5	2.0
Easy	123	48.2
Very easy	127	49.8
Total	255	100.0

The findings in Table 8 show that the majority of participants, 127 (49.8%) indicated that it is very easy to access alcohol in their villages, followed by 123 (48.2%) participants who mentioned that it is easy to access alcohol in their village. The results further show that very few participants, 5 (2.0%) agreed that it is not easy to access alcohol in the area.

4.6.4 How far are taverns/shebeens/home breweries from you?

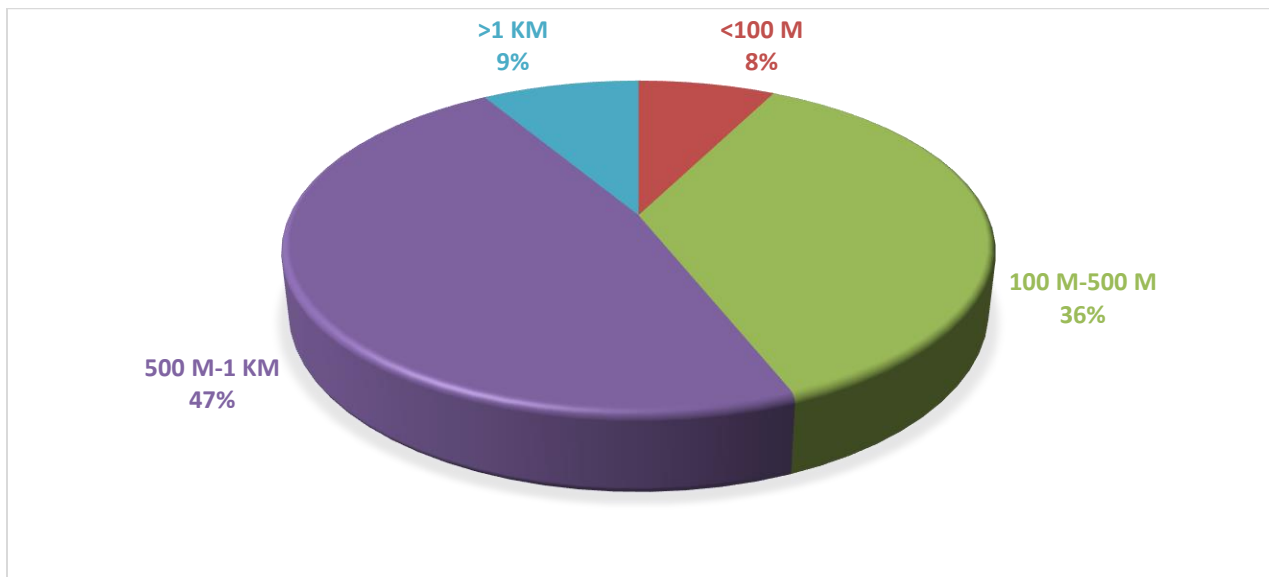


Figure 18: Distance of taverns/shebeens/home breweries (N=255)

It is evident shown from data in Figure 18 that the majority of participants (47%) lived 500 M-1 km away from places where they sold alcohol, followed by 36%. The findings also show that very few participants (8%) lived less than 500m from places where they sold alcohol.

4.6.5 Are there shebeen/tavern owners who adhere to the rule of “alcohol not sold to person under the age of 18”?

Table 4.9 Rule of “alcohol not sold to person under the age of 18” (N=255)

	Frequency (F)	Percentage (%)
Yes	56	22.8
No	199	78.0
Total	255	100.0

The findings in Table 9 show that the majority of participants (199 or 78.0) disagreed there are shebeen/tavern owners who strictly adhere to rules that restrict owners from selling alcohol to any person below the age of 18; hence fewer participants (56 or 22.8%) agreed that there were owners who ensured that alcohol was not sold to a person under the age of 18.

4.7 Perceived hHealth effects of alcohol abuse

4.7.1 Loss of appetite

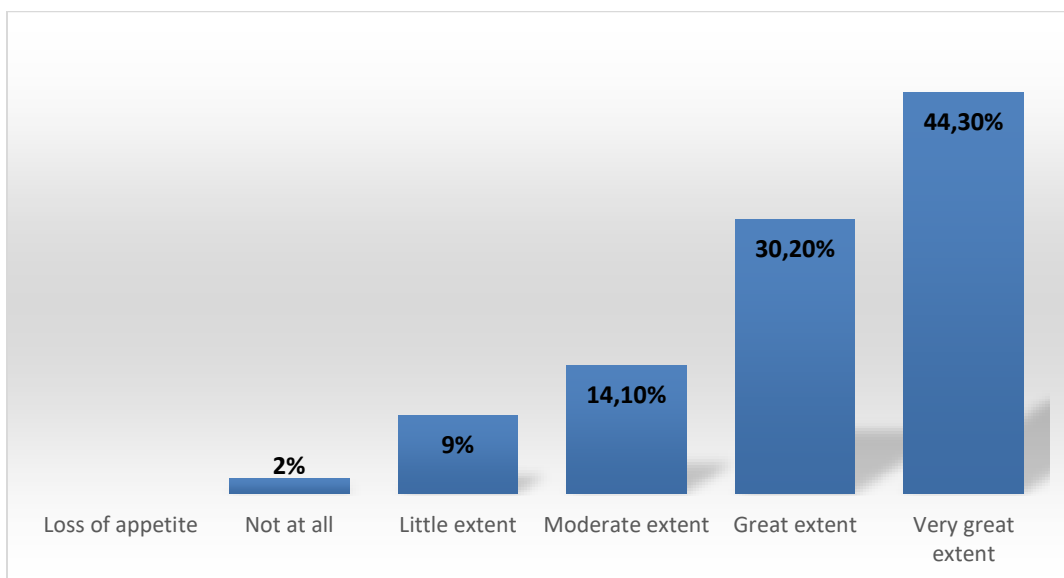


Figure 19 Loss of appetite (N=255)

It is evident shown from the data in Figure 19 that the majority of participants (44.3%) agreed that loss of appetite is one of the effects of abusing alcohol experienced by youth in their villages. Despite the fact that the majority of participants agreed that loss of appetite is one of effects of alcohol abuse, very few participants (14.10%) agreed that alcohol abuse has a moderate effect on youth in their villages. However, findings further show that even fewer participants (2%) said that alcohol abusers experienced no of loss of appetite.

4.7.2 Poor personal Hygiene

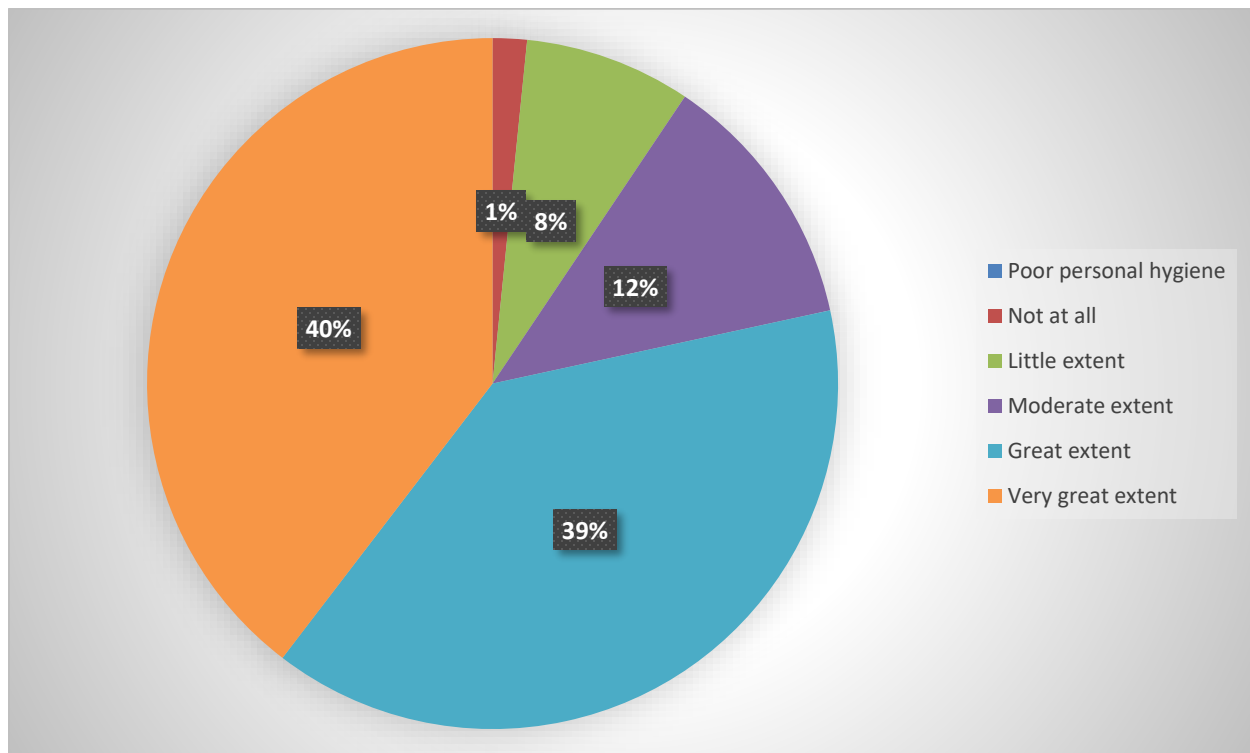


Figure 20 Poor personal hygiene (N=255)

The findings in Figure 20 indicate that the majority of participants (40%) concur that youth who abuse alcohol have poor personal hygiene while 39% agreed that indeed alcohol abusers have poor personal hygiene. The findings further reveal that few participants (8%) disagree with the majority participants (79%), by agreeing that there is no effect at all on poor personal hygiene on youth who abuse alcohol.

4.7.3 Addiction

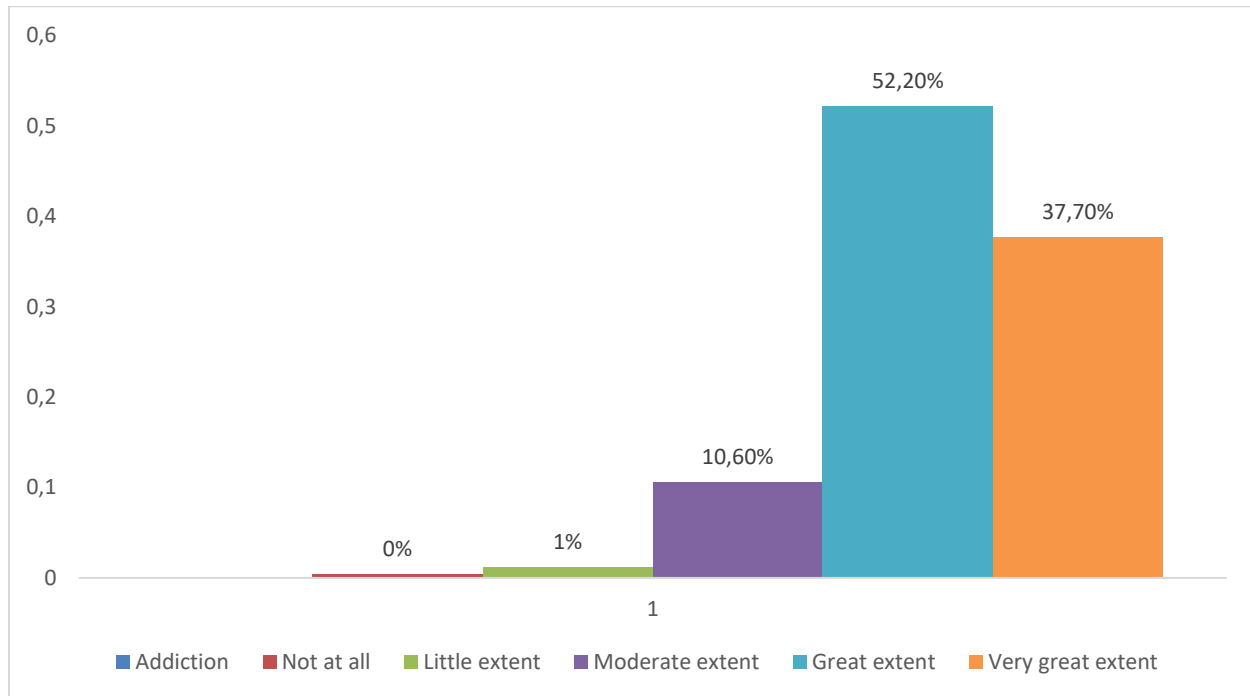


Figure 21 Adiction (N=255)

It is evident shown from the data in Figure 21 that the majority of participants agree that youth who constantly drink alcohol experience addiction. The findings also reveal that the majority of participants (89.9%) concur that indeed addiction is one of the effects experienced by youth who abuse alcohol. However, few participants (10.6%) mentioned that addiction as an effect of alcohol abuse has a moderate effect on abusers, while 1% mentioned that it has little effect.

4.7.4 Lack of concentration in class and at work

The findings in Figure 22 below show that the majority of participants (80.8%) agreed strongly and agreed that most youth in their villages experience poor concentration in class and also at work. The findings further show that, 10.2% mentioned that youth in their villages experience a moderate lack of concentration in class and at work, while 1% participants mentioned that some youth who abuse alcohol did not experience any lack of concentration in class or at work at all.

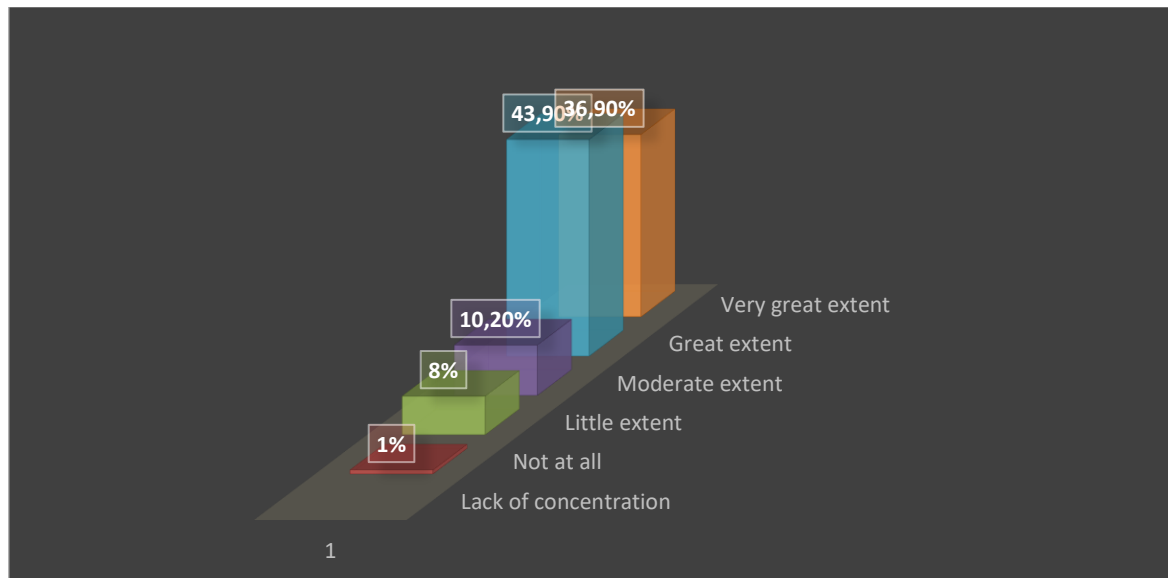


Figure 22 Lack of concentration in class and at work (N=255)

4.7.5 Death

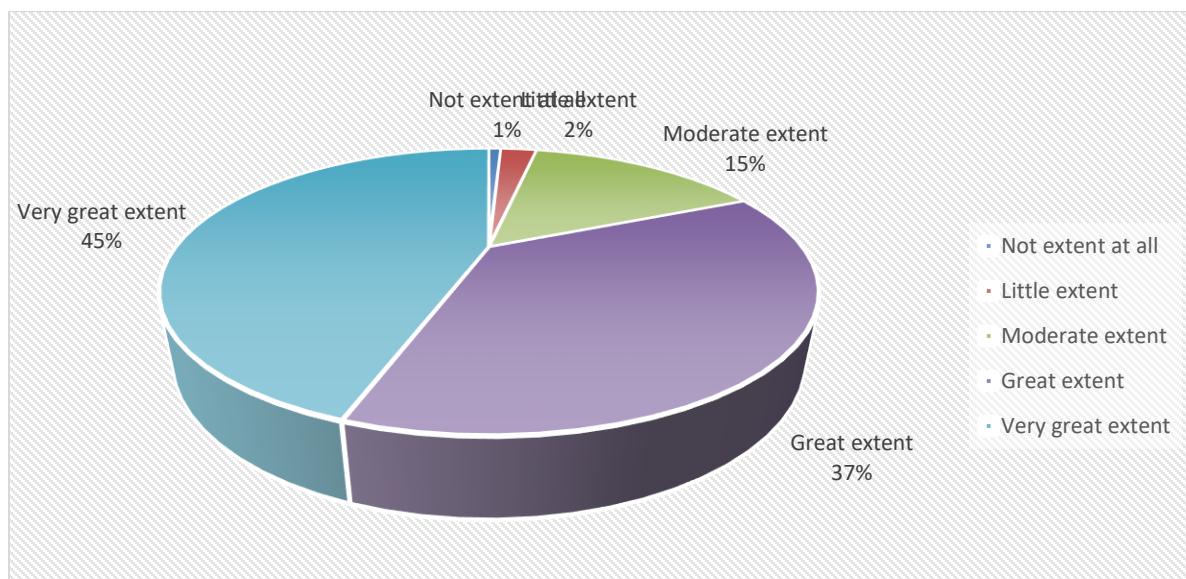


Figure 23 Death (N=255)

The results in Figure 23 indicate that the majority of participants (82%) concur to a very great and great extent respectively that youth who abuse alcohol experienced death. The results also show that fewer participants (15%) mentioned that some youth in their villages experienced a moderate extent of death, while 1 % of the participants mentioned that they did not experience death at all.

4.7.6 Crime

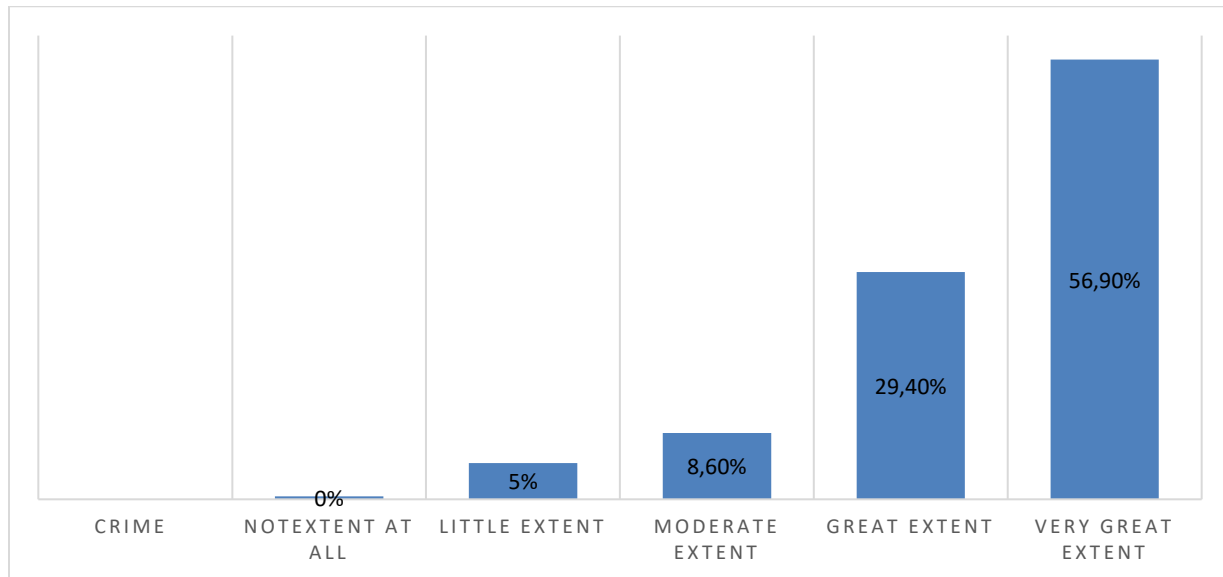


Figure 24 Crime (N=255)

It is evident shown the from data in Figure 24 that the majority of participants (56.9%) agreed to a great extent that youth who abuse alcohol were involved in criminal activities that occur in their villages, followed by 29.4% who also concur to a great extent that indeed alcohol abuse contributes to the criminal activities that are occurring their areas. The findings also show that there is no participant (0%) who disagreed that alcohol abuse makes abusers get involved in crime.

4.7.7 Rape

Table 4.10 Rape (N=255)

Effect	Not extent at all (%)	Little extent (%)	Moderate extent (%)	Great extent (%)	very great extent (%)
Rape	2.4	8.2	19.2	32.2	38.0
N=	255			100.0	

It is evident shown from the data in Table 10 that many participants (38.0%) agreed to a very great extent that alcohol abusers are involved in most rape cases that occur in their villages, followed by participants a third (32.2%) who also concur to a great extent that indeed alcohol abuse contributes to most of the rapes happening in their areas. The findings also show very few participants (2.4%) disagreed that alcohol abusers experience no rape cases at all.

4.7.8 Diseases

Table 4.11 Diseases (N=255)

Effect	Not extent at all (%)	Little extent (%)	Moderate extent (%)	Great extent (%)	very great extent (%)
Diseases	0.4	1.2	4.7	27.8	65.9
N=	255			100.0	

Table 11 show that the majority of participants (93.7%) agreed to a great and very great extent respectively that most of the youth experienced diseases as a result of alcohol abuse. The findings also show that 4.7% of the participants mentioned that alcohol abusers experienced a moderate extent diseases in their villages, whilst fewer(0.4%) mentioned that alcohol abusers do not experience diseases at all.

4.7.9 Family conflicts

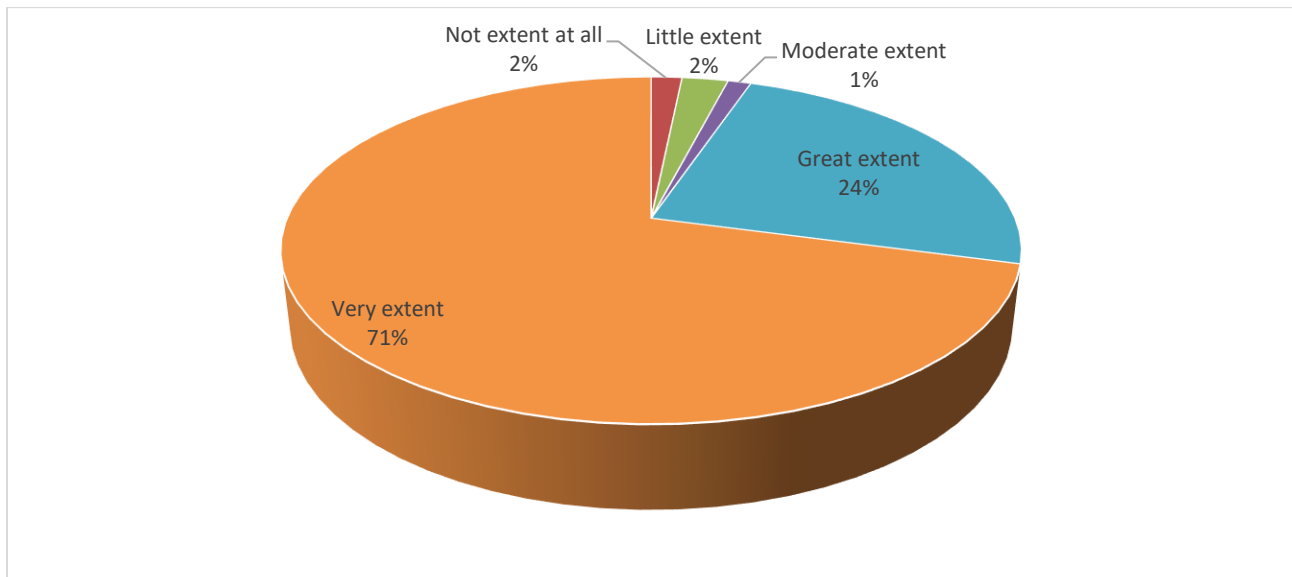


Figure 25 Family conflict (N=255)

Figure 25 illustrates that the majority of participants (95%) agreed to a great and very great extent respectively that most of the youth who abuse alcohol experienced family conflicts. The findings also show that 1.0% of the participants mentioned that alcohol abusers experience moderate family conflicts in their villages, whilst few (2%) mentioned that alcohol abusers do not cause or experience family conflicts at all.

4.7.10 Injuries

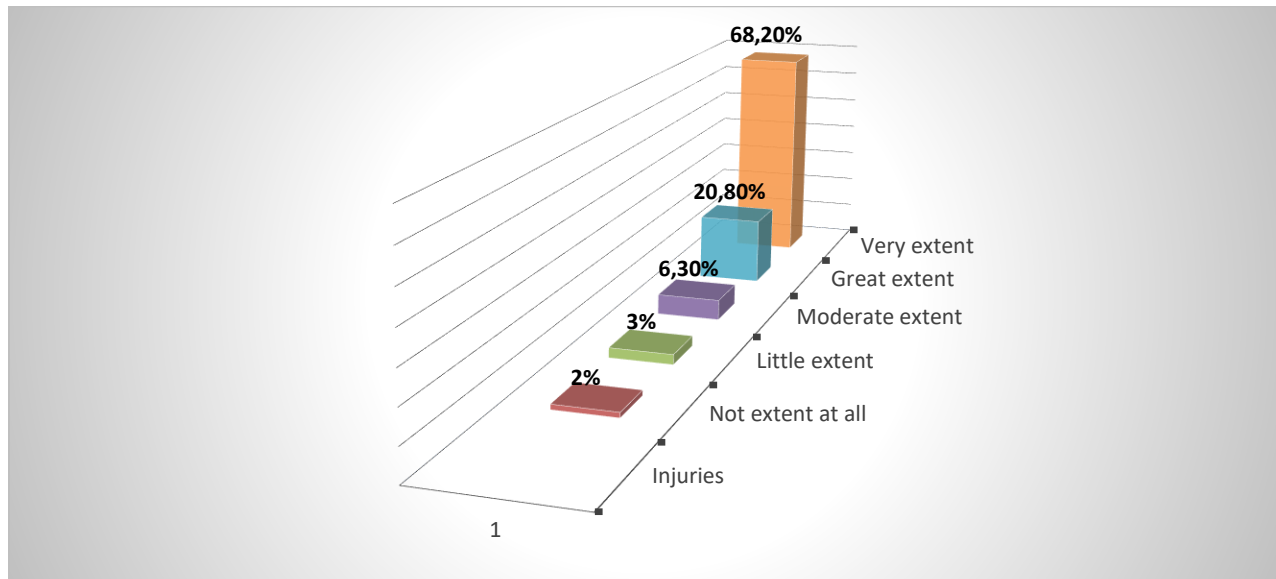


Figure 26 Injuries (N=255)

It is evident from the data in Figure 26 that the majority of participants (89%) agreed to a great and very great extent that most youth who abuse alcohol experienced injuries. The findings further show that few participants (2%) disagreed that alcohol abusers do not experience injuries at all.

4.8 Association between environmental factors such as sources of alcohol beverages, availability of taverns or shebeens, age and alcohol initiation age.

The study revealed that environmental factors and age have a significant association ($P\text{-value} = 0.004$). There was a positive relationship as most of the respondents aged 21-25 years reported that the environments also contribute to alcohol abuse and many of the participants (31.8%) mentioned that they obtained alcohol beverages from the local tavern. The study findings further revealed that the environment and alcohol initiation age have a significant association (0.009). there was a relationship because most of the respondents (45%) started drinking alcohol at the age of 16 years because in each villages there are more three (3) (45%) alcohol outlets.

Table 4.12. Chi-square test

Variables				Age			P Value
		Frequency	%		Frequency	%	
Sources of alcohol beverages	Home	16	6.3%	16-20	38	14.9%	0.004
	Friends	56	22.0%	21-25	84	32.9%	
	Party	62	24.3%	26-30	70	27.5%	
	Local tarven	81	31.8%	31-35	63	24.7%	
	Home breweries	36	14.1%				
	Other	4	1.6%				
Variables				Alcohol intitiation age			P Value
		Frequency	%		Frequency	%	
Tarvens/sheebens/home breweries selling alcohol beverages	One	0	0%	7 years old or younger	11	4%	0.009
	Two	23	11%	8 or 9 years old	5	2%	
	Three	122	46.3%	10 or 11 years old	11	4%	
	None	8	0.8%	12 or 13 years old	15	6%	
	Other	102	40.4%	14 or 15 years old	93	39%	
				16 years old or older	120	45%	

4.9 Summary

The chapter presented the findings of the study and interpretation of the results based on the analysed data. Descriptive statistical analyses were performed to obtain the frequency distribution of the demographic variables. The findings were statistically presented in the form of graphs, tables and pie charts indicating frequencies (f) and percentages (%). The next chapter discusses the study findings.

CHAPTER 5

DISCUSSION OF THE STUDY FINDINGS

5.1 Introduction

This chapter discusses the findings of the study. The main purpose of the study was to investigate the factors contributing to alcohol abuse and perceived health effects among the youth of a rural area at Makhado Municipality, South Africa. The previous chapter presented the findings of the study. Chapter 5 provides a discussion of the findings on the study in relation to the literature.

5.2 Overview of the study

The main objective of the study was to investigate factors contributing to alcohol abuse and perceived health effects among the youth of a rural area at Makhado Municipality, South Africa. The sub-objectives were as follows:

- To measure the rate of alcohol abuse among the youth at these areas
- To assess socio-economic factors contributing to alcohol abuse among the youth of these areas
- To explain the psychological factors contributing to alcohol abuse among the youth of these areas
- To describe the environmental factors responsible for alcohol abuse by the youth.
- To explore perceived health effects of alcohol abuse.

5.3 Rate of alcohol abuse

The study revealed that all participants agreed that they drink alcohol. It further revealed that many of participants (38%) have been drinking for more than four (4) years, while about half (45%) agreed that they drank just a few sips. In addition, the study found that only 6% of the participants agreed that they started drinking alcohol at the age of 12 or 13. This correlates with Wang, Hipp, Butts, Joseand Lakon (2015), who carried out a National Longitudinal Study of Adolescent to Adult Health and the study found that 71% of 9th to 12th grade students indicated having had at least one drink of alcohol (other than a few sips) during their lifetime, with about one fifth starting to drink by the age of 13. Nonetheless, WHO (2014) stated that indeed alcohol is one of the most common psychoactive substances used by adolescents. Most young people began using alcohol between the ages of 12 and 16, an age in which they gain increasing independence and spend more time outside the home unsupervised. This was also confirmed by Tshitangano and Tosin (2016) who found that learners started using substances from 13 to 15 years.

Carvaja and Lerma-Cabrera (2015) also found the development of new pattern of alcohol consumption. This pattern is characterized by drinking large amounts of alcohol over a short period of time, especially in leisure time and weekends. In spite of the fact that young people drink less often than adults on average, they consume more drinks per drinking occasion. Adolescents drink more than twice as much per drinking episode. For adults, this pattern corresponds to drinking five or more drinks in about two hours, while young people take fewer drinks. They showed a pattern of binge drinking. The current study revealed similar results, as it pointed out that the majority of participants (45%) mentioned that they drank more than five (5) drinks per day and some stated that they drank three (3) drinks per day.

The study further revealed similar results as it also pointed out that few participants (10.2) as indicated in Table 2, that they drank alcohol occasionally. A study by Zadarko-Domaradzka, Barabasz, Sobolewski, Nizioł-Babiarz, Penar-Zadarko, Szybisty, and Zadarko, (2018) found that most participants from Poland (82.3%) drank alcohol occasionally, while the statement from the other nations were equally high, with over 50% drinking alcohol occasionally.

The pattern of alcohol use was also assessed by the frequency at which youth consume alcohol. Table 2 shows that the majority of participants (53.7%) drink alcohol on a daily basis. These findings confirm what Mafa and Ananias (2019) have found in their study, where 13% of the participants reported that they drank alcohol on a daily basis, although in the study the number (53.7%) is quite high, as compared to 13%.

5.4 Socio-economic factors contributing to alcohol abuse

Dom et al (2016) reported the negative effects of alcohol consumption during economic crisis periods, most frequently associated with unemployment status. In Italy, during the economic fluctuations, alcohol consumption increased. A Spanish study comparing the pre and post crisis years (2006 and 2010), a rise in alcohol dependence and related disorders was found, especially among those who experienced severe economic losses such as unemployment. The economic of the country plays a significant role on the behaviour of an individual. This was revealed in the current study, that some of participants (36%) stated that they were abusing alcohol because they were unemployed, while 57% mentioned that they had never worked before. A study by Simmango (2014) also established that 61% of the respondents indicated that poverty due to unemployment, unemployed parents or guardians drove young people to substance abuse.

In addition a study conducted by Klingemann (2011) concurred with the study findings, by revealing that unemployment and heavy drinking tend to go together. The causative effect can work both ways: heavy drinkers have a higher risk of losing their jobs, but becoming unemployed often leads to increased drinking. Moreover, both alcohol abuse and unemployment may be caused by a third factor, which may explain why some people are both heavy drinkers and unemployed. A study conducted by WHO (2018) reported that both at an individual and at a population level, rates of drinking are associated with higher income. Thus, within any society, poorer people are more likely to be abstainers than rich people.

Otieno (2016) stated that the reasons for drug/alcohol abuse among students in Kenya Secondary School include ignorance of the harmful effects of drug abuse, lack of parental guidance, shortage of heroes or role models and failure in schools. This correlates with the present study findings because the majority of participants (46%) agreed that they drank alcohol but they were still attending school.

In terms of where participants work, very few participants (11.10%) mentioned that they were working at companies and government offices. Furthermore, they agreed that they drank alcohol. These findings correlates with Smook, Ubbink, Ryke, and Strydom (2017), who argued that most participants reported that substance abuse problems existed in the workplace, that members of management seemed to consume the most alcohol, and that some employers themselves experienced dependency problem.

The study findings revealed that some participants (21%) work contracts had been terminated, while 11.0% of participants were retrenched from their work. Half of the participants (53%) also mentioned that they drink alcohol on a daily basis. The findings contradict to what Klingemann (2011), found in his study, because he stated that the impact of alcohol consumption on productivity and work career has been demonstrated in a large number of studies. Although alcohol consumption does not contribute to any large proportion of the total production losses from work absenteeism, it is well established that alcohol dependent people and heavy drinkers have more sick-leave days than other employees and thus cost their employers a amount of money. This literature contradicts the findings because the results revealed that participants lost their jobs due to retrenchments and termination of contracts, whilst the literature linked heavy drinking with absenteeism and short-term sick leave due to hangovers from occasional episodes of heavy drinking (Klingemann, 2011).

The WHO (2014) in a Survey and mortality found that there are more drinkers, more drinking occasions and more drinkers with low-risk drinking patterns in higher socio-economic, while abstainers are more common in the poorest social groups. The above statement comes into tally with the findings of the study which indicated that 79% of participants mentioned that they save less than R1000,00 for entertainment. However, Carter, Filoche and Mckenzie (2017) disagreed with the findings of WHO; they mentioned that socio-economically disadvantaged groups experience heavy patterns of drinking and have consistently shown high prevalence rates of drinking. A study by Jones and Sumnall (2016) investigating the understanding the relationship between poverty and alcohol misuse found that while excess consumption was more common among people living in less deprived areas, a higher degree of binge drinking was seen among residents with low socio-economic status.

In terms of affordable beverages, beer is the most affordable alcohol beverage. This was revealed in the study findings because most of the participants (67.5%) mentioned that they could afford to buy beer. However, Mahafhe (Traditional/Homebrewed beer) is the second affordable alcohol beverage. This also resonates with the literature that geographical differences exist among the type of alcohol people consume. The mostly consumed beverage in terms of litres of pure alcohol is beer (WHO, 2014). A study conducted by Mafa and Ananias (2019) also agreed with the study findings because it revealed that 30% of the participants of alcohol users have chosen beer as a preferred alcohol. The study further revealed that very few participants (5.6%) prefer to consume home-made liquor.

Settertobulte, Jensen and Hurrelmann (2015) found that belonging to a special group of people is expressed by using symbols. Special patterns of behaviour and attitudes are taken as symbols of a subcultural identity the young people feel committed to (for example, "A real Punk has to be drunk"). These behaviour patterns are often risk behaviours like alcohol misuse. Different groups of adolescents have different mixtures of behaviour patterns that are used for self-description. This statement correlates with the findings of the study, where the majority of participants (57%) spend most of the time with friends, as indicated in Figure 4.12. In figure 13, it was also indicated that 87% of the people spend most of the time drinking alcohol. This makes participants feel they belong to their group by doing what their friends are doing. The findings of the study are also supported by the literature from Klingemann (2011) who mentioned that friends are part of the social environment in which young people learn how to behave after drinking. Young people as well as adults select their friends in accordance with their own drinking preferences. Thus,

networks of friends share a certain compatibility with regard to alcohol to drink and how to behave after drinking.

5.5 Psychological factors contribute to alcohol abuse

The findings further revealed that there is an association between alcohol use and stress. In the study most of the participants (74.9%) mentioned that when they are stressed, they drink alcohol as a way to forget their problems. This was confirmed by Carter, Filoche and McKenzie (2017) that for some young people, reasons for drinking imply a more complex picture. Their reasons included drinking to forget about things, feeling more confident and to relax. For some older youth, drinking has been cited as a means to cope with stress. In addition Anthenelli and Grandison (2012) linked alcohol abuse and stress, they found that in the tension-reduction hypothesis, stress was seen to increase anxiety, and in response, alcohol was consumed to reduce the anxiety. National Institute on Alcohol Abuse and Alcoholism (2012) also associated stress and alcohol abuse. One way that people may choose to cope with stress is turning to alcohol. Drinking may lead to positive feelings and relaxation, at least in the short term.

The study also revealed that young people drink alcohol in order to enjoy a feeling of power. The majority of participants (89%) agreed that they drank alcohol in order to have a feeling of power. Based on a previous review of the international literature covering a 15-year period (from 1989) in 10 to 25 year olds Carter, Filoche and McKenzie (2017) tend to argue with the findings because in their study they found that reasons for drinking appear to be related to how the young person is drinking – where social reasons (for example, enjoy a party) appear to be associated with moderate alcohol use, premeditative drinking (for example, to get drunk) with risky drinking, and coping motives (such as to reduce stress) with alcohol-related problems. Nicholas, Rautenbach and Maistry (2010) identified powerlessness as another cause of substance abuse, where the individual experiences powerlessness, it also makes him/her vulnerable to external influences as ways of coping. Individuals who experience a feeling of powerlessness tend to drink heavily and develop a drinking problem.

The environment in which people found themselves in, workload and poor academic performance were revealed in the study as some of the factors which make youth indulge in alcohol. The study findings were supported by Settertobulte, Jensen and Hurrelmann (2015). It is clear that there is a relationship between school performance and alcohol consumption, with drinking to be seen as both the result and the cause of school failure. A study on environmental and demographic factors

influencing drug and substance abuse among secondary school students conducted by scholar Otieno (2016) revealed that class repetition shows association with drug or alcohol abuse. This study shows that more drug abusers (50%) were those who had repeated at least a class during education life, while for those who had not repeated class, the proportion of drug abusers were lower (38%). This shows that repeating a class increases risk to drug abuse. In addition, Otieno (2016) also reported that failure in school increases the risk of drug abuse. It is important to note that satisfaction with school reduces the risk of drug. Though, some views puts it that satisfaction and good performance reduces the risk to drug abuse.

In another study on alcohol and the workplace, Anderson (2012) found that the workplace could influence workers and those who do not drink. This is because the presence of a drinking climate correlated with job stress and job withdrawal more than did reports of individual colleagues' drinking. Factors such as an uncomfortable work environment, lack of safety, inadequate resources, poor supervision, problems with peers, low salary, little training opportunities, job insecurity and lack of opportunities for career advancement can lead to a decrease in employee job satisfaction, which Setati (2014) confirm would lead to depression. Such an adverse work environment can contribute to employee problems like substance misuse (Mogorosi, 2009).

5.6 Environmental factors which contribute to alcohol abuse

The study findings in Table 7 also revealed that most of the participants (31.8) have mentioned that their sources of alcohol are their local taverns, whilst others mentioned friends (22.0%) and parties (24.3%). Very few mentioned home breweries (14.1%). Mafa and Ananias (2019) revealed that there is a small percentage (5.6%) of young people who drink traditional beer and some who drink all sorts of alcohol they can have access to. It was easier for participants to access traditionally-brewed alcohol as it is available next to their places of residences and was cheaper than commercially brewed alcohol.

Pledger, Martin, and Cumming (2016), confirmed that local taverns contributed to youth alcohol abuse. Survey revealed that the relationships between drinking behaviour and density of alcohol outlets are complex. Previous research demonstrates a positive relationship between alcohol outlet density (clustering) and increased local levels of alcohol consumption (WHO, 2018). According to Otieno (2016), availability of drug peddlers cheaply selling Miraa, tobacco, alcohol and marijuana locally in shops, encouraged students to engage in drug abuse.

Literature from Settertobulte, Jensen and Hurrelmann (2015), shows the influence of friends by stating that as adolescents grow older, the family becomes less important for the socialization process, while the influence of a person's group of friends increases. This is part of the normal process of growing away from parents. In this phase, young people between 12 and 24 years old typically come together in more or less fixed groups, in which adult behaviour is practiced.

In terms of number of taverns/shebeens/home breweries selling alcohol, the findings revealed that about half of the participants (46.3) mentioned that there were three (3) alcohol outlets that sold alcohol in their village, followed by 40.4% who mentioned that there were more than four (4) and five (5) alcohol outlets. The findings correlates with what the survey found, Pledger et al (2016) found that Greater alcohol outlet density has been associated with increased alcohol consumption. A study by Settertobulte, Jensen and Hurrelmann (2015) argued that where alcohol can only be obtained in a few places, its availability is limited and less is therefore drunk. A study by Wood and Bellis (2017) suggested that reducing the availability of alcohol through restricting the density of alcohol outlets can be effective in reducing alcohol related harm

The findings in Table 8 showed that participants selected very easy (49.8) and easy (48.2) in accessing the alcohol. The study further revealed in Figure 18 that most of the participants (47) stay very close to outlets that sell alcohol. It seems as if the influence of staying near alcohol outlets contributed to alcohol abuse by youth due to accessibility. This was confirmed by the survey conducted in New Zealand by the New Zealand Health Surtvey (2012-2013). The survey found that the majority of New Zealanders live in an environment where 85% live within two minutes' drive of an alcohol outlet: 66% live within two minutes of an alcohol on-licence (bars, clubs, restaurants and cafés), and 67% live within two minutes of an off-licence alcohol outlet (bottle stores and supermarkets).

The study further revealed that out of the 255 participants, 199 (78.0%) agreed that there are many alcohol outlets owners who do not adhere to the rule of not selling alcohol to any person below the age of 18 years. National and local governments exercise influence over alcohol consumption, and not only among adolescents, butat three levels: the availability of alcohol or regulations governing to whom it may be sold, where and how it is sold, and the price and taxation of alcoholic beverages (Settertobulte, Jensen and Hurrelmann, 2015). A study on Self-reported alcohol use and binge drinking in South Africa: Evidence from the National Income Dynamics Study, 2014 – 2015, by Vellios and Walbeek (2018), emphasised that to address high rates of

alcohol consumption and the associated economic and social costs to society, public health advocates in South Africa have been supporting higher excise taxes as far back as 1995, arguing that the affordability of alcohol products is a strong determinant of alcohol use.

5.5 Perceived health effects of alcohol abuse

The study findings also revealed that the majority of participants (44.3%) agreed to a very great extent that alcohol abusers experience loss of food appetite. McBride (2015), in the study on alcohol abuse and found that malnutrition: heavy drinking depletes body of essential vitamins; reported that alcohol's effects on the appetite and nutrition is comparable to its impact on the central nervous system. However, Yeomans (2014) argued that there is a minimal evidence for any compensatory reduction in food intake in response to the energy ingested as alcohol.

The study also revealed that the majority of participants (40%) concur that youth who abuse alcohol experience poor personal hygiene. These findings correlates with WHO (2014), which reported that in Botswana, it was claimed by medical staff in local government clinics that habitual drinkers suffer from general self-neglect, particularly poor personal hygiene and a tendency to forget to eat when drinking, which leads to malnutrition.

In terms of addiction, the study findings have revealed that the majority of participants (89.9%) concur that youth who abuse alcohol tend to be addicted to alcohol. The study findings were confirmed by literature from Carvaja and Lerma-Cabrera (2015), who stated that people who drink too much or too often, or are unable to control alcohol consumption, can develop an alcohol use disorder. The literature further argued that although a large proportion of the population consumes alcohol, not all of them become alcohol-dependent. Research also shows that people who drink moderately may be less likely to experience Alcohol Use Disorder.

Figure 22 depicts the association of alcohol abuse by youth and lack of concentration in class and at work. However, some studies have shown that drug abuse leads to poor performance in academics, which may then result in repetition of a class or grade. Otieno (2016) confirmed that in Kenya, some of the most commonly cited effects of drug abuse in school are poor health, exam failure; drop out from schools, truancy and violence. However, related to work concentration, Klingemann (2011) stated that, the impact of alcohol consumption on productivity and work career has been demonstrated in a large number of studies. Although alcohol consumption does not

contribute to any large proportion of the total production losses from work absenteeism, it is well established that alcohol-dependent people and heavy drinkers have more sick-leave days.

WHO (2017) stated that 3.8% of all global deaths were attributable to alcohol; 6,2% for men and 1,1% for women. The harmful use of alcohol is the leading factor for death in men aged 15-59. This statement was confirmed by the findings from the study that revealed that about half of the participants (45%) agreed to a very great extent that youth who abuses alcohol experiences death. Wood and Bellis (2017) also confirmed the findings by stating that higher rates of alcohol related mortality have been reported among lower social economic status/education level groups in many EU countries. Thus, only 3.6% of alcohol users worldwide are alcohol dependent, a condition implying a degree of addiction that makes it difficult for them to abstain or reduce their drinking in spite of increasingly serious harm.

The study also revealed that the majority of participants (56.9%) agreed to a very great extent that youth who abuse alcohol are involved in criminal activities. Jacobs, Steyn And Labadarios (2013), in a study on Mind the gap: Observations in the absence of guidelines for alcohol abstinence among expectant women in South Africa, stated that associations between alcohol abuse and child abuse have also been reported. According to the South African Police Services (SAPS) Crime Report 2010–2011, 65% of social contact crimes, such as murder, attempted murder, rape and assault, are a result of alcohol and, to a lesser extent, drug abuse.

According to Klingemann (2011), It is generally believed that when high-risk activities and socially disruptive behaviour are connected with drinking, they are judged less critically than the equivalent sober behaviour. Alcohol and domestic violence are linked to spouse/partner and family structures. The partners of alcohol abusers also pay a heavy price. In addition, they are at serious risk of violence, as marital violence is clearly more common with problem drinking. The family is liable to a split or a break up, as several studies on the causes of divorce have shown. The above statement just confirms the study findings, where the majority of participants (71%) concurred to a very great extent that indeed youth who abuse alcohol tend to be violent and experience family conflicts.

In terms of homosexuality, rape and immorality, the study findings revealed that many participants (38.0%) agreed to a very great extent that youth who abuse alcohol are the perpetrators of rape. However, the literature from Carvaja and Lerma-Cabrera (2015) contradicts with the findings of

the study. Instead, they revealed the impact of underage drinking was related to unsafe sexual activity. Underage alcohol use has been associated with risky sexual behavior (unwanted, unintended and unprotected sexual activity) and multiple sex partners. For example, 32% of adolescents who started drinking at 13 reported having unplanned sex because of drinking, and 10% reported having unprotected sex because of drinking. Such behavior it increases the risk of unplanned pregnancy and sexually transmitted disease infection. Also, young people who drink are more likely to carry out or be the victim of physical or sexual assault (Carvaja and Lerma-Cabrera, 2015)

According to WHO (2014), alcohol is also linked to incidences of diseases and the course of diseases. Alcohol has also been identified as a component cause for over 200 ICD-10 disease codes. Alcohol-attributable DALYs were for neuropsychiatric disorders consist of 88% DALYs due to alcohol use disorders and 12% DALYs due to epilepsy and unipolar depressive disorder. This literature was confirmed by the study findings, which revealed that the majority of participants (93.7%) agreed that alcohol abusers suffer diseases. In addition, a study by Carvaja and Lerma-Cabrera (2015) revealed that recently, drinking alcohol has been related to the incidence of infectious diseases, such as tuberculosis and HIV/AIDS.

The study further revealed that the majority of participants (89%) agreed that youth who abuse alcohol werre the victims of injuries. These findings were confirmed in the study on alcohol-related injury: An evidence-based literature review reported that for most injury types, alcohol's involvement in the injury is likely to be a matter of increased rather than certainty. The association of alcohol and injury may just reflect alcohol use being more common among those incurring injuries.

5.6 Summary

The discussion of the findings was delineated from the objectives of the study. The study also showed that alcohol abuse and its perceived health effects are a threat to the individual, other people and the nation, especially to the youth. Therefore, it also showed that, alcohol is mostly abused by male as compared to their female counterparts. In addition owners of alcohol outlets do not adhere to the South African policy that state that alcohol is not to be sold to any person below the age of 18 years old and that availability and accessibility of alcohol are some of the determinants of alcohol abuse amongst the youth. The findings also indicated that there is some need for more research on the knowledge and attitudes towards alcohol abuse. As alcohol abuse

is costing South Africa's economy billions every year, it shows that the phenomenon is a reality among the youth in South Africa and change is urgently required to address this issue.

CHAPTER 6

SUMMARY, CONCLUSION AND RECOMMENDATIONS

6.1 Introduction

This chapter outlines the summary, conclusions and recommendations based on the objectives of the study findings with support to literature review.

6.2 Summary of the study

The aim of the study was to investigate factors contributing to alcohol abuse and perceived health effects among the youth of a rural area at Makhado Municipality, South Africa. A self-administered questionnaire was constructed in line with study objectives in order to collect data. The data was captured using Micro Soft Excel Software and later imported to Statistics Package for Social Sciences version 26, for further analysis. The study reviewed previous studies with a view to establish academic gap which the present study sought to bridge.

6.2.1 Rate of alcohol abuse

The first objective was to measure the rate of alcohol abuse among the youth. The prevalence of alcohol abuse in the study is higher among males (60.4%) than among females (39.6%). The initiation age for alcohol consumption is below 13 years old. Most of the youth have been drinking for more than four (4) years and they take more than five (5) drinks per day. The study findings also revealed that a large amount of alcohol is consumed on a daily basis, although several studies have argued that most of the youth are occasional drinkers and much alcohol is consumed during weekends.

6.2.2 Socio-economic factors which contribute to alcohol abuse

The second objective of the study was to assess socio-economic factors contributing to alcohol abuse. The socio-economic factors that were found to contribute to alcohol abuse were, being unemployed, where people work (environment/workload), being retrenched, when the work contract is terminated, saving more money just for entertainment, affordability of beer as a preferred choice of alcohol beverage. Others were friends who influence bad behavior.

6.2.3 Psychological factors which contribute to alcohol abuse

The third objective was to explain the psychological factors contributing to alcohol abuse among the youth. The findings of the study revealed that there is an association between alcohol use and stress. Others were the pressure and expectations from the family or family members, the feeling of having power when experiencing powerlessness, high workload and poor academical performance.

6.2.4 Environmental factors which contribute to alcohol abuse

The fourth objective was to describe the environmental factors responsible for alcohol abuse by the youth. Environmental factors that were found to contribute to alcohol abuse were, the availability of atleast more than three (3) local taverns and home breweries in the village, easy access to alcohol in the villages and availability of alcohol outlets nearby. Other environmental factors which were found to contribute to alcohol abuse were owners of alcohol outlets who were not strict and sold alcohol to person younger than 18 years old.

6.2.5 Perceived health effects of alcohol abuse

The last objective was to explore the perceived health effects of alcohol abuse. The study findings revealed perceived health effects of alcohol as of food appetite, poor personal hygiene, addiction and lack of concentration in class and work. The study findings also revealed that alcohol abusers suffer from death, and are involved in criminal activities, and in disruptive behavior such as family conflicts. Other studies included rape, unsafe sexual activity, injuries and diseases.

6.3 Limitations of the study

The study has several limitations and should be interpreted in the context of these limitations.. First, the findings cannot be generalised to the whole Makhado municipality or Nthabalala Area. Secondly, the major constraint in this research was time factor and budget since the research could not manage to cover all villages that falls within Nthabalala Area. Because of limited budget the researcher had to sample only eight (villages) to be part of the study. Despite the limitations as mentioned, this study highlights that there is a need for further research into the nature of alcohol abuse especially focusing on knowledge and attitude towards alcohol abuse and its effects.

6.4 Conclusions

The study findings revealed that there is a significant association between the availability of alcohol outlets near families and alcohol abuse by the youth. The prevalence of alcohol abuse is high particularly amongst the youth as the initiation age of alcohol consumption is below the age of 13 years. Thus new environmentally-based effective strategies are needed. These strategies include strengthening and implementation on the operation of alcohol outlets and adherence in strictly selling alcohol to persons aged 18 years and above. Effective and sustainable programmes should be initiated to promote a drug-free environment for the youth. The programmes should be those that would help minimize characteristics that may promote abuse of alcohol and enhance those characteristics that discourage alcohol abuse in schools and at family environmental level.

6.5 Recommendations of the study

Based on the above summary and conclusions, the following recommendations were made about factors contributing to alcohol abuse amongst the youth:

- By measuring the rate of alcohol abuse amongst the youth, there is a need for new environmentally-based effective strategies that would help to minimize characteristics that may promote alcohol abuse at a younger age
- The research has found that the environment is a strong setting for alcohol abuse. The government and other ministries (such as the Ministries of Health, Education, Social Development and the Police) should be involved in providing and enhancing the already existing programmes at all levels in all communities (for example, education, awareness campaigns and arrest) in order to reduce the risk of harm arising from alcohol abuse for those abusing alcohol and preventing those who are not yet involved with alcohol.
- The Department of Education, in collaboration with the Department of Health, should introduce subjects that addresses the importance of abstinence in alcohol and the effects of alcohol abuse.
- The researcher also found that youth are spending much of their leisure time relaxing with friends at local taverns. The Department of Cooperative Governance and Traditional Affairs should thus ensure that there are more recreational facilities, in order to keep youth away from alcohol outlets and encourage them to be involved in sport activities.
- The study further revealed that the initiation age for alcohol consumption is below 13 years and most of the learners have indicated that they take alcohol. The Department of

Education and Health should continue to partner in employing school social workers who will render behavioural change programme in schools that will modify the bad behaviours of learners.

- There is also an urgent need for the Department of Police to close all unlicensed alcohol outlets and monitor the licensed alcohol outlets if they are operating within the specified time and their owners are not selling alcohol to person younger than 18 years old.
- To avoid work stress and burnout, every government department should have EAP in each subdistrict.
- Advertisement plays a crucial role in the initiation of alcohol abuse among the youth. There is also a need to ban alcohol advertisement on televisions and any media.
- Traditional authority be involved in establishing and strengthening youth structures that deal with the abuse of alcohol
- People should be informed about effects by activists and health promoters
- Finally, there is a need for further research into the nature of alcohol abuse, especially focusing on the knowledge and attitude towards alcohol abuse and its effects.

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APPENDIX A: RESEARCH INSTRUMENT (QUESTIONNAIRE)

FACTORS CONTRIBUTING TO ALCOHOL ABUSE AND PERCEIVED HEALTH EFFECTS AMONG YOUTH OF A RURAL AREA AT MAKHADO MUNICIPALITY, SOUTH AFRICA

Instructions

1. Do not write your name
2. Read thoroughly and understand before you answer.
3. Answer all questions
4. The questionnaire should be completed and returned back by the researcher immediately
5. Only tick one appropriate answer from each item
6. For any clarity do not hesitate to contact the researcher immediately

SECTION A: DEMOGRAPHIC INFORMATION

1. What is your gender?

1. Male () 2. Female ()

2. In which of the following age brackets do you belong to?

1. 16-20 () 2. 21-25 () 3. 26-30 () 4. 31-35 ()

3. Where do you live?

1. Mathuli () 2. Magobo () 3. Tshathogwe () 4. Ramatshila () 5. Ramulumo () 6. Vari ()
7. Maduwa () 8. Mpofu ()

4. What is your marital status?

1. Married () 2. Single () 3. Divorced () 4. Widowed ()

5. Are you still attending school?

1. Yes 2. No 3. Dropped out

6. If yes to Q.5, type of school

1. Primary () 2. Secondary () 3. Tertiary ()

7. Family Type

1. Mum and Dad () 2. Single Mum () 3. Single Dad () 4. Foster Parents ()
5. Aunt/Uncle () 6. Grandparent(s) () 7. Siblings () 8. Wife () 9. Husband ()

SECTION B: RATE OF ALCOHOL ABUSE

8. Do you take alcohol?

1 Yes () 2 No ()

9 If yes, for how long have you been drinking?

1. < year () 2. 1-2 ()
3. 3-5 () 4. 5-10 () 5. More than 10 years ()

10. How old were you when you had your first drink of alcohol other than a few sips?

1 7 years old or younger () 2 8 or 9 years old () 3 10 or 11 years old ()
4 12 or 13 years old () 5 14 or 15 years old () 6 16 years old or older ()

11 How many drinks do you usually drink per day?

1. Less than one drink () 2. 1 drink () 3. 2 drinks ()
4. 3 drinks () 5. 4 drinks () 6. 5 or more drinks ()

12 How often do you drink alcohol?

1. Daily () 2. Once a week () 3. Weekly ()
4. Monthly () 5. Occasionally ()

13 Have you ever increased your drinking because the amount you used to drink didn't give you the same effect anymore?

1. Yes () 2. No ()

SECTION C: SOCIO-ECONOMIC FACTORS

14 Employment status?

1 Unemployed () 2 Self-employed ()
3 Employed () 4 Student ()

15 If employed, where you do work?

1 Company () 2 Government employee ()
3 Self-employed () 4 NPO ()
5 Student ()

16 If unemployed, have you ever worked before?

- 1 Yes ()
2 No ()

17 If yes to Q 12, what happened to your job?

- 1 Retrenched () 2 Contract terminated ()
3 Quitted () 4 Student ()

18 What is your gross household monthly income?

1. <R1000 ()
2. R2000-R4000 ()
3. R5000-R6000 ()
4. R7000-R8000 ()
5. >R8000 ()

19 How much money do you save for entertainment on a monthly basis?

1. <R1000 ()
2. R2000-R4000 ()
3. R5000-R6000 ()
4. >R7000 ()

20 Which alcohol beverage is affordable to you?

1. Beer () 2. Wine ()
3. Spirits () 4. Mahafhe ()
5. Other: specify.....

21 How often do you drink it?

- 1 Daily () 2 Once a week
3 Twice a month () 4 Monthly ()
5 Occasional ()

22 With whom do you spend most of your time?

1. Spouse () 2. Family () 3. Friends () 4. Schoolmate ()
5. Colleagues () 6. Other.....

23. Do the people you spend most of your time with drink alcohol?

1. Yes () 2. No () 3. Never ()

24. What do you do with your leisure time?

1. Go to party () 2. Chill with friends at a local turven ()
3. Stay home () 4. Attend sports activities () 5. Other.....

SECTION D: PSYCHOLOGICAL FACTORS

25 What do you usually do when you want to relieve stress?

- 1 Sleep () 2 Drink alcohol ()
3 Talk to someone () 4 Other: specify.....

26 Do high family expectation make you drink alcohol?

- 1 Yes ()
2 No ()

27 Do you sometimes drink alcohol in order to experience the feeling of power?

- 1 Yes ()
2 No ()

28 Does too much school work/work-related stress make you drink alcohol?

- 1 Yes ()
2 No ()

SECTION E: ENVIRONMENTAL FACTORS

29. What are the sources of alcohol beverages?

1. Home () 2. Friends () 3. Party () 4. Local turven ()
5. Home breweries () 6. Other.....

30. How many taverns/shebeens are selling alcohol beverages are in your village?

1. One () 2. Two () 3. Three () 4. None () 5. Other.....

31. How easy is it to access alcohol in your village?

- 1 Not easy () 2. Easy () 3. Very easy ()

32. How far are taverns/shebeens/ homes selling homebrewed beer from your home/school?

1. < 100 M 2. 100-500 M
3. 500 M- 1 KM 4. > 1 KM

33. Are there shebeens/taverns owners adhere to the rule of “alcohol not sold to person under the age of 18”?

1. Yes () 2. No ()

SECTION E: PERCEIVED EFFECTS OF ALCOHOL ABUSE

34 Does alcohol abuse have negative effects on a person?

- 1 Yes ()
2 No ()

What are the negative effects of alcohol abuse experienced by youth in your village?

Indicate your response based on a 5-point scale by using X to mark the applicable box

Perceived Health Effects	Not at all (1)	Little extent (2)	Moderate extent (3)	Great extent (4)	Very great extent (5)
36. Loss of appetite					
37. Poor personal hygiene					
38. Addiction					
39. Lack of concentration in class and at work					
40. Death					
41. Crime rise					
42. Homosexuality, Rape and immorality					
43. Diseases					
44. Family conflicts					
Injuries					
45. Other:					

APPENDIX B

RESEARCH ETHICS COMMITTEE

UNIVEN Informed Consent

LETTER OF INFORMATION

Title of the Research Study : Factors contributing to alcohol abuse and perceived health effects among youth of a rural area at Makhado Municipality, South Africa.

Principal Investigator/s/ researcher : Mr M.D. Mudau, Bachelor of Social Work

Co-Investigator/s/supervisor/s : Dr T.G Tshitangano

Brief Introduction and Purpose of the Study: Lately, the abuse of alcohol amongst youth has become a global problem resulting in individual, social and economic implications. Alcohol abuse is the third leading risk factor for poor health causing disease and death in people aged 15-49 years, which is economically the most productive group. In rural areas of Makhado municipality, youth wake up early everyday going to shebeens to drink homebrewed beer (muqomboti). What is worrying is that this tendency is occurring in the era when the country has put in place many funding opportunities for youth to start their own businesses.

Outline of the Procedures: A quantitative approach using descriptive cross-sectional survey through self-administered questionnaire will be applied in data collection. The survey population will be comprised of youth aged 16-35. Systematic sampling technique will be used to select participants. The data will be captured using Microsoft Excel and then analyzed using the Statistical Package for Social Sciences (SPSS) software version 25.0. The findings of the study may assist stakeholder to develop appropriate intervention aimed at the alcohol abuse behavior.

Risks or Discomforts to the Participant: There is no risk in participating in the study.

Benefits: There will be no direct benefit benefits to any participants.

Reason/s why the Participant May Be Withdrawn from the Study: Participants may be withdrawn at any stage of the study if they feel uncomfortable about certain aspects of the study.

Remuneration: Participants will not receive any remuneration or monetary.

Costs of the Study: Participants will not be expected to cover any costs towards the study.

Confidentiality: The researcher will give the participants an assurance that any information which is deemed life-threatening, or which, may disturb the participants' economic, social, physical, health, and psychological make-up, will not be readily made available to anyone else. The researcher will make sure that the true identities of participants are not revealed to anybody, pseudo codes will be used to identify participants.

Research-related Injury: Should there be a research-related injury or adverse reaction, the researcher will be held accountable.

Persons to Contact in the Event of Any Problems or Queries:

(Dr. T.G Tshitangano, Department of Advanced Nursing Science, School of Health Sciences, Email Takalani.Tshitangano@univen.ac.za) Please contact the researcher (079 382 6729/ Email: Delcomudau@gmail.com), my supervisor (082 448 4111/ 015 962 8006) or the University Research Ethics Committee Secretariat on 015 962 9058. Complaints can be reported to the Director: Research and Innovation, Prof GE Ekosse on 015 962 8313 or Georges Ivo.Ekosse@univen.ac.za

General:

Potential participants must be assured that participation is voluntary and the approximate number of participants to be included should be disclosed. A copy of the information letter should be issued to participants. The information letter and consent form must be translated and provided in the primary spoken language of the research population

CONSENT

Statement of Agreement to Participate in the Research Study:

- I hereby confirm that I have been informed by the researcher, (Mr. M.D Mudau), about the nature, conduct, benefits and risks of this study - Research Ethics Clearance Number: __,
- I have also received, read and understood the above written information (*Participant Letter of Information*) regarding the study.
- I am aware that the results of the study, including personal details regarding my sex, age, date of birth, initials and diagnosis, will be anonymously processed into a study report.
- In view of the requirements of research, I agree that the data collected during this study can be processed in a computerized system by the researcher.
- I may, at any stage, without prejudice, withdraw my consent and participation in the study.
- I have had sufficient opportunity to ask questions and (of my own free will) declare myself prepared to participate in the study.
- I understand that significant new findings developed during the course of this research which may relate to my participation will be made available to me.

Full Name of Participant	Date	Time	Signature
I,

(Mr. M.D Mudau) herewith confirm that the above participant has been fully
Informed about the nature, conduct and risks of the above study.

Full Name of Researcher

Mr. Mudau M.D

.....

Date.....

Signature.....

Full Name of Witness (If applicable)

.....

Date

Signature.....

Full Name of Legal Guardian (If applicable)

.....

Date.....

Signature.....

Please note the following:

Research details must be provided in a clear, simple and culturally appropriate manner and prospective participants should be helped to arrive at an informed decision by use of appropriate language (grade 10 level- use Flesch Reading Ease Scores on Microsoft Word), selecting of a non-threatening environment for interaction and the availability of peer counseling (Department of Health, 2004)

If the potential participant is unable to read/illiterate, then a right thumb print is required and an impartial witness, who is literate and knows the participant e.g. parent, sibling, friend, pastor, etc. should verify in writing, duly signed that informed verbal consent was obtained (Department of Health, 2004).

If anyone makes a mistake completing this document e.g. a wrong date or spelling mistake, a new document has to be completed. The incomplete original document has to be kept in the participant's file and not thrown away, and copies thereof must be issued to the participant.

APPENDIX C

INFORMATION SHEET

Title of the study: Factors contributing to alcohol abuse and perceived health effects among the youth of a rural area at Makhado Municipality, South Africa.

Introduction

You are being asked to take part in this study with the above mentioned title. You are selected as a possible respondent through the systematic sampling technique the day a sample is selected, those other youth who are not included in the sample are not going to form part of the study. I humbly request you to read this form and ask any questions you may be having before agreeing to form part of the study.

Purpose of the study

The purpose of the study is to investigate the factors contributing to alcohol abuse among youth at a rural area of Makhado Municipality, South Africa. The researcher is intending to publish this study afterwards and the summary of the results will be made available to the community.

Description of the study procedures

If you agree to take part in this study, you will be asked to complete a questionnaire which will be having the following four sections:

Section A: Demographic information

Section B: Rate of alcohol abuse

Section C: Socio-economic factors contributing to alcohol abuse

Section D: Psychological factors contributing to alcohol abuse

Section E: Environmental factors contributing to alcohol abuse

Section F: Perceived health effects

The questionnaires will be given to you by the researcher at your respective villages. Completion of the questionnaire will take you approximately 20 minutes.

Risks involved

Taking part in this study may sometimes poses unknown risks. You may find that some of the questions on the questionnaire may harm you or you may have a different view. It is not the intention of the researcher when that happens. You may also find that you were once a victim of alcohol abuse and seeing that in the study may remind you of that unfavourable or traumatic condition.

Benefits

You are not going to be given money for participating in this study. However, you are somehow going to benefit. Being a respondent in this study will benefit you: it will give you an opportunity to make your own view regarding alcohol abuse; it will make your opinion to be heard and this may also help make stakeholders spot your village. You will also have a clear picture of what alcohol abuse is and it will help you develop your analytical skills.

Your rights as a respondent

As a respondent, you have the right to privacy, your identifying particulars will not be used in this study, and the researcher will instead use fictional characters or words. The records of this study will be kept confidential. You have the right to fair treatment and withdraw from the study any time you feel like withdrawing. Withdrawing from this study will not make you fail or repeat your grade and you are allowed to ask any question.

I..... having understood the above, as explained by the researcher, I do agree/disagree to be part of this study.

Date:

Contact details for clarity purposes: Delcomudau@gmail.com

: 079 382 6729

APPENDIX D: ETHICAL CLEARANCE

RESEARCH AND INNOVATION
OFFICE OF THE DIRECTOR

NAME OF RESEARCHER/INVESTIGATOR:

Mr MD Mudau

Student No:

11580217

PROJECT TITLE: **Factors contributing to alcohol abuse and perceived health effect among the young of rural area at Makhado Municipality, South Africa.**

PROJECT NO: **SHS/19/PH/07/1704**

SUPERVISORS/ CO-RESEARCHERS/ CO-INVESTIGATORS

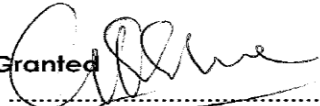
NAME	INSTITUTION & DEPARTMENT	ROLE
Dr TG Tshitangano	University of Venda	Supervisor
Mr MD Mudau	University of Venda	Investigator – Student

ISSUED BY:

UNIVERSITY OF VENDA, RESEARCH ETHICS COMMITTEE

Date Considered: April 2019

Decision by Ethical Clearance Committee Granted

Signature of Chairperson of the Committee: 

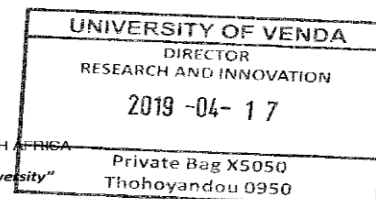
Name of the Chairperson of the Committee: Senior Prof. G.E. Ekosse



University of Venda

PRIVATE BAG X5050, THOHAYANDOU, 09501 LIMPOPO PROVINCE, SOUTH AFRICA
TELEPHONE (015) 962 8504/8313 FAX (015) 962 9060

"A quality driven financially sustainable, rural-based Comprehensive University"



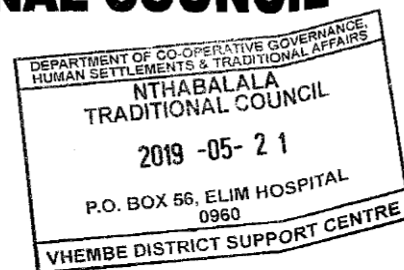
APPENDIX E: PERMISSION TO CONDUCT STUDY

NTHABALALA TRADITIONAL COUNCIL

P.O. BOX 56
ELIM HOSPITAL
0960

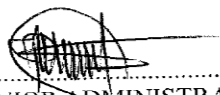
REF: CH 11/8/4
ENQ: Mukwevho T.P
CELL: 072 352 3328

21 May 2019



To Whom It May Concern

1. This letter serves to confirm that **Mudau Mbavhalelo Delco** of ID No. **870703 5874 082** is hereby granted permission to conduct research on factors contributing to alcohol abuse and perceived health effects among the youth.
2. Mr. Mudau M.D is therefore permitted to visit villages within the jurisdiction of Nthabalala Traditional Council to collect or gather information which in turn will help traditional institution to realize the effects and consequences of alcohol abuse in the community.
3. Your co-operation with the above-named will be highly appreciated.



.....
SENIOR ADMINISTRATIVE OFFICER

APPENDIX F: PROOF READER LETTER

SCHOOL OF HUMAN AND SOCIAL SCIENCES

24 January 2020

School of Health
University of Venda
Thohoyandou
0950

Sir/madam

This serves to certify that I have proof-read Mr M.D. Mudau's mini-dissertation titled, "Factors Contributing to Alcohol Abuse and Perceived Health Effects Among the Youth of a Rural Area at Makhado Municipality, South Africa".

The proof-reading entailed editing some parts from it; for example, to avoid wordiness, redundancy; sub-dividing sentences, and so on, to make the document more understandable. However, I have not tampered with the content of the document, except where this constituted repetition or made the document confusing.

The mini-dissertation is presently ready for examination.

Sincerely



V.T. Bvuma
083 423 9227



University of Venda

UNIVERSITY OF VENDA

PRIVATE BAG X5050, THOHOYANDOU, 0950, LIMPOPO PROVINCE, SOUTH AFRICA
TELEPHONE (015) 962 8172 FAX (015) 962 8416
E-mail: Vincent.Bvuma@univen.ac.za

"A quality driven, financial sustainable, rural-based comprehensive University"