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SURVEYS OF DRINKING PATTERNS AND PROBLEMS IN SEVEN DEVELOPING COUNTRIES

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INTRODUCTION

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Survey research on drinking in developing societies

Though earlier examples can be found, the modern tradition of survey research on drinking patterns and problems in general populations is a product of the second half of the 20th century. By the mid-1970s, surveys of adult drinking behaviour had been carried out in at least 10 European and English-speaking countries (Room, forthcoming-b). By 2000, such studies have been carried out in most other developed countries; indeed, many countries have established a tradition of repeated surveys, allowing trends and developments to be monitored in the whole society and in subgroups of the population. Such studies typically include detailed questions about amounts and patterns of drinking and often about contexts of drinking. Often, questions are also asked about the respondent's experience of problems related to drinking, as well as questions from measures for screening or diagnosis of alcohol dependence and other disorders (Room, forthcoming-a).

Such surveys have contributed important information on the demography of drinking – where different patterns of drinking (or abstention) are distributed by subgroups of the population formed by differentiations such as gender, age, socio-economic status, and region of residence. They have become a way of gathering information on alcohol consumption not recorded in official statistics (e.g., Österberg, 2000). They have also given a picture at the population level of the extent and distribution of alcohol-related problems – a broader picture than can be gained by statistics on cases in treatment systems or police activity. As a society builds up a tradition of such surveys, they also become tools for monitoring trends in different social groups, and sometimes for evaluating the effects of policy interventions in the society (e.g., O'Malley and Wagenaar, 1991). They thus become an important tool for alcohol policymaking in a public health perspective.

Survey research on drinking patterns and problems in developing societies has been much less common. The Mexican tradition, already established in the 1970s, is a clear exception (Medina Mora and Borges, forthcoming). Other developing societies with relatively well developed traditions of such research include Costa Rica (Miguez, 1983) and India (Singh, 1989). Otherwise, there have been single surveys in a number of countries, including the Nigerian and Namibian surveys included in this monograph. Also relevant here are surveys which have been carried out in what has been called the "fourth world" – surveys of aboriginal minorities within developed countries (e.g., Hunter et al., 1991; Klausner and Foulks, 1982).

Alongside the tradition of surveys dedicated specifically to alcohol have been surveys carried out for other or broader purposes, which have included some questions about drinking. The Mexican and Indian survey traditions actually straddle this divide: while the international political dynamics which resulted in and often financed the surveys were focused on illicit drugs, national researchers in Mexico and India steadfastly insisted that substantial questioning on alcohol be included too, in view of the substantial health and social problems related to drinking. Alcohol questions have also been included in general-population surveys with a variety of other topical emphases besides illicit drugs: e.g., psychiatric epidemiology, tobacco smoking, psychoactive medications and nutrition. As an example, nutrition was the primary focus of the Seychelles study analysed in this book. Increasingly, general medical epidemiological surveys have also been including questions about drinking, although the particular questions included are often problematic for describing drinking patterns (Rehm, 1998).

Reasons to undertake surveys on drinking in developing societies

Survey research on drinking practices and problems is of course not the only approach to collecting data relevant to alcohol policy and programming in developing societies. At least limited data on production and consumption of commercial alcohol beverages, and on alcohol-related mortality, is available for nearly every country (WHO, 1999). There is a long tradition of ethnographic studies of drinking (Heath and Cooper, 1981; Heath, 1993; Marshall, 1979), and ethnographers have increasingly moved beyond describing drinking from

presumptively tradition-bound societies to studies set in the modern world of intercultural influences and major social changes (e.g., Eber, 1995; Marshall & Marshall, 1990; Colson and Scudder, 1988).

But survey data offer important advantages in a developing-country context. In the first place, there is a way to measure, however imperfectly, the alcohol consumption, which is not recorded in official statistics – which in many countries constitutes the greater part of alcohol consumption. Second, survey data can give a picture of the social location of drinking in a society, and also allows a direct focus on charting the distribution and correlates in the population of the patterns of drinking most likely to be associated with harm – intoxication episodes, and long-term heavy drinking. Third, a survey offers a way to measure directly alcohol-related problems, which do not show up in police or health statistics: problems in family life, for instance, or in work performance. Fourth, analyses of survey data can explore directly the relationship between patterns and contexts of drinking and the occurrence of social and health problems. Fifth, when surveys are repeated over time, they can be used to monitor the situation in the society and to evaluate policy initiatives.

The background of this manuscript

Analyses of surveys on drinking patterns and problems in developing countries have not been widely available. There are a variety of reasons for this. A full report on a survey study is a sizeable and unwieldy document, not suitable for publication as a journal article, so such reports tend to stay in the "grey literature" of reports from research institutes and groups. Also, for obvious reasons, the reports are published in the national language. Researchers have often not had the time or incentives to go on to a further stage of publishing articles on the results in internationally accessible journals. Furthermore, as we have noted, the alcohol items are often collected as a side issue in a survey mostly oriented in another direction, so that they have often had a lower priority in researchers' analysis strategies.

The present manuscript's aim is to start on a remedy for this situation, by putting together survey analyses from a variety of developing societies. It is an outgrowth of the project on Alcohol Policy in Developing Societies, initiated in 1996 by a group of scholars under the auspices of the World Health Organization (WHO). The central aim of the project was to produce a review of the available empirical data on drinking practices and problems in developing societies and on the diversity and effectiveness of treatment, prevention, policy and other societal responses to alcohol problems in such societies (Room et al., forthcoming). The work for the project looked in several directions in developing material for its review, starting with the compilation of a bibliography of relevant research (Ialomiteanu, 1998). One initiative was to develop a series of case studies on alcohol and public health particularly in developing countries (Riley and Marshall, 1999). A related WHO activity was the preparation of a *Global Status Report on Alcohol* (WHO, 1999), gathering and reporting available data for each country of the world on per-capita alcohol consumption, on alcohol-related morbidity and mortality, and on alcohol policies. A third initiative was to look for existing survey data from adult populations on drinking patterns and, where available, alcohol-related problems. The criteria for inclusion in this initiative were such the study include enough questions on drinking to analyse drinking patterns (frequency of drinking, drinking high quantity on an occasion, etc.), include interviews with at least 1000 adults from a defined population, identified for interview with similar probability sampling, and that the data was collected in 1988 or more recently.

Study directors of studies fitting these criteria were invited to prepare analyses of their data in accordance with a specified plan, to maximize comparability. At a meeting in Mexico City on 13-15 August 1998, hosted by the Mexican Institute of Psychiatry, the study directors and WHO staff and consultants met to discuss their drafts and prepare a plan for revising them for the present publication. At the meeting, Andrée Demers agreed that, with Chantal Bourgault, she would take on the task of editing the reports into the present manuscript. The report on Namibia was added after the Mexico City meeting.

The countries included in this manuscript

The availability of suitable data, and not any consideration of country size, world region, or level of development thus dictated the choice of countries for inclusion in this project. Happily, however, the countries included in this manuscript provide a good range of cases on all of these dimensions (Table 1). On size, they range from the most populated country (China) to a small island nation (Seychelles). In terms of WHO's regional groupings, Namibia, Nigeria and Seychelles are from the African Region; Costa Rica and Mexico from the Americas; India from the South-East Asian Region; and China from the Western Pacific Region. In terms of level of development, Costa Rica, Mexico and the Seychelles are classified among the 64 "high human development" countries in the 1998 *Human Development Report* (UNDP, 1998), China and Namibia are among the 66 "medium human development" countries, and India and Nigeria are among the 44 "low human development" countries. Overall, we may say that the range of included countries is characterised more by diversity than by commonality.

There is also wide variation between countries in the recorded per-capita alcohol consumption. To some extent, this probably reflects differences in the degree of unrecorded consumption. Nigeria's true consumption level, for instance, is undoubtedly considerably higher than the recorded level, although Nigeria includes a large abstemious Moslem population. India may well have the lowest actual alcohol consumption of the countries included in the manuscript, although India is nowhere near the bottom of the global range in terms of recorded consumption. The other five countries are all in the upper half of countries for which a consumption figure is available (WHO, 1999), although Costa Rica's reported consumption is less than half of the 11-15 litres per adult reported by the countries, mostly developed, at the top of the range globally (WHO, 1999). But as the survey data results, which follow demonstrate, in countries like Namibia and the Seychelles, the reported consumption may be only half the story.