EXPERIENCES OF PEOPLE WHO ABUSE ALCOHOL IN WAKIVULE VILLAGE, LUWERO DISTRICT

BY

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SEPTEMBER 15th, 2018
Declaration

I John Musisi Kduwanema declare that this study is original and has not been submitted for any other award to any other institution.

Signature.................................................. Date.................... 28/09/18

This dissertation has been submitted for examination with my approval as the students’ supervisor:

Justus Twesigye BSWA; MSW; PhD

Signature.................................................. Date.................... 28/09/18

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Dedication

I dedicate this study to my beloved mother Ms. Sarah Mazzi Sekintu who has tirelessly encouraged me to use my talents productively and to pursue my studies. I also dedicate this study to my family, friends and colleagues who have supported me in many ways during the pursuit of my studies.
Acknowledgment

I wish to acknowledge the advice and support rendered to me by my supervisor Dr. Justus Twesigye during this study. Dr. Twesigye has painstakingly guided me through some of the most challenging aspects of learning how to be a social worker and a new researcher. I wish to thank him for inspiring me to engage in self-reflection and to think about the people that read my work. I admire his patience, humor and unfailing ability to make people feel at ease even when they are in some serious distress. These are skills that I hope to continue improving throughout my professional life.

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Abstract

I conducted an exploratory qualitative case study on experiences of people who abuse alcohol in Wakivule village, Luwero district (Uganda). This study sought to describe the effects of alcohol abuse on individual and their families, the attributions that are given for alcohol abuse and the ways in which people manage consequences of substance abuse. The study uses constructivist narratives and the strengths perspective as theoretical bases. A total of 10 participants were individually interviewed in addition to conducting three key informant interviews and one focus group discussion. Data was subjected to content analysis by way of coding and the identification of emerging themes. Findings indicate that the consequences of alcohol abuse include challenges at work, family conflict, financial problems, economic underdevelopment, marginalization and ill health. The attributed causes of alcohol abuse include physical pain, free will, divine fate, depression, socialization, availability and social injustice. The strategies for managing alcohol abuse include withdrawal from society, rationalization, political activism, self-control, medical and local remedies. These findings show that experiences of alcohol abuse were multi-faceted, diverse, complex and non-linear. Consequently, a holistic understanding of alcohol abuse which gives credence to both medical and anthropological conceptualizations of substance abuse is required. More importantly, people who experience alcohol abuse should be given a voice and credence when studying this phenomenon and designing contextually relevant interventions. In doing so, I call for a developmental social work approach to supporting people who abuse alcohol.
Chapter One

INTRODUCTION

1.1 Background to the Study

Substance abuse is a major social problem worldwide. Statistics from the United Nations organization indicate that 28 million healthy years of life are lost as a result of abusing substances (UN Office on Drugs and Crime, 2017). It is estimated that over 15 million people across the globe have diagnosed and undiagnosed substance abuse disorders. Sub-Saharan Africa bears a significant and growing burden of substance abuse. It is expected that there will be a 130% increase in the burden of mental health and substance abuse disorders within Sub-Saharan Africa by 2050 (Charlson, Diminic, Lund, Degenhardt, & Whiteford, 2014). Mental and substance abuse disorders already account for up to 19% of the disability burden in Sub-Saharan Africa. Yet, many African countries do not have substantial funding to deal with the burden of substance abuse (Bett, Russell, & Kabanda, 2005).

Alcohol abuse is an important category of overall substance abuse. According to the World Health Organization (WHO), alcohol abuse alone accounts for an average of 3.3 million deaths across the world every year (WHO, 2018). It is estimated that the average consumption of pure alcohol by people who are older than 15 years of age is 6.2 litres per person, per year. The fact that less than 40% of the world’s population ever drinks alcohol means that those who drink alcohol are consuming an individual average of 17 litres of pure alcohol per annum. Up to 148 countries have reported incidences of substance abuse and a heightened risk of acquiring HIV/AIDS among people who abuse alcohol (UN Office on Drugs and Crime, 2017; WHO, 2018).

Uganda is one of the Sub-Saharan nations struggling with a substance abuse problem (Kinyanda, et al., 2017). A global status report on alcohol indicated that Uganda had an average per capita consumption rate of 23.7 litres of alcohol per year (Wanjala, 2014). This was higher than in other East African countries such as Burundi (22.0 litres), Rwanda (22.0 litres), Kenya (18.9 litres), and Tanzania (18.4 litres). The central region of Uganda which includes Luwero district accounts for up to 39% of substance abuse cases in Uganda (Nyangoma, 2015). Alcohol abuse is particularly problematic and accounts for over 65% of all recorded substance abuse cases in Uganda (Nyangoma, 2015).
1.2 Statement of the Problem

There is a growing burden of alcohol abuse worldwide (Charlson, et al., 2014). One of the reasons for the high incidence of alcohol abuse is the failure to incorporate views of people who abuse alcohol themselves when designing and implementing interventions (Muhwezi, 2017).

Whereas existing literature has explored clinical explanatory models of alcohol abuse, these models may not have much relevance to people who abuse alcohol (Charlson, et al., 2014). Besides, clinical explanatory models are often expressed in a language and format that is mainly understood by the professionals and experts in the field, and not by lay people such as those that abuse alcohol (Patel, et al., 2016).

This study seeks to explore perspectives of people that abuse alcohol in order to understand their lived experiences. The study is underpinned by the strengths perspective in social work which suggests that human beings are capable of describing their own social situations and suggest solutions that work best for them (Boeri, Gardner, Gerken, Ross, & Wheeler, 2016).

1.3 Objectives of the Study

The overall objective of this study is to describe experiences of people who abuse alcohol in Wakivule village, Luwero district.

1.3.1 Specific objectives

The specific objectives of this study were:

(i) To examine the consequences of alcohol abuse in Wakivule village, Luwero district.
(ii) To describe the attributions for alcohol abuse in Wakivule village, Luwero district.
(iii) To describe the strategies used by people to deal with alcohol abuse in Wakivule village, Luwero district.

1.3.2 Research questions

The main research question for this study is: How do people experience alcohol abuse in Wakivule village, Luwero district? The specific research questions for this study were:

a) How has alcohol impacted the day-to-day lives of people who abuse it in Wakivule village, Luwero district?

b) What do people who abuse alcohol consider to be its causes in Wakivule village, Luwero district?
c) How do people who abuse alcohol manage its effects in Wakivule village, Luwero district?

1.4 Theoretical Framework

This study is based on the strengths perspective, a social work practice model which originated in American psychiatric and correctional settings (see Figure 1 below). According to this perspective, people have untapped personal assets and should be engaged on the basis of self-determination (Saleebey, 2002). This framework has been selected because it is inherently respectful to people who may abuse alcohol in as far as it acknowledges their unique knowledge and experiences of alcohol abuse (Charlson, Diminic, Lund, Degenhardt, & Whiteford, 2014). The strengths perspective is not constrained by the tendency of the clinical models of substance abuse which consider the condition to be a pathology that requires treatment (Rankin, 2007). Rather, the strengths perspective acknowledges that people have a range of assets which can be used to deal with their circumstances (Saleebey, 2002). By rejecting negative labelling and disempowering stereotypes, the strengths perspective gives people an opportunity to define their experiences as well as engaging in the identification and implementation of appropriate interventions (Swahn, Dill, Palmier, & Kasirye, 2014). Moreover, the strengths perspective supports the constructivist narrative as a research methodology. The constructivist narrative is a research approach that allows people to define and describe their own learning and knowledge about social phenomena based on their experiences and reflection on those experiences (Creswell, 2013; Rankin, 2007). This approach rejects the primacy of objective knowledge, thereby giving credence to socially constructed meanings (Rankin, 2007). Whereas constructivist narratives educate and enlighten the researcher, they can also be therapeutic for the subject of research (Bunt Gregory & Britta, 2011).
1.5 Scope of the Study

In defining the scope of my study, this section presents its boundaries and limitations explains the extent of the study and the limitations.

1.5.1 Research population

This study was conducted among a sample of people who abused alcohol and were residing in Wakivule Village, Luwero district. Kickyusa municipality (within which Wakivule village is located) was selected because it is one of the most urbanized parts of Luwero district.
Themunicipality also has the highest concentration of people who abuse alcohol or are at risk of abusing alcohol (Luwero District Local Government, 2012).

The selected population includes people who resided in Wakivule as per the 15th of September 2018. The research population was restricted to residents of Wakivule Village who had either self-identified or been identified by others as being people who abused alcohol. It is acknowledged that alcohol abuse is a stigmatizing experience and that some potential participants could have avoided participating in my study for this reason (Connors, et al., 2013).

1.5.2 Methodological boundaries

A qualitative exploratory case study was conducted. Consideration was given to a quantitative explanatory case study which would survey all people at risk of alcohol abuse within the area, using pre-set scales. However, that option has not been selected considering that the stigma associated with substance abuse would make sampling very difficult (Baker, 2000).

1.5 Justification and Rationale for the Study

The study is justified on the grounds that there is a dearth of literature that describes personal experiences and perspectives of people who abuse alcohol in rural areas (Kabwama, et al., 2016). Such perspectives would enable those that formulate and implement national policies on substance abuse management to consider the contributions of people who abuse alcohol when designing interventions (Boeri, et al., 2016). The study is also justified on policy grounds in as far as it makes a case for developing more substance abuse programs for people living in areas that were once considered to be rural but are now rapidly urbanizing (Muhwezi, 2017).

Findings of the study will add to the body of knowledge that supports social work practice in the field of substance abuse. This study is conceptualized from the standpoint of the first-hand and personal experiences of people who abuse alcohol as opposed to solutions which are typically provided by experts. The study will also lay the ground for further research into experiences and challenges faced by people who abuse alcohol in the community and possible interventions.

1.6 Definition of Key Terms

Alcohol abuse is defined as the habitual and excessive consumption of alcohol to the extent that it leads to harm including social dysfunction and ill health (Bunt Gregory & Britta, 2011). In this case, alcohol abuse is divided into two main forms. The first relates to the
antisocial hedonistic use of alcohol while the second relates to harmful dependency on alcohol (Connors, DiClemente, Velasquez, & Donovan, 2013).

The term “experiences” as used in this study refers to those subjective processes through which people live and perceive social phenomena after exposure to it (Ryff, 1989). Experiences in this context relate to the physical, cognitive, emotional and social dimensions of the knowledge or wisdom that people have or claim to have concerning alcohol abuse (Weaver, 2016). This definition implicitly challenges the notion that experiences of alcohol abuse are objective, logical, homogenous or even linear (Bunt Gregory & Britta, 2011).
Chapter Two

LITERATURE REVIEW

2.1 Introduction

There is a substantial body of literature concerning substance abuse in general and alcohol abuse in particular. Existing literature includes studies that focus on the situation analysis of the global, African, East African and Ugandan context. This literature review focuses on four cross-cutting topical issues.

(a) Situation analysis of substance abuse
(b) Experiences of alcohol abuse
(c) Causes of alcohol abuse
(d) Managing alcohol abuse

The first topic is a general overview of substance abuse. The other three topics are linked to the research objectives.

2.2 Situation Analysis of Substance Abuse

According to Patel, et al. (2016), the highest prevalence of substance abuse disorders (between 6% and 7% of the selected populations) is in the USA and Eastern Europe. The prevalence rate for Central and Western Europe as well as Oceania and the Americas is between 2% and 5% of the population. The Middle East, Asia and Africa record a lower prevalence rate of between 1% and 2% of the population (Ritchie & Roser, 2018). By 2016, about 164 million people across the globe suffered from a substance abuse disorder. Of that number, 68% were male. The highest risk age group for substance abuse is 20-29 years (Patel, et al., 2016).

Africa is experiencing a rise in substance abuse, even though the continent still has one of the lowest prevalence rates when compared to other regions. Fuhr et al. (2014) found that the most popular illicit substance in Africa is cannabis. The African regions with the highest prevalence of cannabis use include Central Africa (13.5%) and West Africa (5.2%). According to Charlson et al. (2014), amphetamine-type stimulants which include ecstasy are now the second most abused drug in Africa. There are currently 28 million people who abuse alcohol in Africa (WHO, 2018). This figure does not include those Africans whose alcohol abuse is undiagnosed and therefore unreported in the official statistics.
Kabwama et al. (2016) found that there is a wide variety of controlled substances that are available on the black market in Uganda. The drugs of choice in Uganda include khat (mairungi), marijuana and alcohol (Dimanin, 2012). Alcohol abuse has attracted interest from researchers such as Nalwadda et al. (2018) because it is the drug of choice for many people who are otherwise limited from accessing other harmful substances. Charlson et al. (2014) identified a number of factors that make alcohol a preferred intoxicant including its relative affordability, proximity to the production facilities, a lax legal framework and socialization towards alcohol as the preferred option. Within the African context, the existence of local brews makes it easier to access alcohol (Nalwadda et al., 2018). Moreover, the local brews may potentially have a much higher alcohol concentration than imported alcohol which is required by law to label and restrict its alcohol content (Muhwezi, 2017). The relative availability and affordability of these local brews has fuelled an alcohol abuse problem within vulnerable populations such as the young, poor and sick (Nalwadda, et al., 2018).

Substance abuse in general and alcohol abuse in particular have been associated with ill-health and even death. It is estimated for example that the risk of suicide increases with the consumption of alcohol (10%), psychostimulants (8%) and opioids (7%). Over 300,000 deaths across the globe were associated with a substance abuse disorder. According to Ritchie and Roser (2018) substance abuse disorders account for up to 5% of the disease burden across the globe. The UN estimates that up to 37,000 Africans die on a daily basis as a consequence of substance abuse (UN Office on Drugs and Crime, 2017). Moreover, about 3.3 million Africans die from alcohol abuse per year (Fuhr, et al., 2014).

2.2.1 Community responses to substance abuse

The community may find it hard to deal with the costs of alcohol abuse even if there are only a minority of people with this problem in a given locality (Bett, Russell, & Kabanda, 2005). Boeri et al. (2016) have suggested that there are a number of factors that lead to this apparent inability to deal with the problems associated with alcohol abuse including the lack of awareness of alcohol abuse issues, prejudice against people who abuse alcohol, a lack of resources to deal with alcohol abuse, low levels of literacy about health issues in general and even collective fatigue after dealing with so many other social problems. Consequently, many people that abuse alcohol are shunned by their own communities and perceived as having very little to contribute in terms of community welfare and community development (Dimanin, 2012). This means that
sometimes social services that would help people who abuse alcohol are not always given the highest priority once subjected to the democratic process (Katungi & Nyamwire, 2016).

A developing country such as Uganda is ill-equipped to effectively and comprehensively deal with all the social ills associated with increasing alcohol abuse, not least because of the lack of appropriate and sufficient resources (Bett, Russell, & Kabanda, 2005). Nevertheless, there have been efforts to mitigate the tide of increasing alcohol abuse. For example, the government of Uganda passed legislation such as the Narcotics drugs and Psychotropic Substances (Control) Act of 2015. Such laws are designed to ensure strict sentencing for drug traffickers (Nakatudde, 2014). Although legislative measures can control the supply side of substance abuse, they do little to address the demand side (Dimanin, 2012). Similarly, these laws do not address the issue of alcohol abuse given the fact that there are many local brews that are not imported and therefore outside the laws address the international narcotics trade (Nalwadda, et al., 2018).

One of the reasons for an ineffective response to the increasing rates of alcohol abuse in Uganda is the lack of accurate and timely information about the livelihoods of people who abuse alcohol or even the nature of the alcohol abuse itself (Dimanin, 2012). There are certain social-cultural barriers in accessing affected populations for purposes of finding out their perspectives and experiences. Nabatanzi(2013) has identified some of these barriers including a generally conservative stance about discussing personal issues, the fear of the social stigma attached to substance abuse, the existence of alternative avenues for dealing with substance abuse such as traditional healers and general suspicion about the intentions of the institutions that are mandated to deal with substance abuse. Between 2010 and 2014, the Ministry of Health recorded up to 85,000 separate cases of substance abuse in Uganda (Nyangoma, 2015). However, many more cases of alcohol abuse in Uganda are hidden and unreported (Nalule, 2015).

2.3 Consequences of Alcohol Abuse

The outcomes for people who abuse alcohol in Uganda in terms of social functioning are bleak (Boeri, et al., 2016). According to Dimanin (2012) many people who abuse alcohol drop out of school and formal employment whilst others join gangs or are otherwise enticed into criminality. Those who abuse alcohol are also at a higher risk of HIV infection (Katungi & Nyamwire, 2016). In addition Swahn et al.(2014) found that abusing alcohol increases the risk of committing crime, engaging in domestic violence, being unemployed, having dysfunctional family relationships and having unstable housing arrangements.
Alcohol abuse is not an individualized and a private problem (Boeri, et al., 2016). Indeed, research suggests that the problems stemming from alcohol abuse can affect the community at large (Dimanin, 2012). In this case, the community includes significant others (children, dependents, spouses and sexual partners), extended family and the other people that live with the person that abuses alcohol (Ruiz & Strain, 2011).

Atuhaire (2006) found that the rehabilitative services that are available for people who abuse alcohol in Uganda are concentrated in Kampala city. The reasons for this centralization include historical location of mental health facilities such as Butabika hospital as well as the commercialization of the drug rehabilitation programs (Shah, et al., 2017). Some NGOs and charities provide a range of rehabilitative services (Kasyate, 2017). However, these rehabilitative services tend to be disparate and scattered depending on the priorities of the particular agencies funding the programs (Tusingwire-Karumira, 2010). The few private agencies that offer alcohol abuse rehabilitation are too expensive for the average Ugandan family (Atuhaire, 2006; UBOS, 2017). Ultimately, this means that people who are poor or who live in rural areas do not get access to these services (Nalwadda, et al., 2018).

Bearing in mind all the negative effects and long term consequences of substance abuse in general (and alcohol abuse in particular) across the globe, it incumbent upon society to identify potential solutions to this problem. In order to provide those solutions, the causes of alcohol abuse must be understood. No matter how comprehensive and detailed a situation analysis of alcohol abuse is for example, that particular problem cannot be solved without understanding why it occurs in the first place (Patel, et al., 2016). Therefore, it is appropriate to consider how and why alcohol abuse arises.

2.4 Causes of Alcohol Abuse

Existing literature has attempted to explain the origins of alcohol abuse. There are two main strands in terms of understanding the causes of alcohol abuse. The first strand is clinical in nature and attempts to diagnose the condition in a very reductivist way (Connors, et al., 2013). This study seeks to complement the medical model by highlighting the anthropological issues in alcohol abuse. This anthropological approach is emic in nature in as far as it understands alcohol abuse from the perspective of the people that are affected by this phenomena (Boeri, et al., 2016). The strengths perspective in social work supports this approach in as far as it does not put limits on the possibilities of people to describe their life situation (Saleebey, 2002).
strengths perspective also believes in the capacity of people who are afflicted by social problems to find resilience and support from within their context. This remains true regardless of how dire their situation appears to be (Bunt Gregory & Britta, 2011). For purpose of clarity and completeness, it is appropriate to first explore the medical model and its explanations of alcohol abuse before exploring the alternative anthropological perspectives on alcohol abuse.

2.4.1 Clinical explanations of alcohol abuse

One of the leading clinical explanatory models of alcohol abuse is the self-medication hypothesis. The self-medication hypothesis has significantly influenced mainstream thinking about the causes and management of addiction (Leeise, et al., 2010). At the core of self-medication hypothesis is the view that alcohol abuse is a manifestation of symptoms and complex stressors within the individual which may include excessive emotional crisis points and trauma (Khantzian, 1997). Therefore, a substance such as alcohol is considered to be an inappropriate and largely ineffective form of treatment. Sam Lee et al. (2012) postulate that substance abuse (cannabis being a controversial example) can (at relatively low levels of use) help the affected person to cope with serious emotional states which would otherwise be unmanageable. The view that a substance such as alcohol can be an effective coping mechanism for suffering is challenged by the assertion that alcohol abuse (even at relatively low levels) causes irreparable damage to the body, brain, mind and social relations of the individual to the extent that it becomes an unacceptable form of treatment (Leeise, et al., 2010).

According to Leeise et al. (2010) alcohol abuse is a self-regulation strategy by those who do not have sufficiently robust alternatives. Hahm et al. (2014) have identified four principal areas in which alcohol abuse may be adopted as a coping mechanism. These include a lack of self-esteem, poor emotional regulation, dysfunctional interpersonal relationships and poor self-care. Such an assertion presupposes that those who have robust self-regulatory mechanisms have no need for substance abuse. This assumption is not supported by the studies which show that individuals with highly complex self-regulatory strategies can still engage in alcohol abuse, albeit with more control over their behaviour than those with poor self-regulatory capabilities (Connors, et al., 2013; Swahn, et al., 2014).

According to Tomlinson et al. (2006) the selection of a particular substance is linked to the particular distressing emotional state that a person is experiencing. In this case the characteristics of the alcohol and its supposed curative powers are an important consideration (Hahm, et al.,
Such propositions presuppose choice on the part of the person abusing the alcohol. However, the economic realities in Uganda and the clandestine nature of other forms of substance abuse may mean that vulnerable people end up abusing alcohol because it is the only readily accessible (Kabwama, et al., 2016). In that sense, it could be argued that people who abuse alcohol do not engage in sophisticated decision-making about whether or not alcohol is the right substance to use for their particular emotional state. Rather, that alcohol abuse as a specific form of substance abuse is a reflection of the limited alternatives in terms of the available mind-altering substances in Uganda (Nalwadda, et al., 2018).

Tomlinson et al. (2006) found a positive relationship between alcohol abuse and co-occurring psychological impairment. Other authors such as Bunt Gregory and Britta (2011) suggest that psychological problems precede alcohol abuse. It is however not clear as to whether the psychological problems are the predictors of alcohol abuse or whether alcohol abuse is the predictor of the psychological problems. Nevertheless, Potvin (2009) found that some psychological impairments such as Schizophrenia are associated with drug abuse. These studies which focus on the psychology of alcohol abuse are limited in as far as they do not explore the non-psychological aspects of alcohol abuse. Yet, there are other studies that highlight the fact that alcohol abuse is a lot more than merely an experience of psychological impairment (Heath, 2012).

Trauma has emerged as one of the most important correlates of alcohol abuse (Tomlinson, et al., 2006). It has contrasting explanations depending on whether the literature supports a social (Bennett, 2008), psychological (Leeise, et al., 2010), psychosocial (Hahm, et al., 2014), biophysical (Martinotti, et al., 2013), or even spiritual (Humphreys, 2015) paradigm. Social trauma in this case is associated with stigma and social exclusion to the extent that alcohol becomes a personal shield and an implicit rejection of the norms of a given society (Bunt Gregory & Britta, 2011). The psychological paradigms focus on how the mind is gradually corrupted by the use of alcohol until dependency arises (Bunt Gregory & Britta, 2011). By contrast the biophysical paradigms explain addiction by reference to dysfunction within the human brain structure (Ruiz & Strain, 2011). The spirituality paradigm explains trauma, not in its physical or mental manifestations but rather as a poverty of spiritual reference or guidance (Humphreys, 2015). Although these studies provide a much more holistic view of alcohol abuse, they are necessarily deterministic and reductivist in nature since they seek to identify potential
interventionist models. It could be argued that the causation which these studies seek to highlight is not fully substantiated by the clear associations that they demonstrate between trauma and alcohol abuse.

Generally speaking, the clinical explanations of substance abuse provide complex models which claim exclusive scientific veracity. However, these clinical models raise even more questions about the continued existence of alcohol abuse in communities. For example, if alcohol is indeed an ineffective self-medication tool that is misguidedly abused to deal with the symptoms of stress, disease and other forms of suffering; why is it the people continue to self-medicate with alcohol regardless of its known ineffectiveness as a salvo for certain unpleasant symptoms? Furthermore, why is it the people who have undergone substance abuse recovery programs that are administered under the medical model still continue abusing alcohol or even relapse back into their old patterns of substance abuse? In any case, the medical models do not adequately answer why (despite the information that is widely available about the dangers of substance abuse) this phenomenon continues to exist in even the most industrialized societies like Norway where clinical interventions are prioritized. Another legitimate question may relate to the relevance of clinical models of substance abuse to an African context, bearing in mind that many of these models were developed in Europe and North America. In order to answer some of these questions, anthropologists have sought to provide an alternative set of explanations for substance abuse.

2.4.2 Anthropological explanations of alcohol abuse

The anthropological conceptualization of alcohol abuse acknowledges the diversity of explanations that may not fit into the clinical explanations that are described above (Humphreys, 2015). There are four major strands that have emerged in the anthropological explanations of alcohol abuse (Heath, 2012). These include influences of culture, the lifestyle model of alcohol abuse, critical medical anthropological perspectives and client explanatory models. These strands explain alcohol abuse from the perspective of the people abusing alcohol and the community within which they live. The explanations that they provide may not necessarily meet the highest standards of quantitative evidence but they nevertheless have qualitative value in as far as they provide an additional dimension to our understanding alcohol abuse (Bunt Gregory & Britta, 2011).
Cultural model of alcohol abuse

Existing literature has acknowledged the cultural dimensions of alcohol abuse. Heath (2012) for example finds that there is inter and intra cultural conflict with reference to the definition of the key characteristics of alcohol abuse. In some societies alcohol consumption is a social event that is not perceived to be harmful, even when the amounts consumed lead to intoxication (Hahm, et al., 2014). However, in other societies intoxication is taboo, regardless of the substance which triggers that state (Bett, Russell, & Kabanda, 2005). The notion of normative limits on acceptable consumption levels can therefore determine the threshold at which acceptable alcohol use turns into alcohol abuse (Bunt Gregory & Britta, 2011).

It is important to note that the clinically defined levels of use that constitute alcohol abuse may be different from the minimum acceptable standards for a given community (Leeise, et al., 2010). A case in point are the Camba people of Bolivia where all adults were found to be routinely intoxicated by rum for several continuous days on a bi-monthly basis, yet this community did not consider this level of alcohol consumption to be a form of alcohol abuse (Heath, 2012). Indeed, a closer examination of the Camba community indicated that intoxication was a socially valued attribute as part of the festive drinking patterns within that society. Despite this socially sanctioned use of alcohol, the Camba community did not exhibit the clinically defined negative consequences of alcohol abuse such as violence, interpersonal aggression or even sexual promiscuity. Such findings demonstrate a mismatch between the clinically defined notions of alcohol abuse and those that are culturally defined.

Fuhr et al. (2014) find that alcohol abuse may actually commence through societal events and practices that are originally designed to achieve certain societal goals. Heath (2012) identified some of these goals including cohesion, solidarity, self-expression, remembrance, identity, the allocation of status, mourning, work, intimacy, fun, cultural transition and worship. Bunt Gregory and Britta (2011) also found that the availability of highly addictive alternatives to traditional intoxicants may fuel the onset of a serious addiction. A case in point is how the Baganda of Uganda consume local brews such as “Mwenge Bigere” and “Bwakata” during funeral celebrations (Nalwadda, et al., 2018). Some members of societies which tolerate alcohol consumption may progress into alcohol abuse when they continue the practice beyond the situations where it is normatively acceptable to consume alcohol (Heath, 2012). In the case of the Camba community, the end of the community’s agrarian rural lifestyle led to the onset of
unemployment and the resultant participation of the community in the illegal trade in cocaine, a highly addictive substance (Heath, 2012). This has led some researchers like Berger (2013) to critique the cultural explanations of alcohol abuse as only being relevant to traditional societies that have not yet been exposed to the social ills of modern life such as the international illicit drugs trade. Berger (2013) also critiqued the cultural model of alcohol abuse for failing to fully account for the psychological dimensions of the phenomenon.

Although the cultural model of alcohol abuse provides a persuasive explanation of the role of the norms and values of the society within which an individual was born and raised, it does not adequately explain why some people continue abusing alcohol despite the limits that are placed on them in their culture. Specifically, the cultural model does not seem to adequately address the role of human agency in alcohol abuse. Instead, it tends to describe people as nothing more than products and manifestations of the collective or predominant culture within which they live. This raises questions about the role of subcultures and countercultures within the community which may encourage substance abuse despite the possibility that this behaviour is generally frowned upon in the mainstream society. Besides, the cultural model seems to refer to idealized traditional societies within which alcohol abuse is controlled and human agency sufficiently subjugated through socialization. That leaves an explanatory gap in terms of why alcohol abuse may occur in contemporary societies which have largely abandoned their traditional norms and which are sometimes an amalgamation of so many different cultures (Dimanin, 2012). Therefore, the lifestyle model of alcohol abuse attempts to address the weaknesses of the cultural model of alcohol abuse.

Lifestyle model of alcohol abuse

The lifestyle model has emerged as an alternative to the cultural model in an attempt to explain the incidence of alcohol abuse by individuals or subsets of communities, despite the overall cultural controls that are placed the community as a whole. The lifestyle model suggests that alcohol abuse is a patterned lifestyle that may be associated with a subculture within a given community (Bunt Gregory & Britta, 2011). In this instance, the people who abuse alcohol construct way of living, thinking and behaving that supports this condition (Kabwama, et al., 2016). Nalwadda et al. (2018) highlighted how these subcultures of alcohol abuse may generate a series of socially constructed values, meanings and understandings that contrast with the mainstream society. According to Bennet (2008) the knowledge, attitudes and norms of these
subcultures may even be considered to be antisocial when compared to the mainstream society within which they occur.

The lifestyle model specifically rejects the notion of a homogenous culture across societies and gives space for those people that may not conform to societal norms or its values (Heath, 2012). Besides, the people that abuse alcohol may deliberately set out to subvert and challenge the norms of society for a number of reasons which include disaffection, resentment or even protest (Nalwadda, et al., 2018). The so called “sub-culture of drug abuse” is a well-known phenomenon in existing literature (Heath, 2012). In order to understand how alcohol abuse occurs within this sub-culture, it is important to move away from the simplistic labels and categorizations that tend to stereotype the people that abuse substances. For example, Power et al. (2018) found that gay men who abuse drugs via intravenous needles can form a set of rules which govern their existence including sharing needles (or other resources) and even taking safety precautions against the transmission of blood-borne diseases like HIV/AIDS. In other words, it is not that these subculture and countercultures do not have norms and values. Rather, they have norms and values that diverge from the mainstream culture that is referenced in the cultural model of alcohol abuse (Heath, 2012). Consequently, the people who abuse alcohol form communities within a community.

Alcohol abuse then becomes a lifestyle with complex dynamics that must be understood separately from the mainstream society, even when the people that lead a lifestyle of alcohol abuse co-exist with other members of the society that do not abuse alcohol (Heath, 2012). According to Kelly et al. (2015) some of the dynamics associated with a lifestyle of substance abuse include specific mechanisms for recruiting and socializing people into the substance abuse; the organization of substance abuse as a distinct economy; the creation of social networks, social capital and social relationships; the selection of specific environments that facilitate substance abuse; the development of a common language or jargon which is understood by those that abuse substances; and the development complex group norms that determine who is in and out of the community of people who abuse substances. The limitation of this particular study is that it focuses on a specific form of substance abuse relating to prescription medicine and within a specific population of young people. It is not clear whether the assertions made by Kelly et al. (2015) hold true for other forms of substance abuse in general and alcohol abuse in particular or whether they are applicable to all communities of people who abuse substances. Nevertheless,
the findings of this study reinforce the view that the people who abuse substances (including alcohol) form societies that are often hidden from mainstream social service providers and clinical facilities (Nalwadda, et al., 2018). The failure to understand these people and how they live means that their needs are not always fully addressed (Connors, et al., 2013).

Although the lifestyle model of alcohol abuse describes how this phenomenon is constructed, supported and perpetuated within a complex system of subcultures and countercultures; it does not adequately address the issues of structure. For example, there is a legitimate question as to how much power and influence a community of people who abuse alcohol has in a wider society that is able to exercise control through a range of measures including the compulsory testing and treatment; prosecution under the law; denial of access to certain economic rights; and generalized societal disapproval of alcohol abuse (Dimanin, 2012). It is those questions about the role of structure that are addressed by the critical medical anthropology model of alcohol abuse.

Critical medical anthropology model of alcohol abuse

The critical medical anthropology model emerged from a recognition of the limitations of the cultural and lifestyle models (Heath, 2012). Specifically, the critical medical anthropology model considered the structural context within which alcohol abuse occurred (Hahm, et al., 2014). Ruiz and Strain (2011) describe this structural context including issues such as systemic discrimination, social stratification and the existence of institutions of social control. A case in point is where disaffected youth turn to drugs such as alcohol, being part of a protest against a society that has ceased to have relevance to them (Bunt Gregory & Britta, 2011). The critical medical anthropology model identifies three key issues that may explain alcohol abuse. These include the social production of suffering, use of drugs for self-medication purposes and the political economy of alcohol (Heath, 2012).

The first explanation for alcohol abuse within the critical medical anthropology model is that of the social production of suffering. In this case, the poor are exposed to privilege to which they have no access and which sharply contrasts with their own social deprivation (Nalule, 2015). In their study about the lives of street children, Bett, Russell and Kabanda (2005) found that the privileged people in a given community exercise their power and influence in such a way as to exacerbate the suffering of the weak and marginalized. This reproduced and intensified
suffering therefore drives vulnerable members of the community into alcohol abuse (Heath, 2012).

The second aspect within the critical medical anthropology model refers to the use of alcohol as a form of self-medication which is intended to mitigate against the social injustices that exist within a given society (Kabwama, et al., 2016). In this case, alcohol abuse creates a vicious circle in which the user is marginalized and degraded into even more serious alcohol abuse (Heath, 2012). Rather than focusing on the clinical dimensions of the self-medication hypothesis that has already been discussed, the medical anthropological view of substance abuse suggests that alcohol abuse is caused by social injustice (Tusingwire-Karumira, 2010).

The final issue within the critical medical anthropology model is that of the political economy of alcohol abuse which makes alcohol readily available to people who would otherwise not engage in alcohol abuse (Nalwadda, et al., 2018). In this case, there are people and communities that benefit from the trade in alcohol. This means that the vested interests prevent any significant interventions from taking place which might render the trade obsolete (Charlson, et al., 2014). As a consequence, people who are susceptible to addiction may be exposed to alcohol and eventually start abusing it.

Although the critical medical anthropology model of alcohol abuse explains the role of structural issues in causing alcohol abuse, it does not fully account for the divergent views about what people may perceive to be or not to be structural issues. For example, the structural issues that are described in critical medical anthropology do not specifically reference the role of the supernatural. In the Uganda context, it leads to the question as to why some people continue visiting witchdoctors, faith healers and herbalists in order to deal with alcohol abuse despite the widespread criticism of these options within the mainstream scientific community (Nalwadda, et al., 2018). The client explanatory models specifically seek to provide an alternative explanation that may not rhyme with the scientific view of alcohol abuse.

Client explanatory models of alcohol abuse

Client explanatory models describe how people may attribute alcohol abuse (and other aspects of mental ill health) to causes that are not proved through rigorous scientific research and therefore also not recognized in mainstream medical literature (Weaver, 2016). Although clinicians are sometimes critical of client explanatory models, they can be an important determinant of health-seeking behaviour (Boeri, et al., 2016). The client explanatory models are
certainly important when designing culturally relevant interventions for alcohol abuse (Hahm, et al., 2014). Weaver (2016) has suggested that some people who abuse alcohol may attribute this condition to supernatural causes that are beyond the scope of clinicians. This may mean that the people who abuse alcohol do not seek medical help but instead seek supernatural interventions including spiritual support (Nalwadda, et al., 2018).

These client explanatory models are particularly important in the Ugandan context where traditional culture and traditional healers play an important in the health-seeking behaviour of the community (Nalwadda, et al., 2018). Some of the explanations for alcohol abuse that have been presented in the Ugandan context include witchcraft by malevolent relatives such as step mothers; curses that are placed on the person by elders, the malevolent efforts of love rivals and jealous workmates who send bad spirits to the person; or a spiritual disease that may be caused by demonic forces that target the individual, clan or community (Kabwama, et al., 2016).

Although client explanatory models give a lot of credence to the personal experiences of the people that abuse alcohol, they are subject to criticism on the grounds that they do not adequately test the veracity of the claims made about these client explanatory models. For example, it is difficult to assess an acceptable measure of effectiveness. There are legitimate questions to be asked as to whether effectiveness is based on the perceptions of the person abusing alcohol (which could actually be clouded by their substance abuse) or the experts who may not have sufficient knowledge about the experiences of abusing alcohol. Moreover, these client explanatory models do not sufficiently address the experiences of those people who abuse alcohol but who also simultaneously do not believe in the power of the supernatural.

Having considered a range of explanations that are provided for alcohol abuse, it is appropriate to consider the reasons as to why many people that abuse alcohol are still living in various communities across the globe. Indeed, they continue to exist despite all the negative effects that are associated with their behaviour and even their inability to access the mainstream interventions that are recommended for alcohol abuse (Bennett, 2008). It is from that perspective that it is appropriate to consider how alcohol abuse and its effects are managed in the community.

2.5 Managing Alcohol Abuse and its Effects

Existing literature has shown that the propensity to fall into alcohol abuse, addiction and self-harm can vary from person to person (Fuhr, et al., 2014). For example, some people do not
progress towards alcohol abuse even after being exposed to it (Ritchie & Roser, 2018). This diversity of experiences extends to the way in which people experience alcohol abuse and its consequences. A case in point is how some people appear to manage the effects of alcohol better than others regardless of their levels of alcohol abuse (Fuhr, et al., 2014). Ruiz and Strain (2011) have identified four major management strategies including seeking medical support, making use of social support systems, engaging with social capital networks and resorting to personal management mechanisms.

2.5.1 Seeking medical support

Some people who abuse alcohol may seek or be offered medical support in the form of detoxification, behavioural counselling, medication and faith-based programs (Charlson, et al., 2014). These interventions are backed by empirical evidence of not only modifying behaviour, but also enabling the client to build coping mechanisms that reduce the negative impact of alcohol abuse (Bunt Gregory & Britta, 2011). The prescribed programs may however not be entirely effective and many of the clients that go through them end up relapsing into negative behaviour patterns once the programs have ended (Connors, et al., 2013). The programs can also be quite expensive and may be inaccessible to people of a low social-economic status who need them (Charlson, et al., 2014). Other programs have been criticized for lacking sustainability and replication because they are only relevant under very specific and controlled situations (Ruiz & Strain, 2011). Moreover, few governments in the developing world have the structures and infrastructure that are necessary to make these programs available to all citizens (Atuhaire, 2006). Nevertheless, these programs have been persistently promoted by those who favour the medical model of intervention, their mixed record of results notwithstanding (Ritchie & Roser, 2018). This then leads to the question as to how people with access and the means to use medical facilities survive despite abusing alcohol. The role of social support systems provides one explanation for their survival.

2.5.2 Role of social support systems

Depending on their location and eligibility, people who abuse alcohol may gain access to certain social support systems (Boeri, et al., 2016). These systems may not tackle the alcohol abuse directly but may instead focus on dealing with the structural issues that may be limiting the personal agency of people and therefore pushing them into alcohol abuse (Patel, et al., 2016). This kind of intervention may take the forms of emotional support, tangible support,
education/information and companionship (Winters, et al., 2013). A case in point is the provision of adequate housing, social care, recovery programs for previously incarcerated people, facilities for immigrant communities and youth employment programs.

The premise behind these programs is that by tackling the social problems that lead to or encourage alcohol abuse, it is possible to systemically deal with the problem before it becomes a crisis (Bunt Gregory & Britta, 2011). The objectives of the social support systems include building resistance, strengthening resilience and facilitating recovery (Saleebey, 2002). Unfortunately, developing countries do not have the resources or political will to invest in institutionalized social support systems (Charlson, et al., 2014). That means that the provision of these services for people who abuse alcohol is patchy at best. It is important to consider how the people that need them first get in touch with these social support systems and continue engaging with them. The role of social capital networks may provide an explanation.

2.5.3 Access to and use of social capital networks

Boeri et al. (2016) have identified social capital as a potential resource for people who are dealing with the effects of alcohol abuse. According to Dimanin (2012) social capital is typically acquired from family, friends, neighbours, clans, communities, tribes, nationalities and even race. People who abuse alcohol may obtain and expend social capital at any of these levels. Indeed, social capital can be accumulated and expended during the process of abusing alcohol (Boeri, et al., 2016). The challenge for people who abuse alcohol is the difficulty in engaging in reciprocity, a necessary ingredient for social capital to be accumulated (Ruiz & Strain, 2011). Many people who abuse alcohol end up engaging in exploitative behaviour which breaks some of the social bonds that might otherwise have provided them a buffer from some of the worst effects of alcohol abuse (Bennett, 2008).

Much as the social capital networks provide a pathway to social support systems that are an alternative to medical support, it is important to recognize that people are not merely agents of social systems (Heath, 2012). There are private moments and private lives in the existence of people who abuse alcohol (Berger, 2013). This then leads to the question as to how those who people are unable to or unwilling to utilize social capital and social networks survive alcohol abuse. The personal management mechanisms may provide an explanation.
2.5.4 Personal management mechanisms

The diversity of people that abuse alcohol and their various personal management mechanisms are recognized in existing literature (Bennett, 2008). According to Humphreys (2015) some of the key management mechanisms including thought-blocking, developing new hobbies, disassociation from other people who enable the alcohol abuse, empowering self-talk, productive distraction, finding spirituality and self-expression. These positive management mechanisms are distinguished from other negative forms of management which may include denial, avoidance, displacement, procrastination, rationalization, passive-aggressiveness, compartmentalization, intellectualization and trivialization (Winters, et al., 2013). Although existing literature has described these personal coping mechanisms in detail, there is a dearth of studies that specifically focus on the experiences of people that are living in rural areas like Wakivule and who are dealing with the problem of alcohol abuse. It is not also clear as to how effective and how appropriate these personal management mechanisms are or whether it is even possible to replicate these individual management mechanisms across a population of people who abuse alcohol.

2.6 Summary of literature review

Existing literature on alcohol abuse highlights the contrast between the medical and psychosocial dimensions of alcohol abuse. The medical model tends to focus on testing for and consequently treating alcohol abuse using a set of prescriptive options. Therefore, the medical model tends to conceptualize alcohol abuse as a pathological anomaly that needs correction through treatment. Because the medical model is etic in its approach, it sometimes fails to account for the perspectives of the people who abuse alcohol and who may have very different perceptions of their reality. The subsequently deterministic understanding of alcohol abuse preferred by clinicians largely ignores the rich constructivist narratives given by the people that abuse the alcohol. In contrast, the anthropological understanding of substance abuse allows the people who abuse alcohol to describe, define and explain the phenomenon. The weakness of the anthropological perspectives on alcohol abuse is that they give too much credence to subjective interpretations of the phenomena, sometimes at the expense of scientific rigour. Ultimately, neither the medical nor anthropological models of alcohol abuse are able to comprehensively and exclusively describe the experiences of alcohol abuse.
There is gap in existing literature by virtue of the dearth of studies that specifically focus on the experiences of small rural communities within a developing country such as Uganda. Moreover, many of the studies that currently examine alcohol abuse adopt a disempowering and technical view of the phenomena. The resultant models then appear to be overly deterministic and removed from the reality of the people that have personal experiences of alcohol abuse. This study seeks to complement existing literature by describing the experiences of people who abuse alcohol in Wakivule village, Uganda. By allowing people to describe alcohol abuse in their own language and according to their own conceptualizations of the phenomenon, this study empowers and gives voice to the community at large. The approach adopted by this study is consistent with the strengths perspective which seeks to empower people rather than subduing them through the reductivist medicalization of their experiences.
Chapter Three

METHODOLOGY

3.1 Introduction

This chapter presents the research design and approach, the study area and population, data collection and data analysis methods and ethical values that were considered during the conduct of this study. It also presents the challenges and limitations of the study and the ways in which they were mitigated.

3.2 Research Design and Approach

A descriptive qualitative case study was conducted in Wakivule village, Luwero district. This study focused on interviewing purposively selected participants. The unit of analysis was some residents of Wakivule village, Luwero district who were known to abuse alcohol or admitted to be abusing alcohol.

3.3 Study Area and Population

Wakivule village is part of the Kikyusa municipality which is located within Luwero district in Central Uganda. Kikyusa is one of the upcoming conurbations in Luwero District and serves as a trading centre for agricultural goods destined for South Sudan (Luwero District Local Government, 2012). Despite its relative affluence when compared to other semi-rural parts of the district, Kikyusamunicipality is plagued by a number of social problems including high levels of unemployment among the, high HIV incidence/prevalence, and high levels of alcohol consumption (Ministry of Finance, 2014). These social problems seem to be spreading out from the municipal centre to the surrounding villages such as Wakivule (Luwero District Local Government, 2012).

Wakivule village is located in what is considered to be a rural area of the municipality. However, that description may not capture the reality of the village as it stands today. Wakivule village is connected to the upcoming town of Kikyusa and Zirobwe. It is located approximately 49 miles from Kampala city. When travelling to the village via Gayaza road, the first 40 miles of the journey are on a modern tarmac highway. The primary economic activity in the area is farming. Maize serves as the staple food and cash crop. However, residents engage in mixed farming which include rearing goats, cows, and poultry and growing sweet potatoes, rice, coffee
and pineapples. The vast majority of the population is subsistence farmers by occupation. The village has recently seen the entrance of large-scale landowners. Some of these landowners were once absentee landlords, but have since taken the opportunity to return and develop their farms. Consequently, many local people who were squatters on various tracts of land have been displaced. There are about 10 major land lords who own about 80% of all the land in Wakivule village. That means that there is a very wide income and wealth inequality between the poor and the rich in Wakivule village.

An initial check on the electoral register and preliminary consultations with the Local Council I Chairman was conducted, I found that Wakivule village had about 220 people; about 40% were male and 60% were female. Anecdotal evidence suggests that about 35% of the male population and 10% of the female population have ever abused alcohol. However, it is not clear how many were in treatment or recovery.

Alcohol abuse is one of the major challenges for the people in Wakivule village. The problem of alcohol abuse is linked to other social problems affecting people in this village. For example, many young men are not in formal employment and do not have access to permanent tenure of land. Some resort to working as labourers for the land owners or working as middlemen when the farmers want to sell their crops. Others have opted to join the Boda-Boda transportation business which involves ferrying passengers to and from nearby towns. When these young men earn money, they invariably spend it on alcohol and partying with local sex workers. This pattern on spending on various forms of entertainment supports the local economy of alcohol consumption. Other anecdotal evidence suggests that many landlords in the nearby Kikyusa town have stopped taking in young families as tenants and instead use their rooms as brothels for a monthly fee or hire them out as semi-permanent bars.

There is anecdotal evidence to suggest that older men that were too physically weak to do manual labour mainly stay at home and take control over the income that is earned by their wives. The wives earn this income through small scale farming or the sale of alcohol. The control that is exercised by their husbands is achieved through the use of domestic violence and social pressure. Those older married men that were successfully able to control the money that was earned by their wives used the money to purchase alcohol and the services of sex workers. Young women did not fare any better than their male counterparts in terms of their life prospects. These young women either got married as quickly as possible or failing that; resorted to sex
work in Kikyusa town in order to earn a living. The sale of alcohol has emerged as one of the most lucrative local businesses. The vending of alcohol was mainly carried out by middle-aged and older women who sold alcohol from within their own homes. The so called “village drunks” have formed a powerful and influential campaigning group which voted out of power any local leader that threatened to shut down these drinking places. As a consequence, there was limited political will to deal with the problem of excessive drinking. In the recent Local Council 1 elections, the sitting chairman was not re-elected and one of the main reasons given was that he had offended the village drunks by threatening to close down their entertainment spaces.

3.4 Selection of Participants

Purposive sampling was used to enrol participants in this study. In this case, the researcher made references to the operational definitions that were given by the local leaders. The criteria for people who abuse alcohol as described by local leaders included the following:

(i) **Anyone that was found consuming during working hours**: This criterion was modified upon extensive discussion with the village elders to exclude anyone drinking alcohol after 6pm or on weekends. The rationale for this definition was based on the widely held assumption that anyone found consuming alcohol during the assumed working hours during the busy harvest and land preparation seasons must necessarily be one of the so-called “village drunks”.

(ii) **Anyone that demonstrated signs of abusing alcohol**: The village leaders were of the view that it was relatively easy to spot someone that was abusing alcohol. Their criterion included the visible signs of personal neglect, a strong smell of alcohol on them during the day and failure to meet their parental responsibilities.

(iii) **Anyone that admitted to abusing alcohol**: The village leaders noted that there were some people that were willing to admit to abusing alcohol. Indeed, some of them were happy to be labelled “village drunks” by virtue of the fact that they had formed a powerful faction that was able to decisively influence the local council.

These inclusion criteria may not necessarily meet the highest standards of sampling and therefore have the potential for bias (Creswell, 2013). For example, it is possible for someone to look unkempt and even to smell alcohol without meeting the clinical criterion for alcohol abuse (Humphreys, 2015). Likewise, there are people who abuse alcohol but are able to meet their parental responsibilities such as paying school fees for their children (Connors, DiClemente,
The researcher developed an amalgamation of inclusion criteria that referenced the subjective views of the village leaders and some of the other widely accepted inclusion criteria for alcohol abuse in existing literature. The unit of analysis was therefore individuals who meet a number of criteria:

- **Residents of Wakivule village, Luwero district during August 2018**: This selection criterion excluded those who were just travelling through the village or on a short-term visit to the locality.

- **People who were identified or self-identified as alcohol abusers**: This selection criterion considered the stigmatizing nature of alcohol abuse and the fact that some people may not want to be identified as having engaged in alcohol abuse (Boeri, et al., 2016).

- **People who were aged 18 years and above by the 15th of August 2018**: This selection criterion deliberately excluded children who had not attained 18 years of age. This because of the challenges of obtaining consent from their parents, particularly given the fact that the consumption of alcohol before attaining 18 years of age is illegal in Uganda (Muhwezi, 2017).

Using the criteria described above, 10 participants were identified for individual interviews while six additional ones were selected for a focus group discussion. A coordinator from within the community was requested to arrange appointments and bring participants into the interview area. The researcher made a case-by-case decision as to whether the potential participants were able to understand interview questions translated from English to Luganda language and to effectively respond to them. Where appropriate, an interpreter or support was called upon to assist in the selection and interviewing process.

The selection of participants made use of information and guidance that was provided by a number of key informants including the Local Council 1 chairman, the local council security officer, the leader of the Village Health Team and people that were found at the local drinking joints. Four key informants were selected among them to participate in this study. The researcher purposively chose individuals from the political leadership, community development, health and gender specializations as key informants. The decision to include these key informants was based on the potential conflict between etic and emic views of alcohol abuse (Boeri, Gardner, Gerken, Ross, & Wheeler, 2016). Specifically, there was a risk that people who abused alcohol
themselves would reject such a label being attached to them by outsiders (Heath, 2012). In addition, these key informants were selected because they were presumed to have insider knowledge of the local population and the people who abused alcohol, even where those individuals had not immediately self-identified as abusing alcohol.

3.5 Data Collection Methods and Process

3.5.1 Research tools

The study used three research tools. These research tools were designed to reflect the research topics that were drawn from the research objectives and research questions (see appendix 1). The first research tool was an unstructured interview guide for the individual participants (see appendix 2). The second was focus group discussion guide (see appendix 3). The third was a key informant interview guide (see appendix 4). Once the sample interview guide had been designed and approved by the supervisor, it was translated into Luganda in order to be fully understood by all the participants. The researcher did a practice run in order to ensure that they were comfortable with the translations.

Validity and reliability

The researcher selected four people to pre-test the research tools for validity and reliability. These four people were automatically excluded from the main research population. The participants for the pre-test exercise were selected in such a way that they were at different stages of the alcohol abuse trajectory. These stages were defined by key informants. The researcher also ensured that there were two men and two women for purposes of gender balance. The first participant in the pre-test exercise had only started abusing alcohol in the last 6 months. The second participant had been abusing alcohol for no more than 5 years. The third participant had been known to abuse alcohol for over 20 years. The fourth person had recently recovered from alcohol abuse following a family intervention. Having transcribed the initial interviews, the researcher concluded that the acceptable standards of validity and reliability had been met (Creswell, 2013). Specifically, the interviews elicited relevant answers and were fairly consistent. This was true even allowing for the diversity of responses in qualitative studies (Creswell, 2013).
Pilot study

A pilot study of two participants (male and female) was carried out on the 25th of August 2018. The comments and recommendations made as a result of this pilot informed amendments to the research instrument and also the research process. For example, the pilot study indicated that individual interviews could last about 30 minutes for the individual participants and 35 minutes for the key informants, the focus group discussion could last about 45 minutes. Participants in the pilot study indicated that they would be comfortable with an interview that lasted no more than 45 minutes, as long as they had some refreshments during the interviews/FGDs. They also indicated that a disturbance allowance of about UGX 2000 might be appropriate to compensate people for taking part of their valuable time to participate in my study. The participants stressed very strongly to me that it would be very dangerous to offer any of the participants an allowance that is greater than UGX 2000 because they were likely to spend it on alcohol. One participant recounted an occasion when one of the people who consume alcohol begged for and was given a gift of UGX 5000. The person that gave them the money was not very familiar with the village or the people that abused alcohol. The person who received the money ended up using the money to drink until he suffered an alcoholic coma. During the pilot study, participants emphasized the importance of carrying out the interviews in a secluded place. Anecdotal evidence suggests that some potential participants worried about being assumed to be HIV positive by virtue of the fact that they were engaged in extended conversation with the researcher.

3.5.2 Obtaining the interviews

The researcher made an initial visit to Wakivule village, Luwero district on the 15th of August 2018 to discuss modalities of the research project with gatekeepers such as the Village Health Team and the Local Council I committee. This gave the researcher an understanding of the situation in the village and the important points to note when undertaking the research project. For example, it was agreed that the phrase “abuse alcohol” should be replaced with the term “consume alcohol” in order to mitigate the potential stigma associated with being interviewed about personal substance abuse (Bunt Gregory & Britta, 2011). Whereas primary participants were identified as people who abused alcohol, the term “abuse” was replaced by

1 This point must be emphasized because of the potential for harm if people who abuse alcohol are given excessive financial allowances to compensate them for spending time on a research exercise.
“use” in the research tools in order to mitigate the risks of bias. This was an important consideration given the risk that participants in a potentially stigmatizing research process such as this can refuse consent on the account of the stigmatizing labels that are used within the research tools (Creswell, 2013).

The interviews were conducted by researcher who read out the questions from the interview guides and explained them so that the participants could answer them. Where appropriate, the researcher prompted participants to expand and explain their answers according to the guide. The participants were provided with refreshments during the interview and a small disturbance allowance of UGX 2000 afterwards. The researcher held a meeting with village leaders and representative from the so called “village drunks” on the 2nd of September 2018 to discuss modalities of collecting the data. It was agreed that key informants would be interviewed on the 3rd of September 2018. The individual participants were interviewed on the 4th of September 2018. A focus group discussion was held on the 5th of September 2018 to conclude the data collection phase of the study.

The key informant interviews

On the 3rd of September 2018, I conducted key informant interviews with three key informants. The first interview was with the former member of the Local Council team. This key informant interview started at 10.30 am and lasted 37 minutes. The second key informant interview was with a member of the Village Health Team. This key informant interview started at 2pm and lasted 43 minutes. The third key informant interview was a former village security officer. This key informant interview started at 4pm and lasted 32 minutes. I visited each of the key informants at their home at the previously allotted time as they had requested. The key informants requested that their names or specific roles are not mentioned in order to avoid being targeted for harassment by people who abuse alcohol. To that end, I merely referred to them as key informants when transcribing the data.

I recorded the data using a smartphone and later transferred the files to a stick storage device on my laptop. All the key informants chose a suitably secluded and quiet place within their home to conduct the interview. The research instrument used was the key informant interview guide (see appendix 4). This guide included the main research topics but the key informants were given the option of answering as people who were affected by alcohol abuse or as people in leadership roles within the community.
The in-depth interviews

On the 4th of September 2018, I conducted out in-depth interviews with 10 participants. The interviews commenced at 10am and ended at 4pm. I allowed for a 60-minute lunch break where no interviews would take place. On average each interview lasted 27 minutes. I recorded the data using a smartphone and later transferred the files to a stick storage device on my laptop. All the 10 participants had been notified in advance and were gathered at a local drinking place that is approximately 200 meters from the venue of the interview.

Each interview as carried out separately under a mango tree in a gated farm within the village. I selected two liaison people from within the group of people who were known to abuse alcohol in Wakivule village, Luwerro district. One was female and one was male, each would be responsible for conducting the participant of their gender to the venue of the interview. Participants entered the gate to the farm and travelled approximately 100 meters to the mango tree. The workers on the farm were working about 500 meters away from the main entrance and could not identify who was coming and going out of the farm. The liaison person would leave immediately before the briefing began, waiting at the gate for the end of the session.

Prior to commencing the interview, all the participants were taken through the informed consent process and requested to append their signature or fingerprint to confirm this. In order to protect their identities, each participant was given a pseudo name that they would use throughout the interview process. One female participant required some occasional translation from Luganda to Lugbara. The female liaison person undertook the role of translating since she was a fluent Luganda and Lugbara speaker.

At the end of the interview, the participant would walk back to the gate where they were received by the liaison person. The liaison person would then get the next participant. The research instrument I used was the key informant interview guide (see appendix 2). This guide included the main research topics but the participants were asked questions relating to alcohol consumption as opposed to “alcohol abuse”, bearing in mind the stigmatizing connotations associated with the term “alcohol abuse”.

The focus group discussion

On the 5th of September 2018, I conducted out a focus group discussion with six participants. The focus group discussion commenced at 11am and ended at 12pm. I recorded the data using a smartphone and later transferred the files to a stick storage device on my laptop. All
the six participants had been notified in advance and were gathered at a local drinking place that is approximately 200 meters from the venue of the interview.

The focus group discussion was carried out under a mango tree in a gated farm within the village. I selected one liaison person from within the group of people who were known to abuse alcohol in Wakivule village, Luwero district. The liaison person would be responsible for conducting the participants to the venue of the interview. The participants entered the gate to the farm and travelled approximately 100 meters to the mango tree. The workers on the farm were working about 500 meters away from the main entrance and could not identify who was coming and going out of the farm. The liaison person would leave immediately before the briefing began, waiting at the gate for the end of the session.

Prior to commencing the interview, all the participants were taken through the informed consent process and ground rules. During the briefing, I particularly emphasized the importance of listening to each other respectfully and that no answer was right or wrong. I explained to the participants that I needed were their views and that they should not feel pressurized to give answers that they thought were most suitable for the research. At the end of the pre-discussion briefing, I explained the importance of confidentiality and not targeting members of the focus group based on what they had said or done during the discussion. Each participant requested to append their signature or fingerprint to confirm this. In order to protect their identities, the focus group discussion members were initially given a unique number to use when responding to the questions. These numbers were also later converted into pseudo names.

At the end of the focus group discussion, the participants walked back to the gate and out of the farm. The research instrument I used was the focus group discussion guide (see appendix 2). This guide included the main research topics but the participants were asked questions relating to alcohol consumption as opposed to “alcohol abuse”, bearing in mind the stigmatizing connotations associated with the term “alcohol abuse”.

3.6 Data Analysis

The recordings were then transcribed verbatim by the researcher, including the researcher’s observations of the reactions of the participants as they answered the questions. The researcher then subjected the transcripts to content analysis in order to highlight key quotations and the themes that emerged from the data. The researcher pinpointed certain repeated themes
which were then grouped together for analysis. Later on, these categories were further refined into higher level themes.

Reference was made to the approach used by Braun and Clarke (2006). The model calls for six stages including familiarization with all the transcripts, generation of initial codes based on repetition patterns, identification of themes within the codes, review of all the identified themes, definition of the themes and naming of the themes (see Figure 2 below).
Figure 2: Thematic data analysis framework

Adapted from Braun and Clarke (2006)

3.6.1 Development of a codebook

The initial analysis of the transcripts led to the development of a number of key codes. These are summarized in Table 1 below. These codes were grouped into the effects, attributed causes and management of alcohol abuse.
### Table 1: Key codes from the research findings

<table>
<thead>
<tr>
<th>Code</th>
<th>Code Name</th>
<th>Code</th>
<th>Code Name</th>
<th>Code</th>
<th>Code Name</th>
</tr>
</thead>
<tbody>
<tr>
<td>1a</td>
<td>Challenges at work</td>
<td>2a</td>
<td>Physical pain</td>
<td>3a</td>
<td>Withdrawal from society</td>
</tr>
<tr>
<td>1b</td>
<td>Family conflict</td>
<td>2b</td>
<td>Free will</td>
<td>3b</td>
<td>Rationalization</td>
</tr>
<tr>
<td>1c</td>
<td>Financial problems</td>
<td>2c</td>
<td>Divine fate</td>
<td>3c</td>
<td>Political activism</td>
</tr>
<tr>
<td>1d</td>
<td>Economic underdevelopment</td>
<td>2d</td>
<td>Depression</td>
<td>3d</td>
<td>Self-control</td>
</tr>
<tr>
<td>1e</td>
<td>Marginalization</td>
<td>2e</td>
<td>Socialization</td>
<td>3e</td>
<td>Medication</td>
</tr>
<tr>
<td>1f</td>
<td>Ill health</td>
<td>2f</td>
<td>Availability</td>
<td>3f</td>
<td>Local remedies</td>
</tr>
</tbody>
</table>

#### 3.6.2 Thematic map of the findings

The codes were grouped under a thematic map. The thematic map has rearranged the chronology of the research questions so that it can describe a narrative or theme which consists of consequences, attributed causes and management strategies for alcohol abuse. Thereafter, the themes were reorganized into three major narratives which are in effect various experiences of alcohol abuse within the participant population. The first theme is that of alcohol abuse as an expression personal characteristics. The second is that of alcohol abuse as a manifestation of living conditions. The third theme is that of alcohol abuse as a response to structural issues. The key themes or narratives are summarized in Figure 3 below.
Although the thematic map is organized in this way, it is important to note that participants moved across the narratives in a non-linear way. Hence, the themes may have distinct features but they always have relationships with one another as illustrated in the thematic map. Each of these themes will be defined before being described using selected quotes from the participants in the next chapter.

### 3.6.3 Clarification of key themes and major narratives

Based on the study objectives and research questions, the themes were initially organized into three categories including:

1. **Consequences of alcohol abuse**: The first consequence (1a) refers to all those issues and events that make it difficult for people who abuse alcohol to obtain, secure, retain
and benefit from their chosen occupation. The second consequence (1b) refers to all those issues and events that make it difficult for people who abuse alcohol to enjoy harmonious relationships with their immediate and extended family. The third consequence (1c) refers to all the ways in which people who abuse alcohol are unable to control and manage their finances in order to meet their essential obligations. The fourth consequence (1d) refers to the absence or underutilization of any legal and sustainable ways for people who abuse alcohol to earning a living, meet their basic needs and contribute to the wellbeing of the community as a whole. The fifth consequence (1e) refers to the ways in which people who abuse alcohol are treated as an insignificant part of the community. The sixth consequence (1f) refers to any physical or mental condition that leads to an impairment, discomfort or disability for people who abuse alcohol.

2. **Attributed causes of alcohol abuse:** The first attributed cause (2a) refers to any unpleasant sensation resulting from the stimulation of nerves that affects people who abuse alcohol. The second attributed cause (2b) refers to the ability of people to abuse alcohol following an independently made decision within their discretion, but without reference to the forces of coercion, fate, constraint or necessity. The third attributed cause (2c) refers to how a superior power of destiny forces some people to abuse alcohol in a predetermined way, beyond their will and personal agency. The fourth attributed cause (2d) refers to how a feeling of helplessness, despondency, powerlessness, hopelessness and dejection forces some people to abuse alcohol. The fifth attributed cause (2e) refers to the way in which people are encouraged by societal norms and values to abuse alcohol. The sixth attributed cause (2f) refers to how the easy access to affordable alcohol within the community allows people to engage in alcohol abuse. The seventh attributed cause (2g) refers to the ways in which the unequal distribution of power, influence, resources, rights and freedoms leads some members of the community to engage in alcohol abuse.

3. **Management of alcohol abuse:** The first strategy for managing alcohol abuse (3a) refers to the situations where people who abuse alcohol limit their interaction and association with other members of the community. The second strategy for managing alcohol abuse (3b) refers to how people who abuse alcohol attempt to justify their
behavior using seemingly logical explanations, but which explanations are ultimately inappropriate or even irrelevant. The third strategy for managing alcohol abuse (3c) refers to all the ways in which people who abuse alcohol engage in determined and sustained campaigning in order to bring about political and social change in their communities. The fourth strategy for managing alcohol abuse (3d) refers to the ways in which people who abuse alcohol are able to moderate their thoughts, desires and actions. The fifth strategy for managing alcohol abuse (3e) refers to the ways in which people who abuse alcohol consume various forms of medicine in order to reduce the negative effects of alcohol. The sixth strategy for managing alcohol abuse (3f) refers to all the locally developed treatments and herbs that are used to treat alcohol abuse without reference to conventional Western medicine.

These categorized themes led to the development of broader and overarching narratives as follows:

(a) **Alcohol abuse as an expression of personal characteristics**: In this case alcohol abuse is understood to be an expression of characteristics of an individual or the consequences of those characteristics in terms of their physical, biological, mental, emotional and psychosocial aspects (Humphreys, 2015). For example, the personality traits of an individual and their behaviour in this context are presumed to be contributing factors to their abuse of alcohol (Swahn, Dill, Palmier, & Kasirye, 2014).

(b) **Alcohol abuse as a manifestation of living conditions**: In this case alcohol abuse is understood to be an experience of one of the facets of dysfunctional living conditions which people are exposed to (Bunt Gregory & Britta, 2011). These living conditions include unemployment, break down in family relations and marginalization (Nalule, 2015). This deprivation may lead some people to abuse alcohol primarily because their life circumstances do not satisfactorily meet their needs and expectations (Tusingwire-Karumira, 2010).

(c) **Alcohol abuse as a response to structural issues**: In this case alcohol abuse is understood to be an experience of the various ways in which institutions and systems of society are organized or re-organized in terms of roles, functions, statuses, rights, responsibilities and the power to make decisions (Dimanin, 2012). For example, these systems and institutions may be organized in such a way as to create unequal
outcomes for individuals and communities (Bett, Russell, & Kabanda, 2005). As a consequence, social injustice eventually pushes some members of the community into alcohol abuse (Swahn, Dill, Palmier, & Kasirye, 2014). It must be noted that some discussion of structural issues has a spiritual element where supernatural powers create unequal outcomes (Nalwadda, et al., 2018).

3.7 Ethical Considerations

Four major ethical considerations were addressed in this study. These are (i) informed consent, (ii) voluntary participation, (iii) confidentiality and (iv) no harm to the participants (Creswell, 2013).

3.7.1 Informed consent

Of particular importance was the issue of obtaining informed consent from vulnerable participants who abused alcohol and who also possibly faced some psychological stress in describing their circumstances (Hahm, et al., 2014). The researcher ensured informed consent in three major ways.

a) The first element of obtaining informed consent was in ensuring that all the participants had the legally defined age of consent and were able to participate in the research. It is recognized that some participants could have had cognitive disabilities which made it difficult to obtain informed consent directly from them. Therefore, the researcher sought the assistance of a guardian for these particular participants.

b) The second element of obtaining informed consent involved designing an interview guide that was easy to understand and appropriately translated for the participants. It is recognized that some of the participants could only be fluent in the local Luganda language. To that end, the researcher identified those participants with this particular need. A liaison person from within the community of people who abuse alcohol was requested to assist in the translation for one of the participants who was not fluent in Luganda and sometimes preferred to speak certain words in Lugbara.

c) The third element of obtaining informed consent was in explaining all elements of the interview process so that they were fully understood by participants. This involved explaining the research process and justification for the study. The explanatory process included an overview of how the information obtained from the research process will be
used. The researcher read out the interview form and explained its meaning or implications to the participants.

3.7.2 Voluntary participation

It is recognized that vulnerable people who abused alcohol could not feel that they were able to exercise their right to decline to participate in an exercise that was sanctioned by gatekeepers such as the local council team and village health team (Kabwama, et al., 2016). In order to deal with this ethical issue, the researcher ensured that all participants were made aware of their absolute right to withdraw from the study at any time during the interviews without any consequences or a need for explanation. The researcher emphasized their participation was an entirely voluntary exercise. In particular, the researcher paid special attention to any situations where the gatekeepers insisted that someone must be part of the study regardless of their own preferences. Three potential participants were excluded on this basis. Even after the selection of participants, the researcher reiterated the voluntary nature of the activities.

3.7.3 Confidentiality and anonymity

Being identified as someone who abuses alcohol can be stigmatizing (Boeri, et al., 2016). Furthermore, some of the participants could not readily identify themselves as being people who abused alcohol. Participating in the research process may inadvertently lead to their identification as people that abused alcohol. The researcher ensured that all the information that was gathered for the study is used in strict adherence to the research objectives. The collected data will be destroyed after their use, e.g. submission and examination of the dissertation and paper publication. In order to ensure anonymity, names and other personal details of the participants will only be known to the researcher. Each participant was given a pseudo name for purposes of preparing the report. Furthermore, the researcher ensured that the interviews were conducted in a secluded area, away from public view. This ensured that participants were not automatically singled out as being people who abused alcohol by virtue of their participation in the study.

3.7.4 Doing no harm to participants

There is a potential risk of doing harm to vulnerable people who abuse alcohol during the study process (Bunt Gregory & Britta, 2011). The harm can be psychosocial in as far as they could be identified as people who engaged in an antisocial activity (Fuhr, et al., 2014). This can
cause the society to marginalize them further. The nature of the interview may cause them psychological distress by virtue of the personal questions that are asked by the researcher. The length of the interview may also cause the interviewees to suffer from hunger, thirst and even boredom (Creswell, 2013).

In order to mitigate these risks, the researcher undertook an initial visit to the Village Health Team and Local Council team in order to ensure that the relevant gatekeepers were in agreement about the research project so that they could not create obstacles to conducting it at a later stage. The contents of the interview guide have been carefully selected in order not cause harm to the participants. For example, the interview guide has already been carefully curated, simplified and shortened in order to make it as user-friendly as possible. The participants were informed of their right to withdraw from the interview at any moment without any consequence for them. Participants were also offered refreshments during or after the interview depending on their preference in order to deal with the risk of becoming hungry or thirsty.

3.8 Challenges that were faced and their Solutions

The main challenge that was faced in this study is the fact that people who abused alcohol were instinctively wary of any research project that apparently sought to evaluate them. They considered it to be a judgement on their lifestyle (Humphreys, 2015). The researcher took special care to explain to the gatekeepers and participants that the purpose of the study was to understand alcohol abuse from the perspective of people who abused alcohol and was not meant to present the village or its occupants in a negative light.

There was a problem arising from the community of the so-called “village drunkards” who created barriers to access through demands for bribes or speaking negatively about the research project. In order to deal with this problem, the researcher first consulted with the gatekeepers for the community of people who abused alcohol. This helped to overcome any concerns they had about the study. One such concern was the idea that the researcher could potentially report participants to authorities e.g. police for engaging in illegal activity. During the pilot scheme, this concern was expressed. The researcher emphasized the fact that anonymity and confidentiality is essential but not absolute in the social work profession. Social workers can act on and disclose information to the appropriate authorities where such a decision is in the best interests of the person (Barsky, 2009; NASW, 2008). If issues of illegality and harm to vulnerable people came up during the interviews, the researcher would be obliged to take it up with the appropriate
authorities such as the community development team and probation office. For example, during the focus group discussion one of the participants requested the researcher to help him access special interventions in order to deal with alcohol abuse. The researcher got in touch with the family and an intervention plan was consequently agreed.

### 3.9 Limitations of the Study

This study was limited in as far as it focused on one village. It is qualitative in nature and therefore could not produce findings that are generalisable to other populations. The study collected data from a selected group of people at a given moment in time and the data captured may not be identical to other contemporary, historical or future events. Moreover, qualitative studies such as this one tend to give credence to the subjective views of the participants (Baker, 2000). The findings they produce may not be scientifically proven as facts and may be clouded by personal biases (Connors, et al., 2013).

A purposively selected sample of under 20 people living in a single village within a single district cannot purport to represent the experiences of over 80,000 people in Uganda who known to be abusing alcohol. Certainly, the experiences of the participants in this study cannot be used to make wider inferences about communities from other global contexts and cultures. However, it must be noted that this not what this study has set out to do. The study from the outset limited its terms of reference to a specific population in a given locality at a given time. It can be asserted that the people who abuse alcohol in Wakivule village (Luwero district, Uganda) have experiences and insights that they may share with people who abuse alcohol in Uganda and the world at large. The insights of the participants in this study therefore have a contribution to the wider body of knowledge about substance abuse, the limitations described above notwithstanding.
Chapter Four

FINDINGS AND DISCUSSION

This chapter presents the findings and their discussion. It highlights the social-demographic characteristics of both the primary participants and key informants. This is then followed by an overview of the key findings using selected quotes as well as referring back to the research objectives, research questions, theoretical framework and literature review. All participants have been given pseudo names which are used throughout the study in order to protect their confidentiality and anonymity.

4.1 Socio-demographic Characteristics of Participants

There were 10 participants who engaged in the individual interviews and their socio-demographic characteristics are summarized in Table 2 below. The mean age for these participants was 41 years of age. About 40% of them were married, 30% single and 30% separated. The vast majority (80%) professed a Christian religious affiliation. Half of these participants did not have a formal education and only one had ever reached secondary school. The mean monthly income for the participants was UGX 43,000. However, there was a significant disparity of UGX 120,000 per month between the highest earning and lowest earning participant.

Table 2: Socio-demographic characteristics of individual interview participants

<table>
<thead>
<tr>
<th>DIMENSION</th>
<th>FINDINGS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age (in years)</td>
<td>Maximum (80)</td>
</tr>
<tr>
<td></td>
<td>Minimum (29)</td>
</tr>
<tr>
<td></td>
<td>Mean (41)</td>
</tr>
<tr>
<td>Gender</td>
<td>Male (7)</td>
</tr>
<tr>
<td></td>
<td>Female (3)</td>
</tr>
<tr>
<td>Marital Status</td>
<td>Single (3)</td>
</tr>
<tr>
<td></td>
<td>Married (4)</td>
</tr>
<tr>
<td></td>
<td>Separated (3)</td>
</tr>
<tr>
<td>Religious Affiliation</td>
<td>Protestant (3)</td>
</tr>
<tr>
<td></td>
<td>Catholic (5)</td>
</tr>
<tr>
<td></td>
<td>Other (2)</td>
</tr>
<tr>
<td>Highest Level of Formal Education</td>
<td>None (5)</td>
</tr>
<tr>
<td></td>
<td>Primary (4)</td>
</tr>
<tr>
<td></td>
<td>Secondary (1)</td>
</tr>
<tr>
<td>Average Monthly Income (UGX)</td>
<td>Minimum (20,000)</td>
</tr>
<tr>
<td></td>
<td>Maximum (150,000)</td>
</tr>
<tr>
<td></td>
<td>Mean (43,000)</td>
</tr>
</tbody>
</table>

There were 6 participants who engaged in the focus group discussion and their socio-demographic characteristics are summarized in Table 3 below. The mean age for the focus group was 56 years of age. Half of the focus group participants were single while the rest were either married or separated. The vast majority (over 80%) of the focus group participants professed a
Christian religious affiliation. Only one participant in the focus group discussion had ever gone to school and that participant had not gone beyond primary school. The mean monthly income for the participants in the focus group discussion was UGX 32,000.

Table 3: Socio-demographic characteristics of the focus group discussion participants

<table>
<thead>
<tr>
<th>DIMENSION</th>
<th>FINDINGS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age (in years)</td>
<td>Maximum (68)</td>
</tr>
<tr>
<td>Gender</td>
<td>Male (4)</td>
</tr>
<tr>
<td>Marital Status</td>
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</tr>
<tr>
<td>Religious Affiliation</td>
<td>Protestant (2)</td>
</tr>
<tr>
<td>Highest Level of Formal Education</td>
<td>None (5)</td>
</tr>
<tr>
<td>Average Monthly Income (UGX)</td>
<td>Minimum (20,000)</td>
</tr>
</tbody>
</table>

There were three key informants and their socio-demographic characteristics are summarized in Table 4 below. One key informant declined to have their perspectives recorded for fear of political retaliation by the local residents who abuse alcohol. The mean age for the key informants was 41 years of age and all key informants were married. The mean average monthly income amongst the key informants was over UGX 260,000.

Table 4: Socio-demographic characteristics of the key informants

<table>
<thead>
<tr>
<th>DIMENSION</th>
<th>FINDINGS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age (in years)</td>
<td>Maximum (47)</td>
</tr>
<tr>
<td>Gender</td>
<td>Male (2)</td>
</tr>
<tr>
<td>Marital Status</td>
<td>Married (3)</td>
</tr>
<tr>
<td>Religious Affiliation</td>
<td>Protestant (1)</td>
</tr>
<tr>
<td>Highest Level of Formal Education</td>
<td>Primary (1)</td>
</tr>
<tr>
<td>Average Monthly Income (UGX)</td>
<td>Minimum (200,000)</td>
</tr>
</tbody>
</table>

There were important differences between the socio-demographic characteristics of the three categories of participants. For example, the focus group discussion had a mean monthly income that was UGX 11,000 higher than that of the participants in the individual interviews. The mean monthly income for the key informants was eight times that of the mean monthly income for the focus group discussion. Moreover, all the key informants had attended primary school and two had actually attended secondary school, whereas five focus group discussion participants and five participants in the individual interviews had not attended any kind of formal education. Given the limited sampling and qualitative nature of the study, it is not possible to
make concrete inferences about how these disparities affect the responses of the participants (Creswell, 2013). Therefore, further research may be appropriate to consider the extent to which socio-demographic characteristics impact on the experiences of alcohol abuse.

4.2 Consequences of Alcohol Abuse

The participants identified six major consequences of alcohol abuse including challenges at work, family conflict, financial problems, economic underdevelopment, marginalization, and ill health.

4.2.1 Challenges at work

Some primary participants noted how they faced various challenges at work due to alcohol abuse. As Rose stated:

I am a labourer and remain a labourer. Alcohol has not changed my occupation. The only difference is that now I have to work harder in order to pay for alcohol I drink. Sometimes I just end up taking a job for low pay in order to have some money. You know that not many people want to employ an alcoholic. When you complain about the low pay, they say that you are just an alcoholic (Individual Interview, 2018).

There are multiple levels of exploitation suffered by people who abuse alcohol in the narrative provided by Rose. First, they are discriminated against when trying to find jobs. That means that they have to take low paying jobs when and if they can find them. Even when they have secured a job, people who abuse alcohol seem to be paid less than those who do not. This kind of discrimination contributes to the social production of suffering (in the form of social injustice) that is recognized in critical medical anthropology as exacerbating the problem of alcohol abuse (Nalwadda, et al., 2018).

Some primary participants noted the difficulty faced by people who abuse alcohol in holding down a job and benefiting from it fully. A case in point is Felix who stated:

When you drink alcohol, you just have no energy for anything else. I have lost so many jobs because of alcohol. It has been very tough. There was a time when I had absolutely nothing in life. I had become hopeless and nobody would give me a job. If I was not drinking, I would be healthy and working, earning my
own money. Everything is better when I do not drink. Nobody wants to give a drunkard a job. Even when you work, they want to tax your money. If you were supposed to have 10,000 shillings in wages, they may just give you 5000 because of your drinking. Some people even fear giving you money because you can drink yourself to death and they will get blamed (Individual Interview, 2018).

In this case, Felix talks about the debilitating effects of alcohol abuse which include reduced ability to attend and perform in his job. Although the strengths perspective talks about capacities as a strength amongst people who abuse alcohol (Rankin, 2007), in this instance the alcohol abuse actually reduces that capacity in a way that is harmful to the livelihood prospects of the individual concerned. Felix highlights a particularly insidious “tax on drunkards” which leads to unequal pay at work, in itself a form of social production of suffering that is recognized in critical medical anthropology as a cause of substance abuse (Nalwadda, et al., 2018). Nevertheless, there is a legitimate concern that money earned through employment can be used by people who abuse alcohol in order to harm themselves and that people paying that money will eventually be blamed for any resultant harm. This finding reflects a conflict between expressing concern for the welfare of people who abuse substances and infantilizing them to the extent that their fundamental human rights are violated (Shah, et al., 2017). Existing literature has highlighted how people who abuse substances are patronized in this way (Ruiz & Strain, 2011).

4.2.2 Family conflict

Some participants reported that alcohol abuse became a source of family conflict. For example, Gerald described the resultant alienation from his family:

My family want nothing to do with me ever since I started drinking alcohol. They think I am a lost cause. I do not get on with them at all. Even if you called them today, nobody would come. Nobody likes or respects me in my family. I think they are also angry because I sold all my inherited property to buy alcohol (Focus Group Discussion, 2018).

Alienation from the family that results from substance abuse is widely recognized in both medical and anthropological perspectives of alcohol abuse (Khantzian, 1997; Nalule, 2015).
From a strengths perspective, the loss of family ties that Gerald describes can reduce the ability of the individual to deal with negative effects of substance. At the same time, Gerald offers plausible and even logical explanations for alienation from his family: he did harm to his family by selling the family inheritance in order to feed his alcohol abuse. This ties in with the notion that people who abuse substances may expend and even exhaust their social capital through a lack of reciprocity, an essential requirement when building social capital (Humphreys, 2015).

Participants explained that alcohol abuse made them less functional as a family unit. For example, Titus stated:

Alcohol consumption definitely leads to family strife. You come home drunk and start beating your wife…something you would never do if you did not drink alcohol. Moreover, if you take things too far you might end up in court and the man is always the one to pay the bribes (Individual Interview, 2018).

In this case Titus is highlighting gender-based violence and intimate partner violence as possible consequences of alcohol abuse. Existing literature has reiterated the association between substance abuse and all forms of violence which do harm to both the person abusing alcohol and his or her associates (Bennett, 2008). At the same time, Titus notes the gendered nature of access to the criminal justice system in which men are treated unfairly and often have to resort to corruption (in this case bribery) in order to escape the clutches of an irrational judicial system. Existing literature has indicated that substance abuse is often associated with a high propensity for engaging in criminal activity and even coming into contact with the criminal justice system (Ritchie & Roser, 2018). However, there is very limited research to highlight the experiences of people who abuse substances and are subsequently mistreated by the court system, more so if that mistreatment is based on gender discrimination.

4.2.3 Financial problems

Some participants reported that alcohol played an important role in their current financial woes. Titus stated:

I am a farmer and have to work regardless of whether I drink alcohol or not. I have to pay bills and to look after my children. I have managed but it is difficult. I have to sell my produce …but the price for maize has fallen so low. The good
thing is that my wife is understanding. Now that I am sick, I also have to make sure that I have money to pay for the hospital bills. My teeth are painful and I also feel a bit weak. Alcohol challenges your budget. Even when you get 5000 shillings, you end up spending it on alcohol instead of buying meat for your children. I lost most of my land and property because of alcohol. However, I retained my house and some land that was inherited. I allow my brother to farm on it (Individual Interview, 2018).

Participants reported people who abuse alcohol are unable to make and sustain long term financial plans. A case in point is Felix who stated:

A drunkard cannot have any serious plans. You have so many plans when you are short of money, but once you get money; they are all gone. For example, you can plan for 100,000 shillings and then decide to use 10,000 shillings of it to buy alcohol. The reality is that you will end up spending it all on alcohol. Sometimes I am so disorganized that I end up taking advances on a job and then failing to finish (Felix, 2018).

This narrative gives an insight into the struggles that people face when they are trying to sustain substance abuse and yet continue with their family responsibilities. In this case the expenditure on alcohol has to compete with medical bills, food and school fees for children. Felix talks about taking out loans from work under the ostensive excuse of dealing with family responsibilities, but then ends up spending the money on alcohol. Even more distressing, is the frittering away of the family livelihood assets which increase the vulnerability of both the individual and their family. Although the strengths perspective refers to the assets of possibility, character and resources (Rankin, 2007); in this case they are missing. Felix and Titus are unable to exercise a good sense of judgement and decision-making in order to prioritize the essential expenditures in their day-to-day life. Instead these participants seem to give alcohol consumption a similar importance to some of the other critical financial obligations that they are required to meet.
4.2.4 Economic underdevelopment

Key informants identified economic under development as a key consequence of alcohol abuse. Sam stated:

This village is going down the drain because of alcohol. Young men no longer want to work. They will end up stealing in my view. We had this terrible story of someone that spent the money he earned over two months of about half a million shillings on alcohol. He ‘drank’ the lot in a single day. Then his boss sent him home with nothing. Meanwhile these village drunkards were cheering him on and stealing money from him. This village will never develop until we get rid of these alcoholics (Key Informant Interview, 2018).

This demonstrates the impact of alcohol abuse on individuals and communities. In this case, the person that abused alcohol is actually able to work hard and earn a living but then ends up frittering it away in a single day. The community of people who abuse alcohol also have a role to play in as far as they enable a person to engage in destructive behaviour whilst also stealing from them. Moreover, other young people who abuse alcohol do not seek or retain work which further leads to economic underdevelopment. In this scenario, there is a symbiotic relationship between the structural social-economic deprivation within the community and the malevolent human agency of people who exploit the situation (Bunt Gregory & Britta, 2011). This interplay of these two forces is one of the reasons why the lifestyle and cultural models of substance abuse have been challenged in critical medical anthropology as failing to fully explain the existence of substance abuse (Heath, 2012).

4.2.5 Marginalization

Participants described their experiences of marginalization within the community following alcohol abuse. For example, Jake stated:

A drunk has no respect. Nobody wants to sit near you at village meetings. Some even say that we stink. When I had an accident, I was penniless because I had spent all my wages on alcohol. Some people helped me to pay the hospital bills but I know that I became the talk of the town. When you start this path of
drinking, just know that you will no longer be a responsible member of the community. They all look down on us (Individual Interview, 2018).

The marginalization that was described by some participants also hinted at the systemic exploitation of people who abuse alcohol. Kenneth for example stated that:

Everybody in this village exploits us drunks. This woman [name withheld] always tricks us into buying alcohol. When you order, she says do not worry the bill will be paid later. After two or three drinks she stands up and says you have consumed alcohol worth 10,000 shillings. Her favourite trick is to grab your testicles to immobilize you. She will then scream for help, alleging you were trying to rape her. Nobody will believe a drunk so the moment she screams; you just agree to the debt. You can end up working for weeks to repay that money (Individual Interview, 2018).

In this instance, the community recognizes the vulnerability of people who abuse substances as described by Jake and Kenneth. The community then uses this knowledge in order to slander, back bite, exploit and defraud people who are known to abuse alcohol. The alleged false rape alarm by the exploitative pub landlady is further proof of the unequal access to justice that people who abuse substances face. Existing literature has already acknowledged the inherent vulnerability of people who abuse substances and how this vulnerability can be exploited in order to ostracize and marginalize them within their communities (Nalwadda, et al., 2018).

4.2.6 Ill Health

Participants identified ill health as a consequence of alcohol abuse. Apollo describes some of the physical effects of consuming alcohol:

Alcohol makes me very sick. When I have really drunk too much, I end up vomiting all night. I sometimes wet my pants and there have been occasions where I have defecated in my pants. It is so embarrassing. I just feel so bad after taking alcohol and yet I continue to take it. Please tell your university to get me a pill that can stop drinking. It would help some of us who are struggling. (Individual Interview, 2018).
In this case the participant has distinguished between the physical (nausea) and the psychosocial (social embarrassment after incontinence) negative consequences of alcohol abuse. This dichotomy of consequences is reflected in existing literature: whereas the medical model describes the physiological effects of alcohol abuse (Hahm, et al., 2014), the anthropological models of substance abuse highlight the psychosocial dimensions of substance abuse in the form of a vicious cycle of deprivation and marginalization (Kabwama, et al., 2016). From a strengths perspective, Apollo recognizes the serious impact of this alcohol abuse and calls for help from the researcher (or his institution). In this instance Apollo refers to the assets of courage and the positive expectations of recovery in order to confront the reality of his situation and then ask for help (Rankin, 2007). It is important to note the request for a catch-all pill which Apollo hopes would resolve the problems caused by alcohol. This is an approach that has already been recognized in the self-medication hypothesis where individuals seek medication to deal with the negative symptoms of an underlying condition that they are experiencing (Khantzian, 1997). Despite the stated negative consequences on Apollo’s health and social status, he is still unable to give up alcohol. This is an important reminder of the limitations of negative consequences in terms of inspiring people to give up alcohol abuse (Kabwama, et al., 2016).

There are some participants who asserted that giving up alcohol had positive effects on their health. A case in point is Felix who explained some of the positive changes in his life since moderating his alcohol abuse:

I have reduced my alcohol consumption since my big crisis. I think my health has improved a bit. When I used to drink alcohol, I was vomiting a lot. It was very uncomfortable. My stomach was particularly affected. Whenever I drink alcohol, I cannot eat food the next day. If I try to eat, I end up vomiting. Stopping also helped to reduce the fights and violence I was facing at night when going back home. (Individual Interview, 2018).

In this instance, Felix recognizes the negative effects of alcohol on his health which he contrasts with a comfortable existence after moderating his alcohol abuse. It is notable that Felix speaks about the possibilities of moderating or reducing alcohol abuse as opposed to stopping it altogether. This may indicate that for Felix, even a mere moderation of alcohol use can have positive effects. It is an assertion that is supported in existing literature where the benefits of
moderating the consumption of alcohol are well documented (Bennett, 2008). In doing so, Felix introduces violence as a consequence of alcohol abuse. In such scenarios the person abusing alcohol is both the perpetrator and victim of violence. These findings tie in with existing literature which has shown that people who abuse alcohol are both perpetrators and victims of violence in a range of contexts including home, work and social gatherings (Bunt Gregory & Britta, 2011).

4.3 Attributed Causes of Alcohol Abuse

The participants attributed alcohol abuse to a number of reasons including physical pain, free will, divine fate, depression, socialization, availability of alcohol and social injustice.

4.3.1 Physical Pain

In terms of pain, alcohol abuse is used as a means of temporarily alleviating the suffering that results from this pain. As Rose stated:

I do not know whether I am healthy because I have not checked myself. However, I have hernia and alcohol helps me to keep it down. Whenever I drink alcohol, I sleep all through the night. It is also very good for my hernia which calms down afterwards. I like Waragi (strong local brew) because it calms down my hernia…especially after I have consumed sugar which is actually very bad for my hernia. I am not interested in the other weak alcohol because they do not help me with my hernia (Individual Interview, 2018).

In this case, Rose consumes alcohol in order to deal with pain as a specific symptom of an underlying organic disease which is hernia. The self-medication hypothesis explains substance abuse in much the same way by highlighting how substances are used to deal with the negative signs and symptoms of diseases, often without the approval of a clinician (Khantzian, 1997). It is particularly notable that Rose focuses on a particular form of alcohol (Waragi) because of its perceived potency to relieve pain. This ties in with the idea that people may select particular substances to abuse based on the perceived curative or pain-relieving qualities that are associated with those substances (Tomlinson, Tate, Anderson, McCarthy, & Brown, 2006). Rose appears to admit ignorance of her actual health status (indicating that she has not undertaken a medical examination); but then goes on to describe the symptoms of hernia-induced pain in very specific ways and also highlight the solutions that she opts for in such situations nonetheless. In
fact, the lifestyle model of substance abuse explains how people are able to construct and perceive their own views about their competency to diagnose and deal with problems, regardless of whether or not the diagnosis and treatment are scientifically proven (Bunt Gregory & Britta, 2011). Rose appears to be misusing her monetary assets and resourcefulness to buy alcohol as an apparent solution to her physical pain. Although the strengths perspective refers to resourcefulness as an asset (Saleebey, 2002), in this case Rose is addressing the problem of hernia-related pain with the wrong solution (alcohol), thereby actually exacerbating her ill-health. This is therefore not a strength, primarily because it leads to negative consequences for the person abusing alcohol.

4.3.2 Free Will

Perceiving alcohol as a pain-relieving agent contrasts with the view that alcohol abuse is a consequence of free will where a person decides to start, moderate or stop consuming alcohol depending on his or her tastes and preferences. As Titus explained:

There is really no value in alcohol consumption. You just drink because you want to drink. If your budget does not support the drink, then you have to give it up. I personally drink because it is just part of my life…like taking tea. Of course, if I do not have money, I will give up. The times are very hard so you have to think carefully before drinking (Individual Interview, 2018).

In the same way as existing literature has highlighted (Fuhr, Fleischmann, Riley, Kann, & Poznyak, 2014), Titus asserts that alcohol has no benefits for him as an individual. Instead, Titus highlights the role of free will and choice. The strengths perspective asserts that even people who are in the most serious forms of substance abuse possess the assets of purpose, character and resolve which they can call upon to recover from a potentially damaging situation such as alcohol abuse (Saleebey, 2002). However, Titus also notes the role of financial constraints in determining whether or not he can afford alcohol. The critical medical anthropology model of substance abuse asserts that the availability of substances such as alcohol (sometimes by virtue of the fact that the individual has the money to purchase those substances) has a role to play in terms of pushing them towards substance abuse (Nalwadda, et al., 2018).
Some participants who believed in freewill explicitly rejected the notion of some supernatural forces that was believed to cause people to abuse alcohol. A case in point is Peter who explained:

I do not believe that there is anything about witchcraft. People actually decide when and how they are going to consume alcohol. There is a man I know in this village. He decided to take alcohol and it ruined his life. When he suffered a lot, he decided that he was going to start consuming soda instead. There are people in this village who do not drink alcohol despite the many drinking places. It is the person that actually decides to do what they want (Focus Group Discussion, 2018).

Peter’s view differs from that of Titus in as far as he highlights the role of negative consequences when determining whether or not someone continues to consume alcohol. Indeed, Peter’s assertion also differs from the self-medication hypothesis by suggesting that alcohol (the substance itself) becomes a source of such significant distress that the individual decides to stop using it as opposed to the alcohol being abused in order to deal with distress (Leeise, et al., 2010). Moreover, the narrative of recovery provided by Peter goes against one of the elements of the critical medical anthropology model which asserts that alcohol abuse creates a vicious cycle in which suffering leads to more alcohol abuse and vice versa (Heath, 2012). According to Peter’s narrative, negative effects of alcohol abuse end up breaking the vicious cycle of substance abuse.

### 4.3.3 Divine Fate

Some participants suggested that divine fate was responsible for alcohol abuse. Simon for example feels that alcohol abuse in an individual is a decision made by God:

You know, sometimes God just decides that you are going to be an alcoholic and there is very little you can do about it. You are just born that way because God chose you to drink alcohol. If you are lucky, you will escape this problem because of God’s will. I unfortunately have been unlucky. I just cannot stop drinking. I want to stop but I cannot. Maybe, I just have to accept my fate (Individual Interview, 2018).
In this case there is an implicit acceptance of the power of fate over personal agency when facing substance abuse. Although the strengths perspective does not explicitly mention spirituality as an asset, spirituality might be considered a form of promise and positive expectations of a better life due to divine interventions (Rankin, 2007). However, in this instance Simon seems to be abandoning the potential assets of courage, resilience and resolve by instead considering the option of surrendering to a fate that he considers to be out of his control. This is an example of how people who abuse substances may develop an externalized locus of control which prevents them from taking purposive action to deal with this problem (Humphreys, 2015).

Other participants like Felix believe that witchcraft and other malevolent activities are at play when people abuse alcohol:

I actually believe that you can be bewitched into drinking. Sometimes the witchcraft itself is put in the alcohol that you first drink. There are some evil people in these villages. Someone once put broken glass in my alcohol and I became very sick. Since then I mainly take Waragi because it is clear and I can see if there is something there [participant laughs]. A lot of witchcraft if put in beers or ‘emikomboti’ [local brew] which are thick and dark (Individual Interview, 2018).

Felix contrasts with Simon in as far as he sees malevolent action on the part of others for triggering negative divine interventions that bring about addiction. In this case, the client’s explanatory model of alcohol abuse socially constructs an understanding of addiction which is contrary to the medical model and is very difficult to prove using conventional science (Weaver, 2016). Nevertheless, it is important to note the role of human agency on the part of others who add unpleasant or harmful substances to certain types of alcohol. From a strengths perspective, Simon is able to utilize his negative experiences of contaminated alcohol to select a clear or transparent alcoholic drink which allows him to visually assess whether it has been contaminated. He continues drinking alcohol, despite the fact that his alcohol of choice (Waragi) is a potent form of gin with powerful intoxicating capabilities (Kabwama, et al., 2016).
4.3.4 Depression

Some participants explained that alcohol consumption was caused by one’s state of chronic or episodic depression and that alcohol was used to alleviate worry associated with depression. Titus stated for example:

The main cause of alcoholism is depression. You can be in your house alone and start thinking bad thoughts. At other times you are unable to sleep well. Alcohol helps to take away the bad thoughts. Alcohol then becomes a way of allowing you to sleep well. You can also have problems when your wife has divorced or left you and your children start hating you. The same thing happens if you think about all your loved ones who have died. However, the biggest problem is your wife leaving you. The house becomes smaller when you have no wife, even if you did not like her that much when she was there (Individual Interview, 2018).

The clinical models of substance abuse acknowledge the role of certain mental health issues such as depression, insomnia, grief and loneliness in causing people to abuse alcohol in much the same way as Titus has described (Sam Lee, et al., 2012). Titus specifically highlights the role of family breakdown (particularly if the person is ostracized by their spouse and children) and the loss of loved ones. From a strengths perspective, the breakdown of the family and bereavement can deprive the individual of relationships as an asset and may therefore reduce their ability to recover from substance abuse (Boeri, Gardner, Gerken, Ross, & Wheeler, 2016).

Some participants saw alcohol as a means of dealing with major life events that have a profound effect on them. Fred explained his situation as follows:

I have had HIV since 1997 and have been taking ARVs [Antiretroviral drugs] since then. All my siblings and children died. I have so many grandchildren and relatives to take care of. I have no permanent job and then this maize crisis has just made us so poor these days. I worry so much and miss my people. I do not know what to do. At least when I drink alcohol, I forget my problems for a few hours (Individual Interview, 2018).

The association between HIV infection and alcohol abuse is well documented in existing literature. It is for example suggested that alcohol abuse can lead to a heightened risk of HIV
infection, but at the same time an HIV infection can lead to alcohol abuse (Kinyanda, et al., 2017). Fred also highlighted additional factors that may increase the risk of alcohol abuse including unemployment, increased family responsibilities and cyclic financial hardships. That assertion suggests that the personal characteristics or circumstances of an individual are mediated by external environmental factors in order to increase their likelihood of abusing alcohol (Charlson, Diminic, Lund, Degenhardt, & Whiteford, 2014). Indeed, this is an implicit rejection of the idea that alcohol abuse is merely an expression of personal characteristics alone but rather, has much wider associations within the person’s environment (Dimanin, 2012). From a strengths perspective, Fred highlights the importance of purpose, resilience and resolve when dealing with a life-changing event such as an HIV diagnosis (Rankin, 2007). In this case Fred does not give up on life or his family responsibilities but instead takes ARVs to treat the underlying organic disease and alcohol to deal with the resultant stress.

4.3.5 Socialization

Participants that believed in the influence of socialization as a causative factor, highlighted influences from individuals with power. For example, Mary stated:

For us married women, we have very little choice but to follow our husbands. I did not drink until I met my husband. At least he continues to buy me alcohol because I do not know what I would have done without him buying me the alcohol [participant looks sad] (Focus Group Discussion, 2018).

Other participants spoke of peer pressure from a community whose entertainment was centred on alcohol consumption. As Felix stated:

I think the main cause is bad groups in this village who are always drinking. When you have bad influences in your life, you will end up drinking too. You might not like alcohol but they attract you after sometime. Your heart eventually becomes addicted to it. After some time, the body needs the alcohol all the time (Individual Interview, 2018).

Both Mary and Felix talk about the power of influential people in their communities and within their families which drives them to abuse alcohol. In the case of Mary, her subjugated position as a wife means that she has to follow her husband’s lead into alcohol abuse. Felix by
contrast has to contend with the negative influences of friends and community members. Felix specifically talks about the struggle between the desire or will (assets under the strengths perspective) to avoid alcohol and the socialization aspect from the community (recognized within the cultural model of substance abuse). Existing literature supports the idea of an internalized struggle for people who live within families and communities whose culture and socialization supports alcohol abuse but who may not want to become addicted to this substance (Heath, 2012).

4.3.6 Availability

A key informant identified the availability of alcohol as the major cause of alcohol abuse. As Charles stated:

The sale of alcohol is a huge business in this village. Some of our wives actually have secret alcohol businesses in the backyard. I however, forbid anyone in my family to drink alcohol. Yes, I know that we are doing a bad thing but on the other hand I have to survive. If they want alcohol, I will give it to them…for a price [key informant laughs] (Key Informant Interview, 2018).

The issue of availability that the key informant describes here has been recognized in the critical medical anthropology model of substance in which a political economy of addictive substances exposes community members to the readily available alcohol (Nalwadda, et al., 2018). The key informant clearly describes a form of exploitation in which someone that is seemingly in a position of responsibility engages in the production and sale of a product that potentially has antisocial connotations. There is some hypocrisy in berating the so called “drunkards” and then providing them with alcohol that fuels their substance abuse. It is telling that Charles flippantly laughs at the notion that people who are abusing alcohol are being exploited for money. This key informant highlights an economic system of winners and losers which conspires to ensure that substance abuse continues.

Some primary participants saw a direct connection between availability of alcohol and the increasing cases of alcohol abuse. Kenneth explained:

I do not think I would have become an alcoholic if there were no bars in this place. The entire village is full of bars. During the day, people use them as
homes but in the evening, they turn into mini bars. You can’t walk a few meters without seeing a place where alcohol is sold (Individual Interview, 2018).

Kenneth describes clearly how an economy of alcohol sale and consumption supports the Wakivule village. More importantly, he highlights the fact that without its ready availability he would most likely not have engaged in alcohol abuse. Existing literature has shown the role of cheap, readily available alcohol in driving otherwise social drinkers into alcohol abuse (Kabwama, et al., 2016). This finding is a challenge to the strengths perspective because it demonstrates that an addictive intoxicant such as alcohol can dampen the resolve and reserve of the individual to resist the temptations of substance abuse.

4.3.7 Social injustice

Some participants considered the structural causes of alcohol abuse to be rooted in the organization of the village which placed some people in abject poverty. Mary for example noted that:

We have become landless in this village because rich landlords have started to claim back all their property. Some of us were once prosperous farmers but we have now been kicked out of our land. When you have nothing else to do to earn an income, you turn to alcohol for comfort (Focus Group Discussion, 2018).

A key informant identified systemic issues that have left a section of the population behind in economic development. Rachael stated that:

Luwero fought the war and we are the grandparents of NRM [National Resistance Movement] but we have got nothing from the government. So many young people have no jobs and end up abusing all sorts of substances. All this government cares for are people from some families and tribes. (Key Informant Interview, 2018).

The kind of social injustice that Mary refers to here has been recognized in existing literature as potential cause of substance abuse (Dimanin, 2012). For example, the social injustice that Mary describes is consistent with existing literature (Kabwama, et al., 2016). This finding is a challenge to the strengths perspective because it demonstrates that an addictive intoxicant such as alcohol can dampen the resolve and reserve of the individual to resist the temptations of substance abuse.

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2 The NRM is the ruling political party in Uganda today and came into power following a guerilla war that was largely conducted in Luwero district between 1981 and 1986.
production of suffering is exacerbated where there is a distinction between those who have power and those who do not (Ruiz & Strain, 2011). In this instance, the assets that are referred to in the strengths perspective may not overcome the structural problems that lead people into substance abuse (Rankin, 2007). It is important to note that Mary speaks of the structural issue of absentee landlords at the meso level, whereas Rachael talks about wider government inefficiencies at the macro level. This finding supports the notion that structural causes of substance abuse can operate at different levels and are actually multidimensional (Bunt Gregory & Britta, 2011).

4.4 Management of Alcohol Abuse

The participants identified a number of strategies for managing the effects of alcohol abuse including withdrawal from society, rationalization, political activism, self-control, medication and the use of local remedies.

4.4.1 Withdrawal from Society

Some participants suggested that withdrawal from society could be a way of controlling alcohol abuse. As Peter noted, getting away from other people who abuse alcohol can increase chances of moderating the habit:

When the money reduces, I simply stay away from drinking places. I know that many people who drink want me to be with them all the time...but I am very good at hiding from them. Because I do not have a wife, there is nobody to open for them when I want to hide for them. They call and call but I keep quiet [a lot of laughter in the group]. That is the truth. The only problem is that I am alone in that house. Only my landlord can take care of me in case I ever collapse (Focus Group Discussion, 2018).

In this case Peter is demonstrating the assets of purpose, courage and resolve in order to moderate his possible interaction with people who might entice him into alcohol abuse. The strengths perspective already notes this type of asset that might be utilized in order to break down the cycle of addiction (Rankin, 2007). On the other hand, this type of solution may be considered to be a form of avoidance which some literature considers to be a negative coping
strategy that does not really deal with the underlying problem of substance abuse (Humphreys, 2015). There are also consequences to this strategy for managing alcohol abuse in as far as it might lead to social isolation and even danger in cases of an emergency. Existing literature notes how people who abuse alcohol are often socially isolated at various times in their day-to-day lives, despite the occasional socialization with other people who abuse alcohol (Nalwadda, et al., 2018).

Some participants were of the view that drinking in isolation is a preferable option because it limits contact with other people who abuse alcohol. According to Fred:

My wife and I are both HIV positive. I introduced her to alcohol. I started drinking alcohol when I was about 17 and then increased it a bit when I was diagnosed with HIV. We just want to make the best of the remaining life we have and forget some of our problems. That is why we decided to only drink at home. I buy a bottle and take it home so that I can share it with my wife in our own privacy. I drink…but not irresponsibly. In fact, these refreshments you have given me will be for my grandchildren. The transport fee, I will buy some Waragi and I share it with my wife at home (Individual Interview, 2018).

It is notable that Fred perceives drinking in isolation at home as being somewhat less risky than drinking in public; yet, some literature suggests that drinking in relative isolation can increase both the risk of addiction and reduce possibilities of finding supportive networks for overcoming alcohol abuse (Boeri, Gardner, Gerken, Ross, & Wheeler, 2016). Fred admits to introducing his wife to alcohol, an admission that seems to support the notion that men exercise a certain influence over their wives in order to encourage them to commence or continue consuming alcohol. At the same time, Fred differs from some other participants in as far as he is able to plan for how he consumes alcohol and how he manages his other responsibilities. This exercise of free will, competencies and reserve is recognized as an asset from a strengths perspective (Saleebey, 2002).

Some participants advocated for the closure of public drinking places as a means of controlling alcohol abuse. A case in point is Kenneth:
I think that the only people who are able to stay away from alcohol are the ones that stay away from the bars. Things would be so much better if those bars were closed. Everybody should be in his or her house (Individual Interview, 2018).

It is notable that Kenneth in this case advocates for draconian mandates that deny people access to drinking places, ostensibly for the good of the entire village. The assertion seems to be that in the absence of personal assets such as character, courage and resolve (Saleebey, 2002); the community should respond by isolating individuals from circumstances in which they abuse alcohol. Such policy options are already utilized, particularly under the medical model which seeks to treat people who abuse alcohol as patients that might need to be first insulated from the wider society before they are assisted (Connors, DiClemente, Velasquez, & Donovan, 2013). However, this approach may involve denial of the right to make choices about how and when they spend their leisure time. The strengths perspective advocates against the process of disempowering people who abuse substances in this way (Rankin, 2007).

4.4.2 Rationalization

Participants who believed in rationalization did not even consider alcohol abuse to be a problem. As Jacob stated:

Alcohol is not a problem for me. I like to be around people and since my family is not here with me, alcohol brings people to me. I actually think alcohol makes a person more responsible than before because they have to work harder in order to earn money to pay for the drink (Focus Group Discussion, 2018).

Although the veracity of some of Jacob’s claims about the positive effects of alcohol abuse may not withstand scientific scrutiny, they nonetheless highlight the ways in which people rationalize alcohol abuse in order to avoid dealing with it as a problem. Rationalization has already been identified in literature as strategy that people use in order to avoid confronting the issue of substance abuse (Boeri, Gardner, Gerken, Ross, & Wheeler, 2016). The lifestyle model of substance abuse specifically describes how people construct ways of thinking, believing and behaving which enable their alcohol abuse (Nalwadda, et al., 2018). It must also be recognized that Jacob’s claim of the sociability factor of alcohol is already recognized from a strengths perspective where relationships play an important role in recovery (Rankin, 2007).
4.4.3 Political Activism

A key informant identified political activism as a potentially powerful strategy for managing the structural consequences of alcohol abuse. Sam described the organization of the “village drunks” into a political force:

When I was one of the leaders, many people used to beg me to deal with the problem [alcohol abuse] but I could not do it. They [people who abuse alcohol] have all registered to vote and the moment you go against them; they will kick you out of office. It is so bad for this village because it means that the drunkards are now running the show in our politics (Key Informant Interview, 2018).

Some participants have found inspiration from motivational speakers within the world of politics in order to engage in some form of community organizing. Felix for example summarizes his epiphany as follows:

I have been listening a lot to Ken Lukyamuzi [local politician] on radio. He talks about the role of the youth in Uganda today and some of the things that we must do in order to achieve our dreams. Lukyamuzi inspired me a lot and I began to look at my situation in a different light. I do not like seeing other people suffering from alcohol and being pushed out of their communities (Individual Interview, 2018).

Another example of this activist approach to dealing with the structural issues is that of Fred who calls for direct action:

We as a community of drunkards have to unite and influence how things are done in this village. Some of my friends in the drinking community organized recently to get rid of an LC chairman that was trying to turn this village into a no-drinking zone as if we are Zirobwe [a nearby town dominated by Muslims who shun alcohol] (Individual Interview, 2018).

Sam, Felix and Fred talk about a type of conscientization, political activism and direct action that is not fully explored in existing literature. However, the strengths perspective refers to certain assets which the people who abuse alcohol turn to (Saleebey, 2002). For example, Fred
talks about the purpose of ensuring that their voices are heard whereas Sam indirectly refers to the courage that is displayed by the people who abuse substances in order to take on community leaders and defeat them using democratic means. The people who abuse alcohol have also established a community which is bound by mutual experiences of suffering and marginalization within the community. There is an element of resolve and purpose in registering to vote for the specific purpose of ensuring that leaders who do not address the needs of people who abuse alcohol in the village are toppled from power. Felix suggests that the political class (such as Ken Lukyamuzi) play a role in the conscientization of people who abuse substances by using mass media to encourage them to seek a better life.

Nevertheless, it is important to note that Sam as a key informant is of the view that this political power that is exercised by the people that abuse alcohol is misplaced and harmful since it prevents the community leaders from tackling the underlying social problems in Wakivule village. It is not clear as to whether Sam is genuinely concerned about the political and social health of the community or whether he is merely irritated that a marginalized group such as the so called “village drunk” is daring to demand accountability from politicians. Further research may be appropriate to understand the extent to which local political structures are accountable to people who abuse alcohol and the extent to which these structures are responsive to the needs of this vulnerable segment of the community.

4.4.4 Self control

Some participants saw self-control as an effective way of managing alcohol abuse. A case in point is Martin who regulated his drinking time:

My trick is only to drink after work. I normally stop work at about 5pm. I then freshen up and make my way gently to the bar. I always have my budget. I will never ever take more than 2000 shillings on any day. I tell my son to hide away all my money even if I call the LC. In that way, I know that I am saving. My family does not treat me badly because they know that I am dealing with this problem responsibly (Focus Group Discussion, 2018).

Withdrawing from influencers who might potentially encourage someone to abuse substances is reported in existing literature as a coping strategy (Humphreys, 2015). In this case Martin has developed a timetable and a modest budget which allows him to compartmentalize
alcohol abuse within a recreational space. The planning involved is an element of resourcefulness which is recognized as of being useful to people according to the strengths perspective (Saleebey, 2002). Moreover, Martin highlights the role of a supportive family that allows him to continue saving despite consuming alcohol. In this case, the intervention is negotiated, where Martin surrenders (to a trusted son) the ability to access funds whilst intoxicated or when he is in dire need of an alcoholic drink. This represents an interesting use of and expenditure of social capital within the family (Boeri, Gardner, Gerken, Ross, & Wheeler, 2016). It also demonstrates the manner in which Martin is able to use and retract his personal agency in response to the anticipated negative impact on his sense of judgement once he consumes or needs alcohol.

Other participants engaged in self-regulation by controlling the amount of alcohol that they consumed or even stopping altogether. As Titus stated:

You have to measure what you are drinking... just like when you are eating. Maybe if you have a budget of 500 shillings that can be enough. Anyway, if you want to drink more alcohol, you just have to work a bit harder. They will give you jobs here if you have your energy. I sometimes take time off alcohol and then decided to come back to it (Individual Interview, 2018).

In this case, Titus engages in a highly complex form of self-regulation which involves controlling both the amount of alcohol consumed and money spent on its consumption. Other forms of self-regulation that Titus refers to involve expanding earning power in order to feed alcohol abuse. The self-medication hypothesis refers to deficits in self-regulation abilities leading to substance abuse (Khantzian, 1997). The above account supports the view that someone with highly sophisticated and fully functional self-regulation powers is able to control their use of potentially harmful substances such as alcohol in this case. In order to engage in this highly rational form of self-control, Titus claims his human agency in the onset and process of alcohol abuse. This kind of purpose, courage and resolve has already been recognized in the strengths perspective as a potentially useful asset for people who abuse alcohol (Saleebey, 2002).

4.4.5 Medication

Some participants sought to engage in self-medication as a means of dealing with the negative symptoms and effects of alcohol abuse. Peter stated:
I have my own tablet that I get from the pharmacy. Whenever I feel dizzy or want to vomit, I take it and feel better. I do not really know what is in that tablet but I use it. My nurse refused to give me a prescription so I use some of the boys in Kikyusa [local town] to get the prescription for me (Focus Group Discussion, 2018).

Peter’s preferred option of a pill to take away negative effects of alcohol abuse are consistent with the tenets of the self-medication hypothesis, albeit with the important difference that in this case the stressor is the alcohol itself such that Peter has to find additional substances to deal with his unpleasant experiences (Khantzian, 1997). Peter exercises the asset of resourcefulness to bypass the controls on medicine that are put in place by the clinicians. However, this resourcefulness may be misguided by virtue of the fact that the resultant drug interactions may end up harming Peter’s health (Bunt Gregory & Britta, 2011). It is important to note the role of members of the community who act as enablers when Peter is circumventing controls on prescription medicines. The political economy of buying and selling controlled substances is recognized in critical medical anthropology as contributing to substance abuse (Katungi & Nyamwire, 2016).

4.4.6 Local remedies

One key informant was of the view that the use of local remedies might counter some of the negative personality and behavioural traits of people who abuse substances. Rachael stated:

There are some local remedies that are used to treat people who abuse alcohol. I understand that the moment someone takes it, that is the end. They will never want to use alcohol again. Apparently, it makes the drink smell absolutely disgusting for them. I also know of another terrible treatment where they get a woman to urinate in the drunkard’s mouth. I mean, it is absolutely terrifying what these people go through. How can a grown man with a family allow a woman to urinate in his mouth? [key informant shrugs his shoulders] (Key Informant Interview, 2018).

The anthropological view of substance abuse recognizes the possibilities of local and contextually relevant solutions such as using herbal medicines (Connors, DiClemente,
Velasquez, & Donovan, 2013). The key informant in this instance talks about the implicit and explicit degradation of people who abuse substances including the recruitment of strangers to urinate in the person’s mouth. The critical medical anthropology model of substance abuse already highlights how the social production and reproduction of suffering (in this case by virtue of degradation, loss of human dignity and deprivation) forms part of the vicious cycle of substance abuse (Nalule, 2015). Nevertheless, it is notable that Rachael highlights the assumed efficacy of the herbal solutions which make the smell of alcohol disgusting to the individual.

Chapter Five

CONCLUSION

The concluding chapter summarizes the key findings of the study. It also evaluates the relevance of the study to social work practice, academic research and policy formulation. This then leads to an overview of the limitations of the study. The chapter concludes with key recommendations.

5.1 Summary of Findings

The main research objective of this study was to describe the experiences of people who abuse alcohol in Wakivule village, Luwero district. This then led to the following main research question: How do people experience alcohol abuse in Wakivule village, Luwero district? The main research objective has been met and the main research question answered during this study. This study has shown that the experiences of alcohol abuse can be categorized into three main strands or narratives. The narratives make reference to personal circumstances, living conditions as well as structural issues in describing the experiences of alcohol abuse. It must be emphasized that these narratives are not mutually exclusive and always have links between and amongst
them. For emphasis, the findings of this study indicate that substance abuse is a result of the combination of personality characteristics, living conditions and structural issues.

5.1.1 Alcohol abuse as an expression of personal characteristics

The first narrative perceives alcohol abuse as an expression of personal characteristics. In that case alcohol abuse is an expression of an individual’s personality, health status, perceptions, attitudes, knowledge and behaviour. This narrative suggests that alcohol abuse arises primarily due to the inability to manage pain. This is despite the fact that some participants responded to pain (particularly from an organic disease such as hernia) by consuming even more alcohol. Some participants did not pay attention to the potential impact of alcohol abuse on their health but instead focused on the immediate need to control pain. The findings under this narrative indicate that free will is at play in as far as people choose when to start and when to stop alcohol abuse. However, the findings also indicate that this free will is not always available to everyone. Some people are unable to resist the temptation of alcohol abuse.

Under this narrative, people who abuse alcohol face ill health as the predominant consequence of alcohol abuse. In other words, alcohol tends to degrade the health outcomes for people who abuse it despite the fact that they may have started consuming alcohol in order to deal with the painful effects of ill health. Alcohol abuse can then create a vicious cycle of ill health, pain, alcohol abuse and even more ill health. Without the key ingredient of free will, the people that abuse alcohol are unable to stop or moderate this vicious cycle.

The findings indicate that one of the solutions that are suggested for controlling the more undesirable personal characteristics include self-control. The participants discussed the issue of self-control in a range of ways including the amount of alcohol consumed, the money spent on the alcohol, the places they consumed alcohol and even the people with whom they consumed alcohol. The requirements of self-control call for a level of personal agency that is not universally available and may even be trumped by structural issues and living conditions.

Medication (in the traditional sense) has been presented as a possible quick and efficient solutions to the problems that arise out of and even cause alcohol abuse. The notion of self-medication is well-established in existing literature. However, the findings of this study indicate that self-medication is sometimes undertaken in a manner that is detrimental to the health of the person and goes against the advice that is provided by medical experts. This in itself serves as a reminder that alcohol abuse does not always respond well to the models and instructions that are
applied by clinicians. Indeed, the findings of this study shows that some participants prefer local remedies to the conventional medications that are abused by others in order to deal with the effects of alcohol.

5.1.2 Alcohol abuse as a manifestation of living conditions

The second narrative perceives the abuse of alcohol as a manifestation of the living conditions of the individual in terms of family, employment and social relations. In this case, alcohol abuse may commence because people are exposed to alcohol. Some participants indicate that despite access, those with sufficiently robust free will and self-control may be able to escape alcohol abuse. The environment within which people live may include significant others such as sexual partners. Indeed, the participants indicated that men played a role in influencing their wives towards alcohol abuse. At other times, the stresses of dealing with a difficult life may cause people to engage in alcohol abuse. The stressors that were indicated in the study include lifelong diseases, poverty, family strife and even abandonment. Alcohol then allows people who are affected by these stressors to temporarily ignore their problems. This implies that the problems are not resolved but are merely postponed. Individuals escape their unpleasant living conditions rather than confronting and changing them under this narrative.

The effects of alcohol abuse that are identified under this narrative tend to emphasize the importance of dysfunction as a manifestation of unfavourable living conditions. The people that abuse alcohol are therefore unable to engage in positive social relationships. There are indications that the social capital that they acquire and expend during alcohol abuse makes it even more likely that they will continue the habit. The dysfunction extends to the manner in which people handle their affairs. People who abuse alcohol are less likely to be able to balance or stick to a budget. As a consequence, they are unable to meet essential financial obligations. The fact that they are unable to meet their needs and responsibilities means that there is a high likelihood of them being marginalized further.

In the face of unfavourable or undesirable living conditions, some people unsuccessfully attempted rationalize the alcohol abuse. This rationalization deliberately ignores the negative consequences of alcohol abuse and instead paints a picture of social functioning which is not supported by evidence from other participants. Other people choose to simply withdraw from society or that part of society that encourages them to consume alcohol. Such a strategy may appear to involve a reclamation of personal agency in the face of a hostile environment.
However, the resultant social isolation can be harmful to the individuals concerned. The findings of this study indicate that some people are unable to or unwilling to mount an effective response to their undesirable living conditions. Alcohol abuse then allows them to ignore the problem or to become part of the problem.

5.1.3 Alcohol abuse as a response to structural issues

Alcohol abuse may be perceived to be a response to a series of structural issues beyond the immediate control of the individual including the organization of their community, divine interventions and societal conventions. Therefore, alcohol abuse may be a manifestation of the deficits and injustices that emanate from the way in which society is organized as opposed to an individual’s personal characteristics.

The narrative of structure in this case indicates that alcohol abuse is a negative and often ineffective response to inappropriate socialization. In this case the individual loses their agency and becomes nothing more than a consequence of the process of socialization. Such a situation can be particularly challenging for people who are unable to exercise free will or deploy their personal agency to overcome a deeply embedded socialization process. This is a case of culture overcoming individual preferences. Other participants even reference the power of the supernatural which effectively prevents them from exercising any control over their alcohol abuse. The extent to which a person believes in the power of the supernatural may be important.

The structural effects of alcohol abuse under this narrative are mainly felt in the arena of economic disempowerment. The people that abuse alcohol cannot find legal and well-paid jobs. They are forced to accept unequal pay and sometimes even end up being denied access to their wages. These consequences are then elevated to the wider economic underdevelopment of the locality. The cycle of economic marginalization is complete where an area that lacks social services is then unable to engage in productive activities that could possibly support those social services.

The responses to the structural dimensions of alcohol abuse were mainly political in the context of Wakivule village. The people that abused alcohol were inspired by others or by their own sense of being marginalized in order to organize themselves into a political force. However, it is not entirely clear whether that political force is a force for good. Indeed, some key informants blame the political activism of the people that abuse alcohol for frustrating any efforts to resolve this problem within the community. It is also notable that the community of people
that abuse alcohol seems to be more effective in these political demands when working in unison. That finding may suggest that personal agency has limitations when it comes to dealing with the structural issues that lead to alcohol abuse.

5.2. Conclusions

The conclusions in this study focus on the situation analysis of substance abuse, the applicability of the strengths perspective and the relevance of the models of alcohol abuse that were identified in existing literature.

5.2.1 Situation analysis of alcohol abuse

The findings of this study indicate that alcohol abuse remains a serious problem in rural areas. The participants in the study speak of an isolating experience which leads to them being ostracized and marginalized by their own communities. The study also shows that alcohol abuse is associated with other social problems such as poverty, gender inequality, domestic violence and social inequity. The participants did not mention any formal interventions that were designed to helped people but instead they relied on local remedies that were not supported by scientific research. There were no facilities to help people who abuse alcohol. Nevertheless, there were indications that some people were unhappy about the fact that they were abusing substances. Some even indicated that they would like to get some help to overcome this problem. The findings of the study therefore reflect the reality that alcohol abuse is a growing and largely unaddressed social problem in Uganda.

5.2.2 Applicability of the strengths perspective

To a great extent, the strengths perspective is very relevant to exploratory qualitative studies. The process of selecting recruiting and interviewing participants as well as the responses they have given indicate that there is capacity for self-awareness, reflexivity and eventual positive change. This capacity is sometimes tapped in order to engage in self-medication and even political activism. At other times, the capacity is untapped where people who abuse alcohol prefer to avoid confronting the issue. It is clear from the narratives of this study that many participants have very clear views about their rights, responsibilities and roles within their community. Some claim to have sufficient human agency to be able to direct the patterns and intensity of their alcohol consumption. Others are able to highlight instances of marginalization and even engage in activism in order to bring about change.
The strengths perspective offers the constructivist narrative as an appropriate methodology for understanding the experiences of people who abuse alcohol based on their own perceptions and in their own language. This empowering approach may offer new and unique options for intervening in cases of substance abuse at community level. That is not to say that alcohol abuse is a universally positive experience. There is evidence in the study that alcohol abuse disempowers and isolates people so that they are unable to trigger their human agency to deal with their problems and address their needs. Further research may be appropriate in order to understand how the experiences of people who abuse alcohol can be incorporated into macro interventions that adopt a developmental social work approach.

5.2.4 Models and narratives of alcohol abuse

This study was conceived from the point of view that the medical model is limited in its understanding of alcohol abuse. The findings of the literature review specifically contrasted the medical model of alcohol abuse with the anthropological view of alcohol abuse. In the event, the findings of this study have shown that neither categorization is complete or mutually exclusive.

In order to fully understand alcohol abuse, it is necessary to make reference to both the medical models and anthropological explanations of substance abuse. For example, some participants specifically talked about self-medication in the form of clandestinely obtained drugs and also local herbal remedies. They also talked about the influence of depressive states and illness, elements that fall within the explanations provided by the self-medication hypothesis. At the same time, other participants spoke of systemic marginalization, socialization, poverty and gender inequality as key issues within the context of alcohol abuse. These aspects fall within the scope of explanations that are provided by the cultural model, lifestyle model and critical medical anthropological view of alcohol abuse. Furthermore, other participants spoke of supernatural powers and divine intervention which falls within the remit of the client explanatory models for alcohol abuse or even other mental health issues.

These are three contrasting strands of explanation for the phenomena but with linkages in terms of the people abuse alcohol. It is on that basis that it can be argued that a holistic understanding of alcohol abuse cannot be limited to one perspective but must necessarily adopt a much wider lens of the phenomena. Further research may be appropriate in order to identify ways in which the medical and anthropological views of alcohol abuse can be incorporated when
intervening in situations that are harmful to individual members of the community and the community as a whole.

5.3 Significance and Value of the Study

This study is relevant to developmental social work practice in as far as it adopts an empowering approach that is based on the strengths perspective. To that extent, the study may provide additional insights to social workers who have to support people who abuse alcohol using a much more holistic approach than the narrow medical approach that has been popular in clinical settings. The findings of this study may inspire the development of unique tools for supporting people who abuse alcohol when they leave medical settings.

From the point of view of undertaking research, this study is relevant in as far as it demonstrates the possibilities of gaining new insights into the knowledge, attitudes and behaviour of people who abuse alcohol without merely relying on pre-existing models that are designed by the “experts” who may not have the kind of empirical experience of substance that has been demonstrated by the participants in this study. The study also demonstrates some of the possibilities of undertaking a constructivist narrative approach to qualitative studies within a rural setting for purposes of exploring social phenomena from the point of view of the people that are experiencing that phenomenon.

This study is relevant to the policy formulation and implementation process with regards to substance abuse in general and alcohol abuse in particular. The study shows that is not enough to impose solutions on communities because of preconceived notions of substance abuse that emanate from clinicians. Instead, this study demonstrates the value of listening to people who abuse substances because they have a unique insight into this condition. Such a paradigm shift will be important for a developing country like Uganda which is dealing with the problem of substance abuse but does not have sufficient resources to provide institutionalized social support or clinical interventions to everyone that needs it. The findings of this study make a case of a developmental approach that puts faith in the ability of people to define their problems and select the most contextually relevant solutions to them.

5.4 Recommendations

It is recommended that quantitative research is taken to test the veracity of some of the assertions, assumptions and descriptions that have been presented in this study. This study
should focus on particular narratives that have emerged unexpectedly after reviewing the findings. The first of these narratives is that of the socialization into alcohol abuse through the influence or coercion exercised by intimate partners based on gender inequality. The second is the political activism of people who abuse substances in order to deal with the structural issues that affect their lives. The third narrative worth exploring further is that of the changes in the patterns of alcohol abuse that emerge when contemporary society is compared to traditional societies.

Furthermore, it is recommended that trainee social workers at Makerere University, other higher institutions of learning and Non-Governmental Organizations (NGOs) explore the possibilities of applying a developmental approach when supporting people who abuse substances. Specifically, the use of the strengths perspective within the local context should be considered. This study has shown that this theoretical framework has relevance to the Ugandan context despite the fact that it was originally developed in the USA within the context of prisons and mental health facilities.

Finally, it is recommended that the government of Uganda through the Ministry of Gender, Labour and Social Development invests in programs that help people to stop substance abuse. This is particularly important at a time when the agricultural sector which employs over 80% of Ugandans is facing a crisis of sustainability following a series of shocks including the recent maize crisis. This study has shown that poverty and inequality can drive people into alcohol abuse which in turn leads to underdevelopment within poor rural communities. Therefore, there is a business case for using the developmental approach to help local communities to tackle this problem rather than leaving the task to the few medical facilities that operate on a residual model to deal with the most serious cases of substance abuse.
References


Appendices

Appendix 1: Construction of Interview Guide

The interview is divided into 3 topical areas that reflect the research questions and key research topics (see appendix 1 for the interview guide). Each topic is divided into a number of open ended interview questions, with the flexibility that the researcher may probe and expand the question in order to elicit more detailed information or to clarify certain issues. The biographical data will be deliberately placed at the end in order to increase response rate since some of the questions included are of a very personal and sensitive nature (Bryce, Spitz, & Ponsford, 2015).

The Topics are broken down as follows on the interview:

- **Topic I**: This topic is concerned with the effects of substance abuse in Wakivule village, Luwero district. The topic will be subdivided into questions 1a, 1b and 1c. The interviewer will ask the participants to describe their life in order to determine how substance abuse has affected their life within the community.

- **Topic II**: This topic is concerned with the attributed causes of substance abuse in Wakivule village, Luwero district. The topic will be subdivided into questions 2a and 2b. The researcher will ask the participants to describe in their own words what they consider to be the causes of their substance abuse.

- **Topic III**: This topic is concerned with the management mechanisms for people who abuse alcohol in Wakivule village, Luwero district. The topic will be subdivided into questions 3a, 3b and 3c. The researcher will ask the participants to describe in their own words how they manage their substance abuse and its effects.

The last part of the interview will focus on the biography of the clients. Six characteristics have been selected in order to understand the history and life situations of the participants. These characteristics include age, gender, marital status, religious affiliation, level of formal education and average monthly income.
Appendix 2: Individual interview guide

INTRODUCTION AND INFORMED CONSENT

Good day to you. My name is John Musisi Kaduwanema. I am a 3rd year student at Makerere University pursing a Bachelors of Social Work and Social Administration Degree. I would like to request you to engage in an interview with reference to my dissertation titled “Experiences of people who abuse alcohol in Wakivule village, Luwero District”. You have been selected to participate in this study because you have indicated that you consume alcohol or others have identified you as someone that consumes alcohol. Please note that this is an entirely voluntary process and you are free to stop the interview at any moment. I will be using an interview guide that has been approved by my dissertation supervisor at Makerere University. Please answer the questions as best as you can.

The interview is expected to last 30 minutes. However, feel free to take your time to answer the questions. I am here for as long as you need to answer the questions in this interview. Here is a tape recorder that will record all our conversations. I will transcribe these conversations later on and use them for research purposes. All the information you give in this interview will be used for my research project only. It will not be shared with other parties. All the transcripts and the recording will be destroyed one year after this interview. Details about you and your family will be kept in the strictest confidence. I may use quotes from the interview but your name or any other identifying details will not be given to anyone. Please sign or put your fingerprint here to confirm that:

(i) You are older than 18 years of age on this day
(ii) You fully understand everything I have said about this study and interview
(iii) You freely agree to participate in this interview

................................................................. [SIGNATURE OR FINGERPRINT AND DATE]

INTERVIEW QUESTIONS

1(a) Please tell me about your life in general?
Prompt for day-to-day routines, employment, income, family relationships and health.

1(b) How has consuming alcohol affected your life?
Prompt for stress factors, community participation, relationships and feelings.
1(c) Please describe what you think your life would be like if you were not consuming alcohol.
Prompt for communal activities, respect, inclusion and leisure activities.

2(a) What do you think causes people to consume alcohol?
Prompt for biological, supernatural, psychosocial, spiritual factors and living circumstances.

2(b) Under what circumstances do you consume alcohol?
Prompt for triggers, personal experiences, vivid examples, processes of addiction, stressors, push factors, pull factors, health, religion etc. as well as perceptions of triggers.

3(a) How do you manage the consequences of consuming alcohol?
Prompt for formal and informal support, resilience, coping strategies, care, jobs, detox programs and medication.

3(b) Please describe how effective you are in managing the effects of consuming alcohol?
Prompt for strategies, gaps, failures, restarts, any lessons learnt and secondary consequences of dealing with alcohol consumption.

3(c) Are there any people that support you? If so, what kind of support do they provide? Do you find this support useful or not? In what ways has this support changed your life? Please explain the reasons for your answer.
Prompt for role of family, village health team and other social networks.

4(a) Below are some general questions about yourself.

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Thank you very much for participating in this interview.
Appendix 3: Focus group discussion guide

INTRODUCTION AND INFORMED CONSENT

Good day to you. My name is John Musisi Kaduwanema. I am a 3rd year student at Makerere University pursing a Bachelors of Social Work and Social Administration Degree. I would like to request you to engage in a focus group discussion with reference to my dissertation titled “Experiences of people who abuse alcohol in Wakivule village, Luwero District”. You have been selected to participate in this study because you have indicated that you consume alcohol or others have identified you as someone that consumes alcohol. Please note that this is an entirely voluntary process and you are free to stop the discussion at any moment. I will be using a discussion guide that has been approved by my dissertation supervisor at Makerere University. Please answer the questions as best as you can.

The discussion is expected to last 30 minutes. However, feel free to take your time to answer the questions. I am here for as long as you need to answer the questions in this discussion. Here is a tape recorder that will record all our conversations. I will transcribe these conversations later on and use them for research purposes. All the information you give in this discussion will be used for my research project only. It will not be shared with other parties. All the transcripts and the recording will be destroyed one year after this discussion. Details about you and your family will be kept in the strictest confidence. I may use quotes from the discussion but your name or any other identifying details will not be given to anyone.

In order to protect your identity, you will be allocated a number which you will use during this discussion as opposed to your name. Please mention your number before speaking. I also request that you do not disrupt other participants. All views are welcome here and everyone will get their turn. Please do not mention any issues that are discussed in this forum to any other outside party.

Please sign or put your fingerprint here to confirm that:

(i) You are older than 18 years of age on this day
(ii) You fully understand everything I have said about the study
(iii) you freely agree to participate in this discussion

.................................................... [SIGNATURE OR FINGERPRINT AND DATE]
FOCUS GROUP DISCUSSION QUESTIONS

1(a) Please tell me about your life in general?
Prompt for day-to-day routines, employment, income, family relationships and health.

1(b) How has consuming alcohol affected your life?
Prompt for stress factors, community participation, relationships and feelings.

1(c) Please describe what you think your life would be like if you were not consuming alcohol.
Prompt for communal activities, respect, inclusion and leisure activities.

2(a) What do you think causes people to consume alcohol?
Prompt for biological, supernatural, psychosocial, spiritual factors and living circumstances.

2(b) Under what circumstances do you consume alcohol?
Prompt for triggers, personal experiences, vivid examples, processes of addiction, stressors, push factors, pull factors, health, religion etc. as well as perceptions of triggers.

3(a) How do you manage the consequences of consuming alcohol?
Prompt for formal and informal support, resilience, coping strategies, care, jobs, detox programs and medication.

3(b) Please describe how effective you are in managing the effects of consuming alcohol?
Prompt for strategies, gaps, failures, restarts, any lessons learnt and secondary consequences of dealing with alcohol consumption.

3(c) Are there any people that support you? If so, what kind of support do they provide? Do you find this support useful or not? In what ways has this support changed your life? Please explain the reasons for your answer.
Prompt for role of family, village health team and other social networks.

4(a) Below are some general questions about yourself.

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Thank you very much for participating in this interview.
INTRODUCTION AND INFORMED CONSENT

Good day to you. My name is John Musisi Kadowanema. I am a 3rd year student at Makerere University pursuing a Bachelors of Social Work and Social Administration Degree. I would like to request you to engage in a key informant interview with reference to my dissertation titled “Experiences of people who abuse alcohol in Wakivule village, Luwero district, Luwero District”. You have been selected to participate in this study because you are a key informant with some knowledge about the Wakivule community which is important for this study. Please note that this is an entirely voluntary process and you are free to stop the interview at any moment. I will be using an interview guide that has been approved by my dissertation supervisor at Makerere University. Please answer the questions as best as you can.

The interview is expected to last 30 minutes. However, feel free to take your time to answer the questions. I am here for as long as you need to answer the questions in this interview. Here is a tape recorder that will record all our conversations. I will transcribe these conversations later on and use them for research purposes. All the information you give in this interview will be used for my research project only. It will not be shared with other parties. All the transcripts and the recording will be destroyed one year after this interview. Details about you and your family will be kept in the strictest confidence. I may use quotes from the interview but your name or any other identifying details will not be given to anyone.

Please sign or put your fingerprint here to confirm that:

(iv) You are older than 18 years of age on this day
(v) You fully understand everything I have said about the study
(vi) You freely agree to participate in this interview

.................................................................................. [SIGNATURE OR FINGERPRINT AND DATE]

KEY INFORMANT INTERVIEW QUESTIONS

1(a) Please tell me about the life in general of people who abuse alcohol in Wakivule village?
Prompt for day-to-day routines, employment, income, family relationships and health.

1(b) How has alcohol abuse affected the lives of members of the Wakivule village community?
Prompt for stress factors, community participation, relationships and feelings.

1(c) Please describe what you think community life in Wakivule village would be like if there was no alcohol abuse.

Prompt for communal activities, respect, inclusion and leisure activities.

2(a) What do you think causes people to abuse alcohol in Wakivule village?

Prompt for biological, supernatural, psychosocial, spiritual factors and living circumstances.

2(b) Under what circumstances do people abuse alcohol in Wakivule village?

Prompt for triggers, personal experiences, vivid examples, processes of addiction, stressors, push factors, pull factors, health, religion etc. as well as perceptions of triggers.

2(c) Why do you think alcohol abuse is a problem in Wakivule village?

Prompt for family, socialization, peer pressure, culture, stress, health, religion and inheritance.

3(a) How do people in Wakivule village manage the consequences of alcohol abuse?

Prompt for formal and informal support, resilience, coping strategies, care, jobs, detox programs and medication.

3(b) Please describe how effective Wakivule village residents are in managing the effects of alcohol abuse?

Prompt for strategies, gaps, failures, restarts, any lessons learnt and secondary consequences of dealing with alcohol consumption.

3(c) Are there any people that support people who abuse alcohol in Wakivule village? If so, what kind of support do they provide? Do you find this support useful or not? In what ways has this support changed the life of the community? Please explain the reasons for your answer.

Prompt for role of family, village health team and other social networks.

Thank you very much for participating in this interview.