Ethno-epidemiology of alcohol use among Zimbabwean migrants living in the UK

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Abstract

Title: Ethno-epidemiology of alcohol use among Zimbabwean migrants living in the United Kingdom

Background: Despite the UK having a relatively long history of migration, very little is known about the relationship between alcohol use and migrants. With more than half of the increase in the UK population over the last decade a result of migration, understanding alcohol use in migrant communities provides an important platform for the formulation of health policies and interventions that suit the cultural diversity that is now prevalent in the UK.

Purpose: This study explored attitudes, perceptions and beliefs related to alcohol use, based on the experiential and lived realities of Zimbabwean migrants who settled in UK from the 1990s because of the political and economic decline in Zimbabwe. This study also investigated the factors associated with increased alcohol intake in Zimbabwean migrants living in the UK.

Method: The study utilized a mixed methods approach by applying a multi-sited focused ethnography, comprising 44 in-depth interviews and participant observations at three sites in the Yorkshire region of the UK. It explored themes emerging from narrated accounts of attitudes, motivations and beliefs shaping alcohol's meaning in UK based Zimbabwean migrants' lives. Findings from the focused ethnography were used as inputs to enhance a questionnaire that collected information on a broad cross section of Zimbabweans across the UK (n=331). The questionnaire measured alcohol intake using the Alcohol Use Disorders Identification Tool (AUDIT) along with questions on demographic, psychosocial and socio-economic attributes.

Results: The findings describe the role of social identity and culture in shaping drinking patterns. The findings also describe the role of Zimbabwean public spaces and alcohol in protecting Zimbabweans from homesickness, isolation and alienation in an environment most perceived as hostile and unwelcoming. The risk of harmful drinking among Zimbabwean migrants was found to be high, particularly in males. High social capital and religious activity were found to be protective against the risk of harmful drinking, whilst being male and experiencing stress exposed Zimbabwean migrants to increased risk of harmful alcohol use.

Conclusion: The findings represent an important contribution to our knowledge of the Zimbabwean diaspora in particular, and to the wider field of alcohol research in migrant populations. The thesis is distinctive in its use of focused ethnography, and demonstrates how mixed methods can be applied in alcohol research to develop culturally sensitive screening and brief interventions on emerging migrant populations. The findings may therefore contribute towards policy formulation and efforts to reduce the harmful use of alcohol by utilizing culturally specific intervention programmes that aim to address 'problematic' drinking patterns in the less understood and hard to reach migrant populations in the UK.

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Declaration

Except where reference is made in the text of the independent research project report, this thesis contains no material published elsewhere or extracted in whole or in part from a thesis or report presented by me for another degree or diploma

No other person's work has been used without due acknowledgement in the main text of the report. This report has not been submitted for the award of any other degree or diploma in any other tertiary institution.

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Chapter 1: Introduction

1.1 Introduction

This chapter introduces the backdrop against which this thesis is anchored. This is followed by a global overview of alcohol and health. A brief description of the population of interest is given, followed by a narrative describing recent migration patterns into the UK to provide context about the magnitude of, and the nature of migration into the UK. An account of the position of the author prior to commencing the study is given. A section, which introduces the overall organisation of the thesis, closes this chapter.

1.2 Backdrop to Study

Settling into a foreign country, with an entirely different set of values and norms regarding alcohol use, marks a crucial time in migrants' lives. During this time, they encounter new social scenes and experience shifting identity. Prior to migration, migrants encounter an array of mediated messages and experiences that form their understanding of the meaning of alcohol in their lives. After migration, with the need to fit in and belong, migrants are highly sensitive to social norms constituting their new surroundings. They keenly observe others' behaviours by attuning closely to conversations with peers and discerning socially acceptable attitudes and beliefs of their host country, and combining this with attitudes, values and beliefs acquired in their country of origin prior to migration. Thus, social and cultural norms and the impact they have on drinking behaviour contribute to the overall coordinated actions and meanings constituting migrants' drinking culture (Savic *et al*., 2016; Renzaho *et al*., 2010).

It is in this backdrop that alcohol use is positioned as playing a central role in many aspects of Zimbabwean migrants' social interactions. Among the many health and social issues relevant to migrant populations, very little is known about the relationship between alcohol and migrant populations in the UK. This study therefore pays attention to exploring the discursive processes underlying the social construction and sense making techniques for interpreting the role of alcohol in the lives of Zimbabwean migrants in the UK. It examines how

Zimbabwean migrants conceive and construct social norms of the UK experience to validate the roles alcohol plays in their lives. Particular attention is paid to exploring alcohol use by and with participants using focused ethnographic research of Zimbabwean migrants in the UK. The perspective that alcohol consumption is not necessarily a problem, but that it can be a normal and normative behaviour in some cultures marks an important aspect of this study. On the other hand, the perspective that alcohol consumption has serious consequences in particular situations is equally paramount. Alcohol use can be seen as problematic in particular contexts, like when taken to extremes. However, in other contexts, alcohol plays a normal role in peoples' lives, is normative and a legal behaviour. Hence, attention is given to both the positive and negative consequences of alcohol use in the view of participants, and how drinking by Zimbabwean migrants may contribute to the development of understanding the factors which influence patterns of alcohol use, and knowledge about their social world.

In the context of this research, the focused ethnography provided an opportunity to demonstrate the necessity for researchers to negotiate the potentially positive and negative consequences of drinking with research participants for whom drinking is a normal part of their social world. Drawing from this backdrop, a Mixed Methods approach was employed by qualitatively applying focused ethnographic methods and using the findings as inputs to enhance a quantitative questionnaire. The questionnaire collected information on a broad range of psychosocial and socio-economic attributes suited to examining the way Zimbabwean migrants in the UK interpret and communicate meaning for their perceptions of alcohol use.

1.3 Alcohol and Health

Moderate drinking is not harmful and may have health and social benefits, but alcohol abuse is a public health concern with considerable social and economic costs (Scarborough *et al.*, 2011). The World Health Organization (WHO, 2014) estimates that in 2010, the worldwide total consumption was equal to 6.2 litres of pure alcohol per person 15 years and older, and that unrecorded consumption accounts for 25% of the worldwide total consumption. It is equally important to note however that a majority of the world's adult population had abstained from drinking alcohol in the past 12 months (WHO, 2014).

The harmful use of alcohol is a worldwide problem resulting in millions of deaths (WHO, 2008). In many parts of the world, drinking alcoholic beverages is a common feature of social gatherings, yet its consumption risks adverse social consequences related to its intoxicating, toxic, and dependence-producing properties (WHO, 2014).

Alcohol use is also a precursor to injury and violence. It is associated with an increased risk of acute health conditions, such as injuries, including from traffic accidents (WHO, 2014). It also causes harm to the well-being and health of people around the drinker (Global Information System on Alcohol and Health, 2014). Furthermore, its negative impacts can spread throughout a community or a country, and beyond, by influencing levels and patterns of alcohol consumption across different countries (WHO, 2008).

Consumption of alcohol and problems related to alcohol vary widely around the world, but despite this variation, the burden of disease and death is significant in most countries (WHO, 2014). The harmful use of alcohol ranks among the top five risk factors for disease, disability and death throughout the world (WHO, 2009). In 2012, about 3.3 million net deaths, or 5.9% of all global deaths, were attributable to alcohol consumption. It is causally relevant for more than 200 International Classification of Diseases (ICD-10) (ICD- 10th Edition) three digit codes, including more than 30 codes where alcohol is a necessary cause. Unintentional injuries alone account for about one third of the 1.8 million deaths caused as a result of alcohol abuse, while neuro-psychiatric conditions account for close to 40% of the 58.3 million Disability Adjusted Life Years (DALYs) (Rassool, 2009 pg: 75). The disability-adjusted life year (DALY) extends the concept of potential years of life lost due to premature death to include equivalent years of "healthy" life lost by virtue of being in states of poor health or disability.

1.4 Defining a 'migrant'

There is no universal consensus on what a first-generation or second-generation migrant is. The IOM (2018) defines a migrant as any person who is moving or has moved across an international border or within a state away from his/her habitual place of residence. This is regardless of (1) the person's legal status; (2) whether the movement is voluntary or involuntary; (3) what the causes for the

movement are; or (4) what the length of the stay is. Generally, a distinction is made between short-term or temporary migration, covering movements with a duration between three and 12 months, and long-term or permanent migration, referring to a change of country of residence for a duration of one year or more, also known as international migration.

While there is no formal legal definition of an international migrant, most experts agree that an international migrant is someone who changes his or her country of usual residence, irrespective of the reason for migration or legal status (United Nations Department of Economic and Social Affairs, 2017). The term ‘migrant’ is at times confused and used intermittently with the term ‘refugee’ yet, though some grey areas exist, the terms have distinct and different meanings, and confusing them leads to problems for both populations (UNHCR, 2016). Refugees are persons who are outside their country of origin for reasons of feared persecution, conflict, generalized violence, or other circumstances that have seriously disturbed public order and, as a result, require international protection (UNHRC, 2018).

The term 'migrant' becomes even more complex when migrants begin to be referred as 'first generation', 'second generation' or even third generation (Dronkers and Fleischmann, 2010). The generational definitions of migrant status are not always clear and are used differently from one country to the other. Generally, the term first generation migrant loosely refers to a person who has immigrated to a new country. The term first generation migrant consequently may refer to either the children of the first generation migrant, regardless of whether they were born in the new country or the country of origin. In Canada for example, the term first generation refers to people who were born outside Canada whereas second generation includes individuals who were born in Canada and had at least one parent born outside Canada (National Household Survey, 2011). Third generation or more or more refers to people who are born in Canada with both parents born in Canada (National Household Survey, 2011).

Taking into account that the terminology is not precise and often ambiguous, the general rule is to use the government's terminology for that country's immigration terminology. Henceforth this study adopted immigrant terminologies based on the UK definitions (Algan *et al.,* 2010). In the case of the UK, native-born children of

foreign-born immigrants make up “the second generation” of migrants and their children subsequently become “the third generation”. The second generation are also at times referred to as migrants in some academic texts (Dustmann and Theodoropoulos, 2010).

In considering what a migrant is, it is also important to look at the reasons why migration takes place. Aspinall and Chinouya (2016, pg: 44) argued that the reasons for Black African migration to the UK is a complex phenomenon. They noted that migration flows ‘‘may include economic migration (work permit holders, au pairs, seasonal agricultural workers, and others), forced migration (as asylum seekers, refugees) family reunion, and migration for education (student visa holders). They also argued that if an ‘act of immigration’ has to have an ‘intention to stay’, it raises questions as to whether those who arrive in the UK for the pursuance of education can be classified as having migrated. ONS data categorise students as either long-term or short-term migrants depending on whether their intended duration of stay is more or less than 12 months (The Migration Observatory, 2018). Other than those migrants who settled in the UK through prescribed legal avenues, there is also the undocumented migrants, meaning those migrants who entered the UK illegally, using various means such as through trafficking. A proportion of undocumented migrants is also either a result of people staying in the country after their asylum application has been rejected, or their visas have expired.

A migrant is someone who changes his or her country of usual residence while an asylum seeker is someone who does so “from fear of persecution for reasons of race, religion, social group, or political opinion” (UNHCR). In this sense, asylum seekers can be counted as a subset of migrants and included in official estimates of migrant stocks and flows. However, the UN Convention on the Rights of Migrants defines a migrant worker as a "person who is to be engaged, is engaged or has been engaged in a remunerated activity in a State of which he or she is not a national." From this a broader definition of migrants follows: "The term 'migrant' in article 1.1 (a) of the UN Convention and Protocol Relating to the Status of Refugees (1951) should be understood as covering all cases where the decision to migrate is taken freely by the individual concerned, for reasons of 'personal convenience' and without intervention of an external compelling factor." This definition indicates that migrant does not refer to refugees, displaced or

others forced or compelled to leave their homes. Migrants are people who make choices about when to leave and where to go, even though these choices are sometimes extremely constrained. Indeed, some scholars make a distinction between voluntary and involuntary migration (United Nations Glossary of Migration Related Terms).

1.5 Population of Interest

1.5.1 Historical background

Zimbabwe is a landlocked country located in Southern Africa, between the Zambezi and Limpopo Rivers. It borders South Africa to the south, Botswana to the west and southwest, Zambia to the northwest, and Mozambique to the east and northeast. A country of 16 million people, Zimbabwe has several official languages with English, Shona and Ndebele the most commonly used (World Population Prospects, 2017). The earliest settlement of the area now known as Zimbabwe goes back about 100.000 years and since then the area has been home to many great kingdoms and states (Sahlins, 2017). Figure 1 shows the geographical position of present day Zimbabwe relative to its neighbouring countries.

Figure 1: Position of Zimbabwe relative to other Southern African Countries

Source: Worldatlas.com

The British South Africa Company led by Cecil John Rhodes was the first to demarcate the present territory during the 1890's, later to become the self-governing British Colony of Southern Rhodesia in 1923 (McFarlane, 2007, Phimister, 2007). In 1965, the conservative white minority government, led by Ian Smith, unilaterally declared independence against the British monarchy and named the country Rhodesia. This was followed by a 15-year guerrilla war led by Black Nationalist forces that culminated in a peace agreement that led to the establishment of present day Zimbabwe on 18 April 1980. In the same year, Robert Mugabe became the first Prime Minister of Zimbabwe following the ending of white minority rule. He has since dominated the political scene and is largely blamed for the collapse of the once thriving economic climate in Zimbabwe that culminated in a mass exodus of Zimbabweans into neighbouring and overseas countries in search of better opportunities. An estimated 3.4 million Zimbabweans, a quarter of the population, had fled abroad by mid-2007 (Meldrum, 2007) with an estimated 3 million of these settling in South Africa and Botswana (Sokwanele Civic Action Group, 2007), with the UK becoming the top European destination.

Zimbabweans are a special case to study, as they are one of the fastest growing African migrant populations in the UK. Although there are no precise figures for the number of Zimbabweans in the UK, estimates suggest that there are more than 200 000 in the country (Pasura, 2008). Unofficial estimates of the total Zimbabwean British population, including those born in the UK of Zimbabwean origin vary significantly. Research aiming to more precisely map the Zimbabwean population found that there are between 200 000 and 500 000 Zimbabweans in the UK, of which 30 000 reside in cities in the Yorkshire and Humber region (Waite and Cook, 2011). Numerous newspapers such as The Observer (2003) have speculated that the population of Zimbabwean migrants in the UK might be as large as 600 000. The Office for National Statistics by contrast, estimated that in 2013 there were 110 000 people resident in the UK who had been born in Zimbabwe (ONS, 2015).

Zimbabweans who migrated to the UK from the late 1990's onwards were largely young working class adults forced to leave because of the rapid collapse of Zimbabwe's economic infrastructure. Their hopes and aspirations were to better

themselves in taking advantage of the educational and work prospects available in the UK. Humphris (2010), states that Zimbabwe has been in the UK's top ten asylum receiving countries since 2000 and that this is attributed to the unprecedented economic decline and political instability that has prevailed in Zimbabwe. Trends in asylum applications have generally followed the scale of state violence and political instability in Zimbabwe.

The IOM characterised Zimbabwean migration to the UK as divided into three waves (Humphris, 2010). The first wave of significant Zimbabwean migration consisted of white Zimbabweans who migrated after the country's formal independence from Britain in 1980 (Humphris, 2010). The second wave, which is the focus of this study, took place between 1990 and 1997, because of the economic hardship that resulted from the application of the International Monetary Fund's Economic and Structural Adjustment Program. The third wave, which is also the focus of this study, began in 1998, as a result of political and social unrest in Zimbabwe. Prior to 2002, Zimbabweans were free to travel to the UK without a visa. This provided an easy route to apply for asylum, however in November 2002 the UK government introduced the requirement for Zimbabweans to apply for visas in order to travel to the UK, making it more difficult for them to apply for asylum (Travis, 2002).

Zimbabweans who settled into the UK during and after the second and third waves of migration faced significant challenges. These challenges included severe de-skilling experienced particularly by the male immigrants who had held professional, academic, and technical occupations prior to migrating and were unable to secure similar employment in the UK (Bloch, 2006). Kirk (2004) noted a Skills Audit of Refugees published by the Home Office in 2004 based on a survey of 2000 refugees which found that of all groups surveyed, Zimbabweans had the highest level of education, previous work experience and levels of literacy and English language. Kirk (2004) also noted that fifty-seven percent had worked as professionals, managers or in professional and technical occupations. Bloch (2008) reported that a study of 500 Zimbabweans found that ninety-seven percent of Zimbabweans in the UK had a formal qualification and an above average level of education compared to the British population and other exiled groups,

indicating that this migrant group may have been positively selected to migrate due to its health and socio-economic characteristics.

1.5.2 Research on Zimbabweans in the UK

Very little is known about alcohol use among Zimbabwean migrants in the UK. In light of findings from this literature review, it appears that most of the studies on the health and wellbeing of Zimbabweans in the UK explored HIV and sexual health (Chinouya *et al*., 2017; Chinouya and O'Brien, 2012; Dodds *et al*., 2008; Chinouya, 2007), with very little known about other health related behaviours and conditions. Some studies about Zimbabwean migrants in the UK have explored economic, political, social and cultural issues and the ways in which the migrant experience among other factors, impact on these issues. (Mbiba, 2012; Magunha, 2009; Bloch, 2008; Bloch, 2007; Bloch, 2005). The following is a summary of some of the research conducted on Zimbabwean migrants in the UK.

Using a cross sectional survey as part of a larger participatory research project, a study by Fenton *et al.* (2002) described the demographic and behavioural factors associated with the human immuno-deficiency virus (HIV) testing among migrants from five sub-Saharan communities in London, Zimbabweans included. The study concluded that HIV testing may be largely associated with an individual's history of sexually transmitted infections or self-perceived risk. Another study by Chinouya and Keefe (2005) examined how black Africans in Middle England, Zimbabweans included, make sense of religion in their daily lives when faced with a life-threatening condition, namely, HIV and the acquired immune deficiency syndrome (AIDS). One of their major findings was that despite the importance of faith in the management of daily life within the context of a positive HIV diagnosis, the church was construed as a space for the generation of stigma, and for having a poor record of maintaining confidentiality.

In another study, Chinouya and O'Keefe (2006) explored the meaning of Ubuntu-Hunhu, and the applicability of this concept to Zimbabwean migrants living in London who had a diagnosis of HIV. They concluded that Zimbabwean migrants in London had complicated needs in respect of confidentiality regarding their own positive HIV diagnosis. The words Ubuntu which originates from the Ndebele language and Hunhu, from the Shona language, signify the activity of being

human or humanness (Chinouya and O'Keefe, 2006). Using the Ubuntu–Hunhu framework, the authors concluded that confidentiality in HIV was crucially important for the individual and those connected to the person living with HIV, including sexual partners, with important implications for public health. Several other studies on the African diaspora in the UK, including Zimbabweans, have concentrated on HIV and AIDS, and the factors which influence both health promotion and HIV transmission (Chinouya *et al*., 2017; Chinouya and O'Brien, 2012; Dodds *et al*., 2008; Chinouya, 2007).

Using multi-sited ethnography, Pasura (2008) analyzed the lived realities of the Zimbabwean diaspora in Britain. Drawing on the basis of data from Coventry, Birmingham, London and Wigan, Pasura (2008) examined the relationship of the Zimbabwean diaspora to the 'homeland' and to the 'hostland' with a particular emphasis on transnational diaspora politics. He also examined the participation of the diaspora in paid work, the configuration of gender relations and roles, and the meanings of diaspora and attitudes towards return or settlement. Other studies by Pasura have examined the Zimbabwean diaspora in the UK, and particularly the processes by which Zimbabweans in the UK negotiate boundaries, assert meanings, interpret their own pasts, and define themselves in relation to others (Pasura, 2010).

McGregor (2007) examined the narratives of Zimbabwean women and men working as carers in the UK. She investigated why social care has become an important focus of employment for Zimbabweans, and explored the means by which migrants of different legal status have negotiated work in this sector. The study concluded that there was significant stress and deskilling among Zimbabwean migrants in the UK as they made efforts to support themselves and their dependents through excessive hours of low-status and often poorly paid work. In another study, McGregor (2006) discussed the experiences and perspectives of Zimbabwean nurses and teachers who came to work in the UK in the context of the opening up of skilled labour markets in Britain to international migrants as a means of rectifying shortages of doctors, nurses, teachers and social workers. She concluded by highlighting the debates about professional mobility and some of the issues involved in reconfiguring gender relations and family life and their role in shaping diasporic identity, and links with Zimbabwe and other places. Other studies by McGregor have investigated Zimbabwean

migrants in the UK in the context of the mass exodus that gathered pace from the late 1990s and the historical explanation for the strength of nationalism expressed in the diaspora (McGregor and Pasura, 2010; McGregor, 2009).

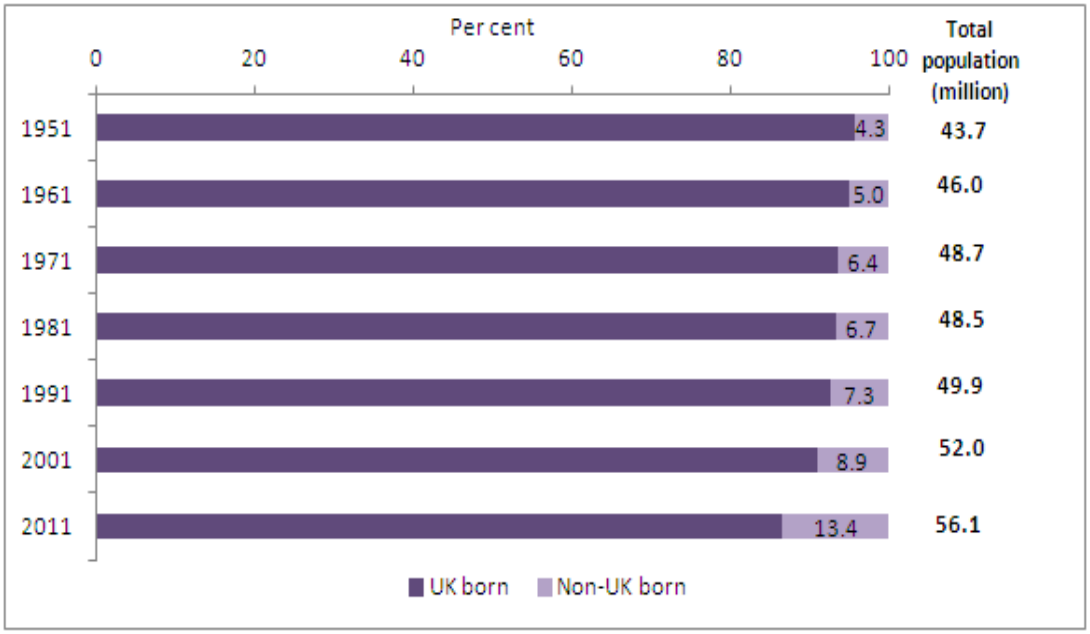
O'Donnell *et al.* (2007) investigated the barriers facing asylum seekers in the UK, Zimbabweans included, and the factors that helped them access health care. Despite respondents reporting positive experiences about their healthcare in the UK, the study identified issues regarding their understanding of how the UK healthcare system works, in particular the role of GPs and referral to hospital specialists. Lawrence *et al.* (2007) conducted focus groups across the UK, to explore factors that might affect the food choices of girls and young women of African and South Asian descent. The study indicated that the communities studied, including Zimbabweans, took time, price, health and availability into consideration when making food purchases. The study also indicated that the communities were also quite similar in their use of 'Western' foods which tended to be of the fast food variety which participants said were used when there was not enough time to prepare a 'traditional' meal.

In light of findings from the available literature on Zimbabwean migrants in the UK, it is clear that this population has attracted some interest among health and social care researchers, particularly so within the field of HIV and sexual health research. Other disciplines such as the politics and economics of migration and the dynamics of transnationalism in the context of Zimbabwean migrants in the UK has also attracted attentions from a wide range of academics (McGregor, 2010; McGregor and Pasura, 2010; Magunha, 2009). However, despite the fact that the Zimbabwean diaspora in the UK has raised interest among researchers from a wide range of disciplines, little is known about this population in the context of other contentious and high priority health and wellbeing issues pertinent to migrant populations in the UK and elsewhere. Drawing on this backdrop, this thesis aims to shed further light into the health behaviours of Zimbabwean migrants in the UK, and to build on what is already known about this population, by focusing on attitudes, perceptions and beliefs about alcohol use and the factors which influence drinking patterns among Zimbabwean migrants living in the UK.

1.6 Immigration Patterns of UK based non-UK born populations

Despite ongoing controversy regarding the flow of immigrants to the UK and efforts to restrict the entry of unauthorised workers, the high numbers of arrivals continue. The UK economy continues to depend on new immigrants to fill major low wage service and production jobs (ONS, 2016). The Office for National Statistics (ONS, 2011) estimates that 13% (7.5 million) of the resident population of England and Wales was born outside the UK. It is also estimated that while the total resident population of England and Wales increased by 28% (43.7 million to 56.1 million) between 1951 and 2011, the non UK born population almost quadrupled, meaning that migration contributed to just under 45% of the total population change over the last 60 years. Censuses also show large increases of particular migrant groups in particular decades (ONS, 2011). ONS (2011) figures show that Zimbabwean born residents in England and Wales rose by 136% in the decade 1991-2001 and a further 151% in the decades 2001-2011. Asylum applications from Zimbabwe nationals increased from 1700 between 1992 and 2000 to 30 300 during 2001-2011. Figure 2 below shows the proportion of the England and Wales resident population born abroad, starting from 1951 to 2011.

Figure 2: Proportion of resident population born abroad, England and Wales; 1951-2011



Source: Office for National Statistics (2013)

1.7 Researcher Positionality prior to Research

1.7.1 Introduction

Having chosen to use a mixed methods approach to my data collection, the reasoning behind undertaking ethnography as one of my MM strands was threefold. First, I aimed to use the outcome of the ethnography to inform the development of questionnaire items for a survey, which would be implemented in the second phase of my data collection. Second, my aim was to capture the socio-cultural dynamics of Zimbabwean migrants' relationship with alcohol in order to further deepen my understanding of attitudes, beliefs and perceptions of Zimbabweans towards alcohol, as proposed in my research objectives. I had concluded that the survey on its own would not have been able to capture some of the subjective attributes related to alcohol use in relation to the population of interest. Third, I had, in my mind, designed the ethnography to support, through triangulation, the empirical evidence that was expected to arise from the survey. In order to achieve this, I had estimated that the fieldwork would take me through a period of about 10 to 12 weeks of interviews and participant observations at Zimbabwean settings in at least three large UK cities, namely Sheffield, Nottingham and Leeds.

1.7.2 Rationale

I had planned to commence my fieldwork around March 2015. My plan was to deliberately approach the ethnography with an open mindset and allow patterns and 'themes' to emerge naturally from the participant observations and interviews. On one hand, I had set out to base my field accounts on my own personal understanding and construction of events based on my observations and a collection of participant narratives. On the other hand, I had felt a strong urge to use a framework focussing on alcohol-use not just from the point of view of its pathological links or as a social problem, but more so as a culturally valued resource which plays multiple roles in Zimbabwean lives. The urge to use a framework or terms of reference was based on my perception that it is unscientific to initiate data collection without an idea of what exactly I wanted to know. I had explored how to position myself in ethnographic research and particularly

acknowledged De Laine (1997) who argued that ethnographers do not work with either a priori theory or variables but that these are expected to emerge from the enquiry. On the other hand, Kirk and Miller (1986) emphasized the importance of having a general plan prior to commencing the data collection phase. I made the decision at that time to go into the field and let the research process unfold by remaining focused on my research objectives. Both arguments suited my position and therefore I made the decision to adopt a pragmatic approach by acknowledging the need to have a loose framework for the data collection which would not interfere with the opportunity for variables to emerge naturally from the research enquiry.

Prior to commencing the ethnography, I was aware of the impossibility of being entirely independent of the research process. I am a Zimbabwean migrant and have lived in the UK for more than seventeen years. I felt that my reasoning and motivations for choosing to live in the UK were most likely to be similar to my participants' own reasoning and motivations. This means that that there was already an inherent potential for bias in my thought processing before the start of the field work. My exposure to Zimbabwe by virtue of being born and raised there until the age of 29 means that that I was already well versed with the norms, values and beliefs about the study population and other attributes relevant to its culture. I was aware from the point of commencing my fieldwork of the fact that I shared the same background as my participants. This made me choose to use a reflexive approach based on its wide acceptance in the field of ethnography.

During my initial reading around ethnographic research, I was attracted to Coffey's (1999) definition of reflexivity as ''an ongoing conversation about experience whilst simultaneously living the moment.'' This made me expect to go through a series of adjustments to my approach as I went through a field that was largely unbeknown to me. To increase the rigour and plausibility of ethnographic research, it is suggested that researchers include a reflexive account in their report. It is for this very reason that I chose to employ reflexivity to minimise the inevitable biases linked to playing the dual role of both a peer and the researcher.

My goal when in the field was to observe, interact with participants and report my findings as an 'insider', meaning that I had to immerse myself (in the best way possible) in the lives of participants, and their daily routines. This also meant that

to be accepted by participants as an 'insider' required a climate of complete trust between me and them. This is a position supported by The American Anthropological Association (2004) which states that ''cultivating an ethical climate for ethnographic research requires trust among all involved in the process of implementing a research project''. Reflecting on the specifics of my study, the American Anthropological Association (2004) added that because the ethnographer often resides in the participants' community or geographical area and participates in community life, trust develops between the ethnographer and participants as a result of ongoing relationships. On the other hand, however, I was aware that to increase the integrity and trustworthiness of my findings meant I had to adopt a more objective stance. This called for a need to 'remove' myself from participants' lives and experiences, by playing a more passive role while in the field. The question remained as to how I would justify my findings as objective rather than just an expression of mere subjectivity. In this respect, I felt that a reflexive approach fitted this dilemma as it would enable me to continually monitor myself. I felt that a reflexive approach would also allow me to transform my personal experiences into publically accountable knowledge by revealing how the outcome of my study may have been 'co-created or co-produced' by myself and my participants. A reflexive approach also had the potential to address the challenges I faced in addressing my position as a 'researcher' and my participants as the 'researched'.

1.7.3 Reflexivity in the research process.

Without some degree of reflexivity any research is blind and without purpose (Finlay, 2002). Khoo-Lattimore (2015) advocates the use of reflexivity when researchers navigate their dual role as peer and researcher. The importance of *being* reflexive is acknowledged within social science research and there is widespread recognition that the interpretation of data is a reflexive exercise through which meanings are made rather than found (Mauthner *et al.,* 2003). Reflexivity in ethnography involves recognition of the researchers' integral part of the social world being studied (far, 1996). Although not always referred to explicitly as reflexivity, the project of examining how the researcher and intersubjective elements impinge on, and even transform research, has been an important part of the evolution of qualitative research.

Freshwater and Rolfe (2001) argue that a post-modernist approach to reflexivity implies that scientific research is not an accurate window on external reality but one truth claim among many. Davies (2008) argues for the use of reflexivity at both personal and broader cultural levels and for its integration into ethnographic research. Issues of positionality and reflexivity in ethnography have raised the significance of interrogating status of power and privilege of researchers' positions. More specifically, it has also raised critical awareness of how researchers' own identity and position impacts the way research questions are developed and conceptualized, data are collected and analyzed, and how analysis is interpreted and written (Lew, 2011). Coffey (1999) argues that one of the strengths of ethnographic research is the real involvement of the fieldworker in the setting being studied. She states that the possibility of total immersion is not a weakness, but a failure to acknowledge and critically engage with the range of possibilities of position, place and identity. However, Finlay (2002) acknowledges that the process of reflexivity is not always straight forward because the process of engaging in it 'is full of muddy ambiguity and multiple trails as researchers negotiate the swamp of interminable deconstructions, self-analysis and self-disclosure'. To counteract these opposing views, my strategy was to to go into the field and let the research process unfold by allowing my participants to openly express their views and by remaining focused on my research objectives.

1.7.4 My academic, professional and personal biography

I hold an Advanced Professional Diploma in Nursing Studies (Mental Health) from the University of Sheffield which included nursing registration in the UK. This enabled me to practice as a registered nurse in a wide range of mental health settings across the UK. These experiences provided me with the lens through which my research interests have developed. As someone with a background in risk assessments, clinical and managerial supervision, care planning and evaluation, I naturally found it helpful to reflect on my research practice through a process of experiential learning and reflexivity. Of particular interest to me has been the topic of alcohol and substance misuse which dates back sixteen years. During my placements in various mental health services in the Yorkshire and Humber region of the UK, I was perturbed to learn of the profound link between

alcohol use and mental illness. Almost every case I was involved in had a link to alcohol to varying degrees.

It was during my practice as a Registered Mental Health Nurse that I noted an overrepresentation and increasing numbers of Zimbabweans who were undergoing treatment for a wide array of mental disorders, some with underlying forensic histories. 'Forensic' means related to, or associated with, legal issues. Forensic mental health services provide assessment and treatment of people with a mental disorder and a history of criminal offending, or those who are at risk of offending. I wondered if there was something special going on within the Zimbabwean community which may be linked to their migrant experiences. I had also noted with interest a wide range of media reports about cases of UK based Zimbabweans' drinking and driving and suicides. As well as this, within my own social circle, I was aware of matrimonial problems and mental illness in the Zimbabwean community.

Alongside practicing as a Registered Mental Health Nurse, I went on to complete a Master of Public Health. I chose this post-graduate route because of my experiences in clinical practice and my inherent interest in health inequalities, gender, stress and ethnicity. After reading some of the research conducted by the School of Health and Related Research Alcohol Team at the University of Sheffield, I realised there was a gap in knowledge with regards to the understanding of ethnic and migrant communities in relation to alcohol use. I felt that the current policy on alcohol use in the UK was exclusive of, and alien to the needs of migrants who perceive alcohol use entirely differently. This, in my view, may have rendered health policies ineffective in certain subgroups of the UK population.

Prior to commencing the fieldwork, I conducted a literature review to understand what was known about the health and social issues relevant to the use of alcohol among migrant and ethnic minorities in different parts of the world. The other reason for reviewing the literature was to embed and ground my research within a body of knowledge. This inadvertently pre-exposed me to the subject area, which was later to have an inevitable impact on both my data collection methods and the interpretation of my findings. The literature review in itself also raised

significant epistemological and ethical challenges which researchers face when conducting ethnographic research.

1.8 Thesis Structure

This thesis is divided into seven chapters.

Chapter 1 introduces the purpose of this study. It also provides an overview of alcohol and health. This is followed by an account of the population of interest. A brief description of what a migrant is and the history of recent migration patterns into the UK is given to provide context. An account of the position of the researcher prior to commencing his fieldwork closes this chapter.

Chapter 2 presents the scoping literature review. It demonstrates the rationale for employing a scoping review and the strategy used in searching for the relevant literature, followed by the search results. A global overview of the patterns of alcohol use and the major predictors of, factors influencing alcohol; and its consequences and benefits is described. An overview is then given situating alcohol use in the context of the UK, Africa in general; and then Zimbabwe. A global overview of alcohol use in migrant communities is also discussed. The strategies to reduce the harmful effects of alcohol, at both a global and a local level are discussed. A section which comprehensively discusses the methodological challenges which researchers face in measuring alcohol intake is included. Concluding this chapter is a summary of the literature review findings and justification of this study based these findings.

Chapter 3 begins by defining the aims and objectives of this study. This is followed by an outline of the rationale for using Mixed Methods (MM), including the philosophical assumptions underpinning this study. The MM research process is separated into a qualitative and a quantitative strand. Included in each of these two strands is a narrative of the philosophical and theoretical perspectives underpinning the research process, the methods employed in the data collection, the rationale for choosing these methods, and the data analysis procedures employed. Ethical considerations, dilemmas and challenges faced by the researcher when conducting the focused ethnography are also discussed.

Chapter 4 presents the focused ethnographic findings, divided into five sections. It provides an overview of the ethnographic findings by drawing upon the interconnection between the three themes. It draws upon the constructivist, constructionist philosophical approach as its guiding framework. The first three sections describe findings related to the three main themes, namely ‘gender issues and hegemonic masculinity’, ‘cultural identity and its preservation', and 'stress, coping and social cohesion'.

Chapter 5 draws upon the results of the survey by taking a positivist philosophical approach as highlighted in the methodology chapter. The first section provides detail of the descriptive statistics. The second section provides an account of the inferential statistics conducted using STATA. This is presented in the form of a written account, accompanied by tables depicting explanatory variables in relation to AUDIT risk categories, followed regression model estimates of odds ratios, confidence intervals and *p* values. Findings from the survey provided additional insight into drinking estimates in relation to specific demographic, socio-economic and psychosocial factors.

Chapter 6 draws together the findings of both the qualitative and quantitative strands of the Mixed Methods design. This chapter took the logic of the pragmatist MM position in that neither quantitative nor qualitative approaches alone were sufficient to develop a complete analysis of the research questions. Henceforth, participants' narratives are integrated with results from the survey using descriptive statistics and ordinal logistics regression to further contextualize the ethnographic findings. A framework which identifies alcohol as playing multiple roles in the lives of Zimbabwean migrants is developed by showing gender, religiosity, drink and driving, marital status and health status as demonstrating significant associations with an increased risk of harmful drinking.

Chapter 7 closes this study. It begins by providing a summary of the contributions of this study to the body of knowledge. Recommendations for further research are then discussed in the context of research, policy and practice, including a description of methodological challenges, and future direction of using mixed methods in alcohol research. Following this is a discussion of the research limitations. The potential use of screening and brief interventions (SBI) to reduce

alcohol harm among Zimbabwean migrants is then critically discussed. Closing this chapter and the thesis is a reflexive account of the experiences of the researcher when conducting the focused ethnography, followed by the concluding remarks.

1.9 Conclusions

This chapter introduced the purpose of the study, and its aims and objectives. An account on alcohol and health provided insight into the magnitude of, and consequences of alcohol use to health. Insight into the pressures on health services across the world as a result of alcohol abuse is provided. The implications of alcohol abuse to morbidity and mortality rates is also provided, therefore acknowledging the importance of alcohol policy and alcohol intervention programs as current and future steps to reduce the harmful effects of alcohol use. The term 'migrant' is introduced and critically discussed to provide context to the population of interest. An account on the population of interest provided insight into both the gap in knowledge, and the magnitude of the latest phase of migration of Zimbabweans into the UK. A description of immigrant patterns to the UK acknowledged the increase of UK based non-UK born migrant populations and situated Zimbabwean migrants in the wider context of UK immigration patterns. Evidence is given which establishes Zimbabweans as a unique UK immigrant population in the context of the reasons for migration, the nature of migration, and the cultural diversity Zimbabweans bring to the diaspora. An account of the position of the author prior to commencing this study followed by an introduction to the overall organisation of the thesis closed this chapter. The next chapter presents a review of the literature.

Chapter 2: Literature Review

2.1 Introduction

This chapter presents a scoping review of the literature. The aims of the literature review are presented, followed by a demonstration of the strategy used in searching for the relevant literature, and the search results. Information on the patterns of alcohol use across the globe is provided, followed by a review on the major predictors of and factors influencing alcohol use, divided into four subsections, namely socio-economic status, acculturation, ethnicity and religiosity. This section is followed by a discussion of the consequences of alcohol use, divided into three subsections, namely the burden of disease, social problems and economic costs associated with alcohol use. A narrative of the benefits of alcohol use is provided. An overview is then given which situates alcohol use in relation to the UK, Africa in general and then finally Zimbabwe, being the point of origin of the population of interest. A global overview of alcohol use in migrant communities is then discussed to provide a wider context of alcohol use in relation to the population of interest. The strategies to reduce the harmful effects of alcohol, at both a global and a local level are discussed. This being a largely ethnographic thesis, a section on the history and perspectives of anthropology in alcohol research is discussed. A comprehensive review of the methodological challenges which researchers face in measuring alcohol intake is provided. Following this is a summary of the review findings, and justification of undertaking this research.

2.2 Aims of the literature review

The broad aim of this literature review was to identify peer reviewed studies which focus on alcohol use among migrant communities. The rationale for this was to identify a gap in knowledge and to situate the research question in the context of the available knowledge regarding attitudes, perceptions, beliefs; and patterns of alcohol use among migrants in different geographical settings. Furthermore, the literature review aimed to situate this study's research method in the context of

what is known to work, in a pragmatic sense, using sources of evidence from current and previous alcohol studies.

To achieve these aims, a scoping review was adopted. Colquhoun *et al.* (2014) described a scoping review as ‘‘a form of knowledge synthesis that addresses an exploratory research question aimed at mapping key concepts, types of evidence, and gaps in research related to a defined area by systematically searching, selecting, and synthesizing existing knowledge’’. Levac *et al.* (2010) stated that ‘‘scoping studies are concerned with contextualizing knowledge in terms of identifying the current state of understanding; identifying the sorts of things we know and do not know; and then setting this within policy and practice concepts’’

Some of the alternative terms being used in place for a scoping review are: scoping study, scoping project, scoping exercise, scoping report, scoping method, scoping exercise, systematic mapping, and rapid review (Colquhoun *et al*., 2014; Pham *et al*., 2014). Dijkers (2015) noted that the scoping review as it exists today may have first been named by Mays, Roberts and Popay (2001). They argued that scoping reviews ‘‘aim to map rapidly the key concepts underpinning a research area and the main sources and types of evidence available, and can be undertaken as stand-alone projects in their own right, especially where an area is complex or has not been reviewed comprehensively before’’. More recently, Daudt *et al.* (2013) proposed that scoping reviews aim to map the literature on a particular topic or research area and provide an opportunity to identify key concepts, gaps in research; and types and sources of evidence to inform practice, policy making and research.

2.3 Rationale for using a scoping review

Scoping review methods were chosen because they allowed a wide overview or map of the literature in a previously underexplored topic. Other approaches to the literature such as systematic review were deemed inappropriate because of the need for a more focused review question.

Scoping review is also useful here to provide a "preliminary assessments of potential size and scope of available research literature, and aim to identify nature and extent of research evidence (usually including ongoing research)" Grant and Booth (2009).

The scoping review is a suitable method for clarifying working definitions and conceptual boundaries in the field of alcohol research, unknown to the researcher, while simultaneously identifying gaps in existing literature/research in relation to the research question (Peters *et al.*, 2015; Arksey and O'Malley). The iterative nature of a scoping review (Peters *et al.,* 2015; Levac *et al.*, 2010) allowed for the updating of the review as the study unfolded. Scoping reviews can involve multiple structured searches rather than a single structured search typical of systematic reviews (Pharm *et al.*, 2015, Levac *et al.*, 2010; Grant and Booth, 2009). For this reason, though still systematic in nature, it was felt that a scoping review would have the ability to produce more meaningful results to meet the review questions when compared to systematic review methods, and therefore inform the researcher of the available research in the broadest sense.

2.4 Scoping review Methodology

The scoping review methods adopted here follow the process outlined by Arksey and O'Malley in 2005. This approach to scoping reviews has been widely adopted (Dijkers, 2015; Colquhoun, 2014). Levac *et al.* (2010) argued however, that while this framework provides an excellent foundation for scoping study methodology, the framework would benefit from ongoing development to support consistency in reporting. Arksey and O'Malley's (2005) framework consists of six stages as illustrated in the table below. Five of the stages outlined will be adopted for this review.

Table 1: Proposed scoping review methodological guide by Arksey and O'Malley

Stage	Process
1	Identify the research questions: what domain needs to be explored?
2	Find the relevant studies, through the usual means: electronic databases, reference lists (ancestor searching), websites of organizations, conference proceedings, etc.
3	Select the studies that are relevant to the question(s)
4	Chart the data, i.e. the information on and from the relevant studies
5	Collate, summarize and report the results
6 (Optional)	Consult stakeholders (clinicians, patients and families, policy makers, or whatever is the appropriate group) to get more references, provide insights on what the literature fails to highlight, etc.

2. 5 Search Strategy

Using Arksey and O'Malley's framework, scoping review guidelines were used given the broad aims of the literature review. A comprehensive search was conducted in four electronic databases via EBSCO Host, namely PsycINFO, MEDLINE, ASSIA and CINAHL. The rationale for using PsycINFO is based on its good coverage of psychological literature, and the psychological impact of physical illness. The database also covers articles from areas such as education, medicine, nursing and social work, which are all relevant to the research question. Covering publications from more than 49 countries, PsycINFO has the advantage of providing sources of information on a global scale, a strength considered relevant to the aims of the literature review., MEDLINE was chosen because of its good coverage of publications also related to medicine and nursing. Also, MEDLINE provides authoritative medical information on the healthcare system, a topic area considered relevant to the broad aims of the review. With records from 650 journals in 16 different countries, including the UK, Applied Social Science Index and Abstracts (ASSIA) was chosen because of its capacity to provide a wide range of publications from different parts of the world. ASSIA has good coverage of abstracts for health, social services, psychology, criminology, sociology, economics, politics, race relations and education, all of which are relevant to alcohol research. ASSIA is updated monthly, making it a good source of the most up to date information. CINAHL was chosen to complement both PsycINFO and MEDLINE in providing authoritative literature in the nursing and allied health fields.

Search terms, derived from the topic's key words were used in the data search. Arksey and O'Malley call these domains. They are as follows: -

a. Alcohol use, Alcohol abuse, Alcohol misuse, Alcohol consumption
b. Migrant*, Immigrant*, Migration, Ethnic*/ Ethnic minorit*, Black/ Black Africa*
c. United Kingdom, Great Britain, England
d. Acculturation, Zimbabwe*, Socio-economic status, Africa(n)

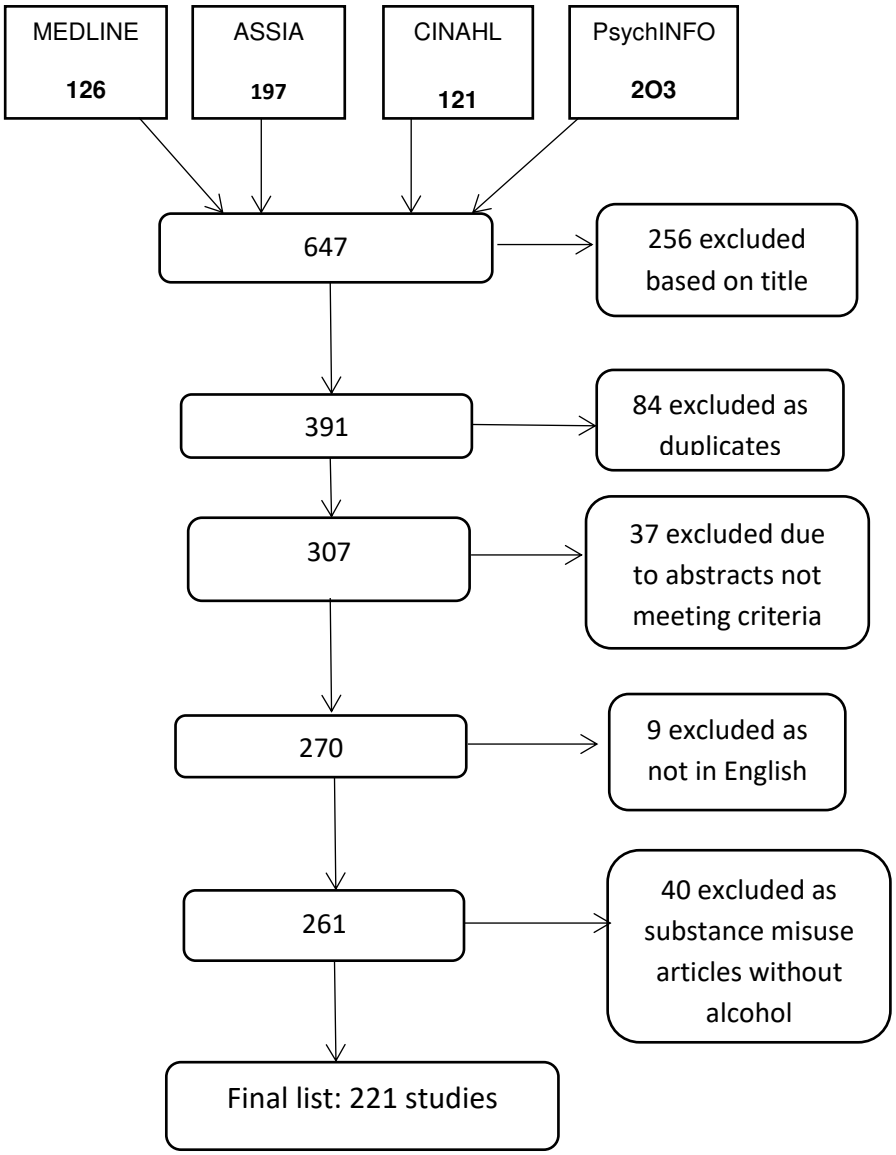
2.5.1 Screening studies for eligibility

A decision was made not to apply strict quality criteria to have a wider selection of studies. All duplicates were removed before screening was commenced. Only studies published in English were included because the study was conducted in the UK whose official language is English. Also, studies published in English removed the inherent bias that can arise from errors in interpretation of a different language into English. Studies were only included if they had present any of the search terms listed in category 'a', in combination with one or more of the search terms in category 'b', and 'c' or 'd'. Studies that had the terms 'substance misuse/abuse' were also selected for review.

A three-stage screening process was used in the selection of the literature. First, the titles were screened for inclusion and exclusion criteria. All studies whose titles met the inclusion criteria were imported into Ref-Works database for further scrutiny. Second, the abstracts were screened to confirm the studies met the inclusion and exclusion criteria. Thirdly, a full text review of the remaining studies was conducted to establish studies which met the criteria for inclusion in the review.

A total of 647 articles published from 1990 onwards were identified. These studies were imported into RefWorks for further scrutiny. A total of 256 articles were excluded based on their title, to leave 391 for further scrutiny. A further 84 articles were excluded as duplicates. The remaining 307 articles were further reviewed. A total of 37 articles were subsequently excluded even though they met the title criteria, the reason being that they did not meet the outlined inclusion and exclusion criteria. Of the 269 articles that remained, nine were excluded because they were not published in the English language. Although not originally intended for scoping reviews, the PRISMA diagram in figure 3 below illustrates the inclusion and exclusion process.

Figure 3: PRISMA diagram illustrating study exclusion process



2.5.2 Quality appraisal

Quality assessment and appraisal criteria typical of systematic reviews were not used as part of the study selection process in order to have a wide selection of studies. Because the included studies employed a wide range of different methodologies, not one appraisal tool was found to be sufficiently robust to effectively appraise all the included studies. Various appraisal tools which fit both qualitative and quantitative research designs, such as checklists and other

structured approaches are available (Pluye, 2013), but are not an essential step in scoping review methodology.

2.5.3 Data extraction and abstraction

Following Arksey and O' Malley's (2005) framework illustrated in Table 1, all the relevant studies retrieved from the four electronic databases were collated onto an excel spreadsheet and summarised by name of author, date of publication, the study's geographical location, the study methodology and the methods employed; and the study domains and broad themes of the study. An excerpt of this chart is illustrated in Appendix 1. All the relevant studies were critically analysed and relevant issues pertinent to the research question discussed. Some of the publications were discussed and critiqued with peers, and the researcher's supervisory team to provide more insight into the methodological approaches applied, and the themes emerging from the studies.

2.5.4 Summary of Search Results

No studies concerning alcohol use among African migrants in the UK were retrieved. Except for two articles, which both concerned alcohol use among Irish migrant communities in UK all other retrieved studies took place elsewhere. Three studies conducted in the UK were concerned with ethnicity and alcohol use, however ethnic populations do not always necessarily equate to migrants. Most studies on alcohol use and migrants took place in the USA. These studies mostly employ quantitative methods using samples from immigrants of Mexican and Latino ancestry. Other sporadic studies took place Germany, Sweden, Italy, Spain and Russia. No studies were identified concerning alcohol use among African migrants in France, despite 10.4% of France's migrant population originating from Sub-Saharan Africa (Worldatlas, 2017). Very few studies were conducted in Australia, China and the Pacific Islands. Four retrieved articles concerned alcohol use by Zimbabweans from their point of source. These four studies were concerned with the relationship between alcohol use and risky sexual behaviours, with emphasis on HIV. 31 retrieved studies were conducted in South Africa, with most of the studies concerned with the relationship between

alcohol use and risky sexual behaviours, including HIV transmission. The literature research also retrieved a wide range of research concerning the relationship between alcohol use and drink and driving, road traffic accidents, domestic violence, and foetal alcohol syndrome. Some studies conducted in Kenya, Uganda, Namibia and Botswana were also retrieved. Like the South African studies, these were concerned with alcohol use and HIV.

2.6 Summary of the evidence

The following subsections (2.7 to 2.17) provide a summary and discussion of findings from the literature review.

2.7 Patterns and levels of alcohol use- A global overview

The consumption of alcohol, and particularly the impact of its misuse, remains a key consideration in terms of public policy making at both international and national levels. An article entitled 'Alcohol Consumption Factsheet' by the Institute of Alcohol Studies (2013) stated that the diverse nature of harms and patterns of consumption means public policy can impact on a range of stakeholders beyond industry including local authorities, health professionals, the emergency services, community groups and the public. WHO (2014) acknowledged that the true picture of alcohol consumption is often shrouded in myths and assumptions. Clausen *et al.* (2009) and Rehm *et al.* (2003) indicated that alcohol related burden is linked to at least two different dimensions of consumption: average volume and patterns of drinking. Parry *et al*. (2011), Selten and Cantor-Graae (2007), and Tonigan *et al.* (1998) all provided evidence indicating that patterns and levels of alcohol use are not evenly distributed across the world and that alcohol policy and intervention studies call for different strategies to reduce the harmful effects of alcohol.

A report by WHO (2014) and Rehm *et al.* (2003) showed that in general, average volume of drinking is highest in established market economies in Western Europe and the former Socialist economies in the Eastern part of Europe and in North

America; and lowest in the Eastern Mediterranean region and parts of South East Asia including India. A study by Anderson and Baumberg (2006) noted that most of the alcohol in a society is drunk by a relatively small minority of drinkers. However, Clausen *et al.* (2009), argued that in most of Europe, less than 20% of the adult population are abstainers. This contrasts with reports from several African studies where estimate abstention rates are as high as 80% for women and 50% for men (Martinez *et al*., 2011).

A publication by the Arnett and Robineau (2016) reported the UK as having one of the highest levels of alcohol consumption among Organisation for Economic Cooperation and Development (OECD) countries and as one of the few countries where alcohol consumption increased in the past 25 years. Findings from the WHO alcohol research team (2014) indicated that alcohol consumption is the leading risk factor for disease burden in low mortality developing countries and the third largest risk factor in developed countries. Another publication by WHO (2011) reported that in South Africa, a low mortality developing country, more than 5 billion litres of alcohol is consumed annually, equating to 9-10 litres of pure alcohol per person. Studies show that this is among the highest per capita consumption rates in the world.

Rehm *et al.* (2009) found that disease burden is closely related to average volume of alcohol consumption, and that for every unit of exposure, is strongest in poor people and in those who are marginalized. Rehm *et al.* (2003) argued that although exposure to alcohol varies considerably between regions, the overall exposure by volume is quite high and patterns are relatively detrimental, suggesting that this uneven exposure, pattern and levels of alcohol use calls for different strategies to reduce its harmful effects. Findings from Clausen *et al.* (2009) also showed that in many lower income countries, alcohol consumption and heavy drinking occasions also appear to have increased significantly in recent years, due partly to the increased availability of commercial alcohol and the introduction of high alcohol content beverages.

2.8 Predictors of and factors influencing alcohol use

Findings from studies by Bloomfield *et al.* (2008) and Anderson and Baumberg, (2006) support the notion that the nature of alcohol consumption is influenced by a wide range of demographic and socioeconomic attributes and that this differs across genders, age, groups and context. Several other studies have also identified a variety of factors at the individual and the societal levels which affect the volume and patterns of alcohol consumption. Huerta and Borgonovi (2010) argued that some factors can increase the level of alcohol consumption which in turn increases the risk of alcohol use disorders and other alcohol-related problems in those who consume alcohol and others. Warner *et al.* (2010), and Sloan *et al.* (2009) have all identified that the factors, at both the individual and above the individual level, most widely thought to influence alcohol consumption are socio-economic status, acculturation, ethnicity, and religiosity. The following sub-sections provide further evidence emerging from the literature review to explain the link between these factors and alcohol consumption.

2.8.1 Socio-economic status

The American Psychological Association define socio-economic status (SES) as the social standing or class of an individual or group, often measured by determining education, income, occupation, or a combination of these dimensions. Studies by Doku *et al.* (2012) and Hatch *et al*. (2011) provided evidence to show that SES is widely used in alcohol research and is clearly considered as an important variable in alcohol research and a benchmark for investigating health inequalities. Wiles *et al.* (2012) argued that the role of SES in explaining alcohol consumption behaviours is contradictory. Early studies by Marmot (2006) and Adler *et al.* (1994) showed that in many cases the associations between SES and health outcomes take the form of a gradient – the higher the SES the better the health. Many different explanations for socioeconomic gradients in health have been proposed, but alcohol research studies do not well establish the causal pathways through which SES determines health in such an orderly way.

Demakakos *et al.* (2008) and others have suggested that subjective social status (SSS) is an important predictor of health. Euteneuer (2014) and Singh-Manoux *et al.* (2005) have both even suggested that SSS predicts health outcomes above and beyond traditional objective measures of social status, such as education, income and occupation. On the other hand, Finch *et al*. (2013) and Hamilton *et al*. (2013) examined SSS as a health correlate by exploring its role as a potential mediator of the associations between objective indicators of SES. However, research aiming to establish whether subjective social status predicts health and changes in health better than the traditional objective measures were inconclusive (Giatti *et al*., 2012; Brown *et al*., 2008). A systematic review by Euteneuer (2014) concluded that SSS is a comprehensive measure of one's social position that is related to several poor health outcomes and risk factors for disease. Singh-Manoux *et al.* (2005) explored both objective and subjective measures of SES by entering them simultaneously in a model to predict change in health status. They found that it was the subjective measures that continued to be significantly associated with health and changes in health, therefore concluding that subjective SES is a better predictor of health status and a more precise measure of social position than the objective measures of social status.

Hanson and Chen (2007) argued that some studies have established an inverse relationship between SES and alcohol use, not all have found this relationship, and some have found a relationship with SES only for some groups, or ages, or one gender. Suliman *et al.* (2010) in their study on predictors of transitions across stages of alcohol use in South Africa indicated that lower SES, no school education in women, and being older than 25 years of age were associated with alcohol problems. Lower SES as a predictor for alcohol related problems is also supported by Grittner *et al.* (2012) who stated that people with lower socio-economic positions were at an increased risk of hazardous drinking. However, evidence from alcohol surveys and mortality studies, particularly from the developed world, suggest that there are more drinkers, more drinking occasions and more drinkers with low-risk drinking in higher socio-economic groups while abstainers are common in the poorest social groups (WHO, 2014). Cutler and Lleras (2006), showed that better educated individuals appear to be somewhat more likely to engage in some forms of risky behaviours such as consuming alcohol but better at managing such behaviours by stopping or keeping

consumption low before problems escalate. Anderson (2006) concluded that people with higher incomes are more likely to use alcohol than people with low incomes. The review also established an apparent contradiction in socio-economic status, employment status and alcohol use. Suliman *et al*. (2012) argued that this may be because, in low to middle income countries such as South Africa, the poorest segments of society may be unable to purchase alcohol, hence the rate of consumption would then increase in those who are earning at least some money.

2.8.2 Acculturation

Acculturation, which is defined as adaptation to the norms, values, and culture of the host society is thought to play an important role in shaping drinking habits among immigrant communities (Bryant and Kim, 2012; Raffaelli *et al.,* 2007; Hines *et al.,* 1998). Zuniga *et al.* (2013) demonstrated that in theory, the migration experience, which begins in the country of origin, continues through the period of transit, and concludes in the destination country, placing these individuals at increased risk of harmful alcohol use. Wong *et al*. (2011) described the same picture as Zuniga *et al*. (2013) by arguing that even after facing the difficulties of migration, immigrants may be exposed to additional challenges inherent in the acculturation process that subjects migrants and refugees to a unique set of challenges.

One could assume that acculturation leads immigrants to adapting themselves to the level of alcohol consumption of their host country. On the other hand, one may also assume a low level of acculturation to be associated with levels of alcohol consumption prevalent in their origin country. Findings from alcohol research on migrant communities support the latter theory by revealing that the patterns of alcohol use resemble the patterns of their country of origin. For example, Weiss (2008) established that immigrants from the Soviet Union who settled in Israel continued to drink at rates significantly higher than their host population. Wuyts *et al.* (2016) argued that these findings mean that migrants from high alcohol consumption countries such as Poland or Russia tend to consume more alcohol than the general population in their host country whereas

migrants who come from low alcohol consumption counties such as Israel and Greece tend to consume less alcohol than people in their host country. Agic *et al.* (2011) established that migration alone may not be the primary factor shaping patterns of alcohol use, but that the stress of the acculturation process within challenging and hostile environments may influence alcohol use and abuse patterns. Several studies on acculturation have revealed that among first generation migrants, attitudes towards, and patterns of alcohol use in the country of origin are strong determinants of alcohol use in the host country (Wuyts *et al.*, 2016; Weiss, 2008).

The general view is that immigrants, particularly recent arrivals, exhibit lower rates of alcohol consumption compared to the host population (McDonald, 2006; Brown *et al*., 2005) and that increased time in the new country results in changes to norms and beliefs regarding alcohol use (McDonald, 2006; Johnson *et al*., 2002). De la Rosa *et al.* (2013), and Landrine and Klonoff (2004), argued that when alcohol consumption patterns among migrants are followed-up over time, the drinking patterns start to converge with those of the dominant culture. Becares *et al.* (2011) on the UK, supported this notion when they concluded that second generation ethnic minorities who originate from low level alcohol consumption tend to consume more alcohol in comparison to their corresponding first generation migrants. However, Schiff (2005) suggested it is not always clear to what extent these changes occur as most migrant communities live in their own cultural enclaves, have their own shops, recreation, extra-mural activities, cultural activities and printed media.

Several studies in the US including one by Arfken (2011) indicated that, in some cases, immigrants exhibit higher rates of alcohol consumption compared with those left in their origin country or the host population. Bacio *et al.* (2013) explored the different hypotheses which have been advanced to explain the mechanisms underlying this immigrant paradox. These included the erosion of cultural factors which protect immigrants from harmful drinking. Mulia and Zemore (2012) and Mulia *et al.* (2009) suggested that proxies of acculturation including country of birth, duration of residency in the host country, and language proficiency are associated with alcohol use among ethnic minorities in the US. One way that the relation between acculturation and alcohol use has been conceptualized is the

'acculturation model', which states that alcohol consumption patterns reflect the extent to which the norms/practices of the host society surrounding alcohol consumption have been adopted (Sam and Berry, 2010; Berry, 2005). Agic *et al*. (2011) argued that acculturation and dissemination of old drinking customs into new contexts may cause drinking patterns that used to be weekly or reserved for special occasions to become more frequent and problematic.

Research on alcohol use among migrants acknowledges the role of factors other than culture in influencing patterns of alcohol use. A study by Haasen (2008) on Afghan Migrants in Germany concluded that the stress that accompanies migration places migrants in a vulnerable position to alcohol related problems. Leshem and Sicron (1998) found that most immigrants suffered a real drop in their occupational status due to the immigration, which in turn is likely to increase the level of stress, resulting in an increase in the risk of experiencing alcohol related problems. The combined effect of low integration in the host society, low acculturation, and high stress may lead to harmful alcohol consumption. Schiff *et al.* (2005) argued that extensive migration between countries with different alcohol consumption patterns may provide an opportunity to examine cultural differences within the country, as well as possible changes in habits within cultures, because of adaptation to the habits of the majority culture. Several studies have concluded that a minority status such as being a migrant is a protective factor for heavy drinking (Mulia and Zemore, 2012; Raffaelli *et al.,* 2007; Johnson *et al.,* 2002) whereas others have concluded that being a migrant puts one at a higher risk of alcohol problems (Kaptsan *et al.,* 2006; Greenslade, 1995). Either way, Schiff *et al*. (2005) noted that culture plays a prominent role in influencing the risk or resiliency factors for alcohol use or abuse.

2.8.3 Ethnicity

Gardener and Connolly (2005) define an ethnic group as ''a collectivity within a larger population having real or putative common ancestry, memories of a shared past, and a cultural focus upon one or more symbolic elements which define the group's identity, such as kinship, religion, language, shared territory, nationality or physical appearance''.

Recent developments in epidemiology show the importance of ethnicity and/or race in furthering our understanding of the aetiology of alcohol use disorders (Castro, 2013). Ethnicity research is also useful for informing decisions on the design and implementation of culturally sensitive prevention programmes and helping to identify appropriate interventions.

McKinney *et al.* (2009) concluded that patterns of alcohol use vary across ethnicities, with notable differences existing for estimates of current drinking, level of drinking, binge drinking, alcohol abuse and/or dependence, beverage preference, driving under the influence of alcohol, alcohol treatment, and alcohol related adverse outcomes. Lee and Chen, (2017) and Ramisetty *et al.* (2010) agree that some ethnic groups experience disproportionate burden of alcohol-related ailments. Also, Becares *et al.* (2011), and Caetano *et al.* (2000) showed that variation in alcohol use exists between ethnic groups. Arfken (2011) argued that alcohol abuse and misuse exists among every racial and ethnic group examined to date. Caetano (2010) and Chartier (2010) provided evidence of recent advances in alcohol research which continue to build our understanding of alcohol consumption and related consequences in ethnic minority groups. Agic *et al.* (2010) revealed that the type and sizes of alcoholic beverages consumed in each community, drinking levels that are considered 'normal' or 'excessive', as well as the perception of alcohol related problems are largely shaped by cultural beliefs, attitudes and norms towards alcohol which often differ from the host population. Their findings confirmed that ethnic background has a powerful influence on alcohol consumption practices and related behaviours, as well as on belief systems on alcohol.

Luczak *et al*. (2017) examined whether the pathway from an early age of drinking initiation (ADI) to alcohol use disorders (AUDs) symptoms in early adulthood is moderated by ethnicity and genetics. Their study concluded that ethnicity and the aldehyde dehydrogenase gene (ALDH2*2) altered the relationship of ADI as a risk factor for AUD symptoms. Being Chinese and possessing an ALDH2*2 allele within Koreans both buffered against the risk for AUD symptoms associated with earlier ADI. In an earlier study by Luczak *et al.* (2001), ethnic group differences were found, with Whites having the highest rate of binge drinking, followed by Koreans and then Chinese.

A study by Delker *et al.* (2016) noted that in the USA the National Epidemiologic Survey on Alcohol and Related Conditions, and the National Survey on Drug use and Health, there is significant variability in alcohol consumption and its consequences among ethnic groups. Both surveys identified that white respondents reported the highest prevalence of current alcohol consumption, whereas alcohol abuse and dependence were most prevalent among Native Americans. Yeh *et al*. (2016) also reported that Native Americans and blacks were more vulnerable to alcohol related consequences. Evans *et al.* (2017) concluded that persistence of substance use disorder, including alcohol, varies by ethnicity, suggesting that an understanding of this relationship could be used to inform screening and treatment programs.

Cacciola *et al*. (2014), among other variables, examined the role of ethnicity in an ethnically diverse sample of undergraduate students. They concluded that ethnicity (being non-Hispanic) was associated with the likelihood of binge drinking among students who reported consuming alcohol. Also, white students were more likely to report using alcohol than both Black and Asian students. Other studies on college student samples in the USA have also shown significant associations between alcohol use and ethnicity. Montoya *et al.* (2014) indicated that among college students, lower levels of Anglo orientation were associated with increased alcohol consumption. Meyers *et al.* (2017) argued that differences in alcohol consumption by ethnicity may be explained by variation in drinking related norms among different ethnic groups in the context of specific religious institutions.

Fish *et al.* (2017) concluded that Native Americans who identified less with mainstream culture demonstrated a positive association between their cultural alcohol beliefs and their weekly drinking, suggesting that ethnicity-driven alcohol beliefs could be an appropriate target for alcohol interventions. Studies on USA ethnicity groups also show that Blacks and Hispanics experience higher rates than Whites of recurrent or persistent dependence, and profound consequences of alcohol consumption (Vaeth *et al.,* 2017; Chartier and Caetano, 2010). A more complete understanding of the association between alcohol consumption and ethnic minority groups is needed to enable researchers to face the challenges of

reducing and ultimately eliminating health disparities in the field of alcohol research.

Jester *et al.* (2015) on their research with African Americans show that the endorsement of positive alcohol expectancies differs from that of Whites during childhood and that it predicts different alcohol outcomes in later life. In a study by Lee and Chen (2017), logistics regression models found that adverse childhood experiences (ACEs) were significantly associated with excessive alcohol use, with ethnicity moderating the relationship. They concluded that it was not clear why the relationship between ACEs and heavy drinking differed by ethnicity; however, they suggested the development of alcohol prevention strategies to address the needs of all ethnic groups. Preliminary analysis in a study by Banks and Zapolski (2017) reveal that race moderated the relationship between alcohol expectancies and alcohol consumption. They concluded that more positive expectancies predicted alcohol use among white youths, but not African American youths, suggesting that alcohol expectancies, which were thought to be important mediators of the relationship between social and personality factors and adolescent alcohol use may not be as impactful for African Americans.

The real extent of alcohol use in the UK is unknown, however, Best *et al.* (2001) and others have found clear ethnic differences in the use of alcohol in the UK. Hurcombe *et al.* (2010) reported a lower alcohol consumption rate by African Caribbeans compared to their white counterparts. Becares *et al.* (2009) noted that alcohol use is increasing among ethnic minorities and argued for a greater understanding of alcohol related behaviour among UK ethnic minority people to establish the need for preventive care and advice on safe drinking practices. Becares *et al*. (2009) also noted that alcohol drinking rates of ethnic minorities (excluding Irish) in the UK are lower than those of the white majority, and that variations in alcohol intake exist between ethnic groups. Orford *et al.* (2004) have found increased alcohol consumption among second-generation ethnic minorities. An early study by Martin, Blum and Roman (1992) had already suggested that the UK exposes ethnic minority people to unique stressors that elevate the risk for drinking as a means of reducing or coping with stress. Overall, the evidence suggests that minority ethnic groups are under-represented proportionately in seeking treatment and advice for drinking problems, although

their rates of drinking may be like those of the host population (Hurcombe *et al*., 2010). Changes in the UK ethnic composition may therefore continue to present challenges to services if culturally sensitive interventions that meet service users' needs are not addressed.

2.8.4 Religiosity

Religiosity is often defined as an individual's conviction, devotion, and veneration towards a divinity. Gallagher and Tierney (2013) stated that in its most comprehensive use, religiosity can encapsulate all dimensions of religion, yet the concept can also be used in a narrow sense to denote an extreme view and over dedication to religious rituals and traditions. Meyers *et al.* (2017) argued that among other factors, religiosity is known to predict alcohol use, and to be a protective factor against many health problems, including AUDs. Research, including by Freeman (2017) exploring the relationship between religiosity and substance use, including alcohol use behaviours; typically find a significant inverse association between those two variables. Nakash *et al.* (2016) suggested that religion provided a sense of meaning that serves as a protective factor against alcohol use. Chamsi-Pasha *et al.* (2016) concluded that religiosity may reduce risk behaviours and contribute to health decision making related to alcohol use. Ransome and Gilman (2016) also found an inverse association between religiosity and alcohol use and concluded that future research is needed to conduct more fine-grained analyses of the aspects of religious involvement that are potentially protective against AUD.

One hypothesis for the relationship between religion and alcohol problems is that religious involvement leads to greater social integration and social support and that this leads to less alcohol use and fewer alcohol problems (Bowie *et al*. 2005). Religious involvement is also thought to provide a source of collective support on which members can draw during crisis or other difficult times (Schieman *et al*., 2013: pg 457). Religion's role in shaping moral attitudes regarding alcohol has led researchers to a long standing interest in the relationship between religion and alcohol use. Although less research is devoted to the interface of religion and alcohol use, Miller (1998) argued that religious involvement is consistently associated with decreased risk of alcohol use.

Johnson *et al.* (2000) argued that extending beyond the traditional functions of worship and spiritual development, religious institutions have long been a social resource and provider of instrumental support as well as promoter of social control in minority communities. In many denominations such as Seventh Day Adventists, Jehovah's Witness and Pentecostal churches, alcohol use is seen as incompatible with religion or spirituality. As a result, its use is either forbidden or strongly advised against. Meyers *et al.* (2017) concluded that US adults reporting greater public religiosity were at a lower risk for AUD. Their findings indicated that public religiosity may be particularly important among non-Hispanic Blacks, while intrinsic religiosity may be particularly important among non-Hispanic Whites. Drabble *et al.* (2016) used three population-based surveys waves (2000, 2005, and 2010) and concluded that high religiosity was found to be protective against hazardous drinking among women. Overall, the review showed that among other health problems, religiosity is protective against AUDs, and predictive of alcohol use.

2.8.5 Factors at the individual and above the individual level

At the individual level, several studies have provided evidence supporting a relationship between marital status and alcohol consumption behaviours, with divorced people likely to consume alcohol at higher levels than those who are married, with the association varying somewhat by country (Kretsch and Harden, 2013; Liew, 2012; American Psychological Association, 2012; Prescott, 2001). Liang and Chikritzhs (2012) concluded that being never married, divorced or separated was a strong indicator of hazardous alcohol consumption behaviours. Another study conducted by the Australian National Health and Medical Research Council (NHMRC, 2009) also concluded that respondents who were never married, divorced or separated regularly consumed alcohol at risky levels for long term harm. The implications of these findings and those from other studies with similar conclusions clearly serve as evidence of the importance of understanding factors at the individual level to predict alcohol consumption.

Nelson *et al.* (2013) argued that setting aside the individual level, environmental factors such as economic development, culture, availability of alcohol and the level and effectiveness of alcohol policies are also relevant factors in explaining

differences in vulnerability between societies, historical trends in alcohol consumption, and alcohol related harm. Young *et al.* (2012) explored the association between proximity and density of local outlets; and alcohol use by concentrating on two of the characteristics outlined by Campbell (2009), namely outlet type and number of outlets; and neighbourhood characteristics both of which are thought to influence health outcomes. (An outlet is a licensed premise where alcohol can be sold either to take away or for consumption within the premise). They concluded that both of these factors were important predictors of adolescent alcohol consumption and those fine grained individual-level measures of exposure may be necessary to detect such effects.

2.9 Consequences of Alcohol Use

2.9.1 Burden of Disease due to Alcohol use

Alcohol consumption, particularly heavier drinking, is an important risk factor for many health problems and, thus, is a major contributor to the global burden of disease (Beaglehole *et al*., 2011; Rehm *et al*., 2009). Alcohol consumption has been identified as a component cause for more than 200 health conditions covered by ICD-10 disease and injury codes. In a comparative risk assessment conducted by WHO, the detrimental effect of alcohol consumption on the global burden of disease and injury was surpassed only by unsafe sex and childhood underweight status but exceeded that of many classic risk factors, such as unsafe water and sanitation, hypertension, high cholesterol, or tobacco use (WHO, 2009).

WHO (2014) reported that excessive alcohol use is a global public health problem accounting for above 6% of mortality and 5% of DALYs lost worldwide. WHO (2010) reported that every year, the harmful use of alcohol kills 2.5 million people, including 320 000 young people between 15 and 29 years of age. In 2012, WHO (2014) estimated that 3.3 million deaths, or 5.9% of all global deaths, were attributable to alcohol consumption.

WHO (2015) reported that overall 5.1% of the global burden of disease and injury is attributable to alcohol, as measured in DALYS. Lim *et al.* (2013) noted in their

study that globally, alcohol misuse is the fifth leading risk factor for premature deaths and disability among people between the ages of 15 and 49. Rehm and Shield (2014) argued that without alcohol consumption there would be no deaths or disability from these diseases. Peltzer (2011) and Schneider (2007) indicated that the cost of alcohol consumption outweighs the benefits. Cooke and Moore (2002) argued that in the United States and other advanced economies, the production and sale of alcohol accounted for a small share of gross national product. Despite this, the deleterious effects of alcohol consumption on health outcomes are high and constitute a substantial economic burden on populations, reducing the overall standard of living.

Alcohol is the third leading risk factor for poor health globally, and harmful use of alcohol was responsible for almost 4% of all deaths in the world, according to estimates by WHO (2011). Many studies have ranked alcohol consumption as a risk factor for death and loss of healthy life years, as well as being a source of personal and social harm (Nutt *et al*., 2010; Van Amsterdam *et al*., 2010; WHO, 2009). Allamani *et al*. (2011) also considered alcohol consumption as one of the most important health determinants throughout Europe, exerting a substantial impact on public health. Babor *et al*. (2010) argued that policies and interventions exist that can reduce alcohol use, but that there is still a need to understand more about why alcohol use and abuse change in populations and how alcohol-related harm can be reduced. A study by Borges *et al.,* (2006) concluded that acute alcohol use, defined as alcohol use within a period of 6 hours, was a risk factor for non-fatal injuries.

Epidemiological studies including one by Allen *et al.* (2009) have investigated the relationship between alcohol consumption and the risk of cancer and have found statistically significant increased risk of cancers of the oral cavity and pharynx, oesophagus, larynx, rectum, liver, breast, and all cancers combined. Scoccianti *et al.* (2013) reported that the International Agency for Research on Cancer had concluded that there is sufficient evidence that alcohol causes cancer of the oral cavity, pharynx, oesophagus, larynx, colorectum, liver, and female breast. WHO (2011) stated that the harmful use of alcohol ranks among the top five risk factors for disease, disability and death throughout the world. The most current global alcohol status report by WHO (2014) stated that in low mortality developing countries, alcohol consumption is the leading risk factor for disease burden and

the third largest risk factor in developed countries. It is argued that despite the large burden of disease attributable to alcohol consumption, it has remained a relatively low priority in public health policy in many countries. The Department of Health's Models of Care for Alcohol misusers (2006) stated that in the EU alone in 2004, alcohol was responsible for 1 in 7 male deaths and in 1 in 13 female deaths in the group aged 15-64 years, resulting in approximately 120 000 premature deaths. Despite this gloom picture, a majority of the world's adult population had abstained from drinking alcohol in the past 12 months.

Clausen *et al*. (2010) provided evidence linking alcohol consumption to a range of severe health and social problems. Several studies, including one by Caetano (2010) agreed to the argument that when considering the consequences of alcohol use, the two aspects that are important to understand the risk of harm are the average volume consumed and the drinking pattern. There is also a general consensus that heavier drinking, in particular, is an important risk factor for many health problems and, thus, is a major contributor to the global burden of disease.

Rehm *et al*. (2009) identified alcohol use disorders, which include alcohol dependence and alcohol abuse, as the largest disease category contributing to the alcohol-attributable global burden of disease for the year 2004, making up one third of this burden. Though it cannot be claimed that all the mortality associated with AUDs is causally attributable to AUD, (defined as an Alcohol Use Disorder Identification Test (AUDIT) score of 8 and above), Rehm *et al*. (2014) argued that there is good evidence that alcohol consumption and AUD can cause mental disorders such as depression. Vega *et al*. (2003) noted a growing interest in the co-occurrence of AUD and psychiatric disorders in recent years. This co-occurrence is termed dual diagnosis, a condition that is marked by a great functional impairment and self-destructive behaviour.

A positive association between alcohol use and behaviours that increase the risk of acquiring HIV have been established (Setshedi and Monte, 2011; Shuper *et al.*, 2010). Hahn *et al*. (2011) made many important associations between alcohol use and HIV, including sexual risk-taking behaviours, decreased self-care behaviours such as poor medication adherence, and impaired immunity, which can increase susceptibility to HIV infection and accelerate HIV disease

progression once infected. Setshedi and Monte (2011) argue that although causality has been difficult to prove there is sufficient evidence to warrant action. Most notably, new evidence points to a causal link between alcohol use and infectious diseases such as tuberculosis and pneumonia (Parry *et al*., 2009; Rehm *et al*., 2009). Hahn *et al.* (2011) suggested that alcohol use likely has a large impact on the HIV epidemic via behavioural pathways such as sexual risk-taking behaviours and decreased self-care behaviours such as poor medication adherence. Hahn *et al*. (2011) also argued that alcohol may impact biological pathways such impaired immunity, which can increase susceptibility to HIV infection and accelerate HIV disease progression once infected.

In contrast to evidence suggesting benefits of moderate alcohol consumption, particularly in relation to reducing the prevalence of ischaemic heart disease, new UK guidelines on safe drinking reported by the Department of Health (DoH) (2016), warn that drinking any level of alcohol increases the risks of a range of cancers. Arguments for the protective effects of moderate alcohol consumption pervade the research literature. Wright *et al.* (2006) concluded that drinking less than 1 drink a week ($p=0.09$), between 1 drink weekly up to 2 drinks daily ($p=0.001$) and more than 2 drinks daily ($p=0.003$) were associated with less cognitive decline compared to never drinkers, after adjusting for socio-demographic and vascular risk factors. Roerecke and Rehm (2010) found that consumption of amounts as little as 60 grams of pure alcohol on one occasion at least once a month eliminated any protective effect of alcohol consumption on mortality. Bailey and Sokol, (2011), and Bertrand *et al*. (2005) concluded that in women, misuse of alcohol use during pregnancy can cause brain damage to the foetus, with long term developmental and social consequences. Overall, the literature suggests that on the whole the physical effects of alcohol consumption are negative including liver damage which can lead to alcoholic cirrhosis; pre-disposing drinkers to infections.

2.9.2 Social and economic costs due to alcohol use

Scarborough *et al.* (2011) argued that moderate drinking is not harmful and may have health and social benefits, but that alcohol abuse is a public health concern with considerable social and economic costs. Laslett *et al.* (2015) stated that alcohol consumption is often mistakenly constructed as a problem that affects individual drinkers rather than people around them. Several studies, including one by Rehm *et al.* (2006) have also long established the health and social consequences of alcohol consumption for heavy drinkers. However, the Institute of Alcohol Studies (IAS, 2015) noted that alcohol consumption can have a range of negative impacts on people other than the drinker, for example through physical violence, road traffic accidents, relationship problems, financial difficulties, feeling scared in public places, or reporting negative impacts on children due to another person's drinking. It has also been established that alcohol use can result in harm to other individuals such as family members, friends, work colleagues and even strangers (WHO, 2014). A report by the Institute of Alcohol Studies (IAS, 2015) stated that in the UK, the cost of alcohol's harm to others was estimated in 2004 at up to £15.4 billion including £1.4-1.7 billion to the health service, up to £7.3 billion in crime and public disorder costs and up to £6.4 billion in workplace related costs.

The costs associated with alcohol are enormous compared to other commodities. For example, Rehm, (2009) noted that the costs associated with alcohol amount to more than 1% of the gross national product in high and middle income countries, with the costs of social harm constituting a major proportion in addition to health costs. Considering that beyond health consequences, the harmful use of alcohol inflicts significant social and economic losses on individuals and society at large, the harmful use of alcohol continues to be a factor that has to be addressed to ensure sustained social and economic development throughout the world (WHO, 2014). The social, health and economic burden from alcohol calls for effective preventive interventions to address the harm it does to individuals and society at both the local and national levels. Due to global, national and regional concerns regarding the harmful use of alcohol, policies and strategies that aim to reduce the harmful use of alcohol are being implemented through the efforts of the WHO, governments and other national bodies. In light of a growing

population worldwide and the predicted increase in alcohol consumption in the world, the alcohol attributable disease burden as well as the social and economic burden may increase further unless effective policies and measures based on the best available evidence are implemented worldwide (WHO, 2014)

2.10 Benefits of Alcohol Consumption

Alcohol has played a central role in almost all human cultures since Neolithic times (Peele and Brodsky, 2000). Studies indicate that humans have been consuming alcohol on a regular basis for 10 000 to 15 000 years (Potter, 1997). Alcohol occupies a unique place in many human societies; it is a widely used drug, tolerated physiologically and socially, with a place in religious ceremony, in ritual, in spontaneous celebration, and in everyday social transactions (Potter, 1997). All societies, without exception, make use of intoxicating substances, alcohol being by far the most common (Social Institute Research Centre, 1998).

Although heavy drinking may lead to poor health status, several studies suggest moderate drinking has beneficial health and societal outcomes. Suggested benefits are reduced use of expensive acute healthcare, reduced risk of cardiovascular disease, including coronary heart disease (CHD) and associated myocardial infarction (Murray *et al*., 2002; Rehm *et al*., 2001; MacDonald & Shields, 2001; Booyse and Parks, 2000; Rimm *et al*., 1991). Constanzo *et al.* (2010) concluded that in patients with cardiovascular disease, light to moderate alcohol consumption (5 to 25 g/day) was significantly associated with a lower incidence of cardiovascular and all-cause mortality. The benefits of moderate alcohol consumption for better health and longer life expectancy compared with abstinence are advocated in numerous studies, including one by Nova *et al.* (2012), particularly along the lines of subjective health. Before the surge in the scientific curiosity on how moderate drinking affects health and disease, emphasis was on alcohol dependence, treatment and prevention strategies. Undeniably, a number of studies have found a J-shaped relationship between alcohol consumption and total mortality (Gaziano *et al*., 2000; Camargo *et al*., 1997; Doll *et al*., 1994). This relationship suggests moderate drinkers have the

lowest mortality rates, heavy drinkers the highest, and abstainers and light drinkers a rate that falls somewhere in between (French and Zavala, 2007).

Peele and Brodsky (2000) perspective on alcohol emphasizes harms disproportionately relative to benefits with the major exception being research establishing beneficial effects of moderate drinking on cardiovascular health and overall mortality. Stranges *et al.* (2006) concluded that in male current drinkers, moderate alcohol consumption (2–2.9 drinks per day), wine and mixed beverage consumption were associated with better physical health. Some studies have also found that moderate social drinking brought more perceived benefits compared to intoxication. For example, Stranges *et al.* (2006) also concluded that overall, intoxication and liquor drinking are associated with poorer self-perceived health status than regular, moderate consumption of other alcoholic beverages, such as lagers and wine. An earlier study by Poikotainen *et al.* (1996) also concluded that moderate drinking is related to perceived good health.

A study by Epstein *et al.* (2010) concluded that perceived drinking norms affected the perceived benefits of alcohol consumption. However, findings from a wide range of studies reveal the positives of alcohol consumption, particularly with regards to subjective health. Other benefits of alcohol consumption include its use in managing stress, its ability to raise and enhance mood, and its use as a medium for social integration and sociability. A 1989 survey carried out to assess the public perception of the risk and benefits of alcohol use in a metropolitan and rural New South Wales sample indicate that the major perceived benefit is relaxation and medication (Hall, 1996).

2.11 Alcohol consumption in the UK

A report by the NHS (2011) suggests that the UK has one of the highest levels of alcohol consumption among OECD countries. The same report stated that the UK is one of the few countries where alcohol consumption increased in the past 25 years. The Department of Health (2015) estimated that the harmful use of alcohol costs the NHS in England around £3.5 billion a year. It also estimated that 8% of all hospital admissions in the UK involved an alcohol related condition. Alcohol Concern (2016) estimated that 10% of the UK burden of disease and

death is due to alcohol, making it one of the three biggest lifestyle risk factors after smoking and obesity. Alcohol Concern (2016) also estimated that a total of 7.5 million people in the UK are unaware of the damage their drinking could be causing, and that alcohol misuse is costing around £21 billion a year in health, crime and health productivity costs. Singleton (2002) noted that in the UK, dependence on alcohol has been estimated at 7%, while levels of hazardous or harmful drinking are higher with prevalence rates of 38% and 15% for males and females, respectively. Excessive consumption of alcohol is a major preventable cause of premature mortality with alcohol-related deaths accounting for 5.3% of all deaths in England and Wales in 2005 (ONS, 2017). The same report also noted that 11% of adults in Great Britain were frequent drinkers (drank alcohol on at least five days in the week before being interviewed) in 2012 and that men were consistently more likely than women to be frequent drinkers.

The UK has seen an increase in alcohol related deaths; escalating from 6.9 per 100 000 populations in 1991 to 13.0 in 2004 (ONS, 2016). In 2012 there were 8367 alcohol related deaths in the UK with males accounting for 65% of them with death rates highest among men aged 60-64 years (ONS, 2014). The ONS (2014) also reported that of the four UK constituents, only in Scotland were male and female deaths significantly lower than in 2002. The severity of the burden of alcohol prevalent in most parts of the UK has attracted significant research and media interest in the past decade (Becares *et al*., 2011; Bhala *et al*., 2010; Bernards *et al*., 2009). This includes the notion of minimum pricing, an initiative which is supported by the National Institute of Health and Clinical Excellence (NICE) and England's Chief Medical Officer (NICE, 2016).

The prevalence of alcohol consumption in the UK presents worrying statistics in the middle to older age categories (ONS, 2011a). In 2009, the ONS (2011a) noted that a higher proportion of 25-44 year-old than 16-24 year-old men reported drinking over the Royal College of Physicians (1987) recommended weekly limits of 21 units of alcohol (26% and 21% respectively. Wilson *et al.* (2013) argued that even among those in later life, trends towards increased consumption of alcohol even at levels well short of dependence raises public health concern. Surveys conducted in the UK, including the General Household Survey (2007), the Opinions and Lifestyle Survey (2013), and the General Lifestyle Survey (2011)

have all shown a steady decrease in both the quantity and frequency of alcohol consumption since the turn of the century. However, men have continued to drink significantly more than women.

2.12 Alcohol consumption in Africa

Alcohol consumption has a long social history in Africa (Schneider *et al.,* 2000). Traditional drinking patterns in Africa are largely ceremonial/ event-based with the most common drink being home-made, fermented beverages (Clausen, 2009). Schneider *et al*. (2000) stated that Africans have been making and imbibing alcoholic beverages from a wide array of fruits, grains and other natural substances for as far back as the historical record goes, and continue to do so. They noted that alcoholic beverages in Africa range from palm-wine in coastal West and East Africa, to banana beer in the Great Lakes region, to mead (*tejj*) in Ethiopia and maize/sorghum beer across Southern Africa. They also argued that Indigenous people consumed fermented intoxicating drinks as an important component of social and ritual gatherings. Fermented drinks have typically been a source of vital nutrients, but at the same time they have inscribed social hierarchies, based on a combination of political precedence, gender and generation. During the pre-colonial period, alcohol was not typically a commodity for sale in the Sub-Sharan Region. While alcoholic drinks have often been made by women, it is senior men who typically defined who could drink, how much and in what contexts. Nurani (2008) noted that these traditions and behaviours have been supplemented more recently by consumption of mass produced alcoholic beverages and a broader range of contexts and modes of drinking.

WHO (2014) reported that within Africa, an estimated 43% of those aged 15 years or above have ever used alcohol and 39% used it in the last year. A study by Azar *et al.* (2010) reported that the prevalence of AUD is estimated at 4% globally and 3% in Africa. Several studies have concluded that in Africa particularly, AUD are associated with acute and long term medical complications and may interfere with the treatment of chronic conditions such as HIV/AIDS due to poor treatment adherence. (Scott- Sheldon *et al.*, 2013; Chersich and Rees, 2010; Rehm and Parry, 2009).

Changes in alcohol production, marketing and western oriented attitudes towards alcohol are some of the transitions affecting many African countries, with an increasing tendency to turn to commercial alcohol beverages such as lager, spirits and wine, particularly among the younger generations. Clausen *et al.* (2009) suggested that patterns of alcohol consumption, along with attitudes and perceptions regarding alcohol, vary across African countries. Clausen (2009) also argued that there is a significant difference between African drinking patterns and attitudes compared to European countries. According to WHO (2014) the overall per capita adult (age ≥ 15 years) level of alcohol consumption in the Africa region is 6.15L of pure alcohol per year, which equates to about half of the alcohol consumed in Europe. Overall, a higher proportion of women compared to men abstain from consuming alcohol. WHO (2004) reported that abstention rates in Africa are as high as 80% for women and 50% for men or estimated at 70.8% of adults 15 years and older. These figures suggest that heavy alcohol consumption takes place in the minority of populations who drink. A BBC News report (2013) noted that for example, in Kenya, while it is the case that 85% of the population had not had a drink in the past year, compared with just 14% in the UK, Kenyans had consumed almost twice as much per person as in the UK. The high abstention rates in Africa are largely because many African countries, particularly in the North, have large Muslim populations who are life time abstainers.

Suggs (2001) brought fascinating interpretations of the role of beer drinking among men in a small town in Botswana. He concluded that alcohol consumption within this community serves as an indicator of masculinity, prosperity, hierarchical ranking and power. He concluded that beer drinking within this community is viewed as one important aspect of men's ability to control and distribute life's blessings including the productive and reproductive capabilities of women. He also noted that places for drinking included elders in bars and young men outside, a practice that symbolized a tradition of respect for elders, however with opportunities for higher education and with emerging capitalism among the young men, the power and respect granted to elders had begun to wane. Despite these changes, the role of alcohol for both the young and the elders of this community still serve an important aspect of their day to day living. Among the Etsio of Western Kenya, Myers and Stolberg (2003) noted that beer drinking in this community is pervasive, beer parties are a central social event and that there

is a highly developed vocabulary pertaining to beer use. They also noted that beer parties are used to organize work groups that will work hard and accomplish much in a short period of time.

Parry and Hoffman (2017) noted that Sub- Saharan Africa provides particularly fertile ground for growing market share due to the high proportion of the population in many countries who do not yet consume alcohol, especially among females, the high youth population in many countries, and the growth in GDP in certain countries. They argued that the global alcohol industry's new focus in low and middle-income countries mirrors the moves made by big tobacco companies in penetrating these markets, and that low advertising costs, weak regulation, and high-intensity consumption of beer in these markets made an ideal environment for global brands. The increasing amount of marketing campaigns disguised as philanthropic initiatives being undertaken by global alcohol corporations to endear themselves with the people and (more importantly) with the politicians, and increase alcohol consumption in Africa are common ground. One such initiative is the Beers for Africa 8-pack campaign by South African Breweries (SAB) in collaboration with Stop Hunger Now Southern Africa, a charity organization which packs and distributes meals to feed hungry children and people living in poverty. Through their Beers for Africa 8-pack, consisting of beers from Botswana, Lesotho, Mozambique and South Africa, Tanzania and Zimbabwe – the brewer claims it is helping address hunger in Africa by selling the beer 8-pack to raise funds to feed hungry university students.

Colonial regimes, especially in British West Africa, came to depend heavily on the revenues derived from imports of Dutch gin and other distilled products made in Europe. In South Africa, profits from municipal beer-halls, selling a version of manufactured beer that mimicked what rural Africans drank, underwrote the costs of implementing segregation and later apartheid. However, Black South Africans were debarred from purchasing bottled beer, wine or spirits until 1962. In this way, alcohol became a marker of racial hierarchy, as it did in the settler colonies. With the growth of distilleries and breweries across Africa during the mid-twentieth century, the influx of private capital (often in the shape of European brewing interests like Heineken), state revenue imperatives and changing consumer preferences became more fully intertwined. Bottled beer became the

marker of urban sociability, pushed on by increasingly sophisticated advertising imagery. After independence, governments invested in breweries - creating an exception to the rule that state enterprises generally ran at a loss. However, those who wished to mark their elite status would tend to opt for imported whisky brands.

The current debate about alcohol in Africa has reached new horizons. (CNN, 2013). Kabwama *et al.* (2016) claimed that some African countries like Uganda have excessively high levels of alcohol consumption. In general, African alcohol consumption per capita is low by international standards (WHO, 2014; WHO, 2004), although it might represent a considerable proportion of household income. With the prolific expansion of African cities, and the growth of a more affluent middle class, consumption patterns are also changing. This is reflected in the increased consumption of wine in the oil-producing states such as Angola, which now provides the largest market for Alentejo wines outside the European Union (Augustine, 2017). Even in South Africa, black people who have historically preferred bottled beer, have begun to alter their drinking patterns. This is generally in the direction of wine and spirits. However, the emerging pattern is partially offset by other factors. On the one hand, the push of South African Breweries (SAB) across the continent, accompanied by the global restructuring of the brewing industry, is leading to ever-more assertive attempts to defend the market for beer. On the other hand, the growth of the Pentecostal movement has seen a revival of the fortunes of temperance across Africa. More than ever, therefore, alcohol finds itself at the intersection of debates about money, morality, and consumption.

2.13 Alcohol Consumption in Zimbabwe

Historically, traditional structures and cultural taboos strictly controlled the production of alcohol in Zimbabwe. Acuda (1995) argued that its use was permitted only to certain people deemed to have attained appropriate levels of maturity. However, as more and more Zimbabweans left their villages for the large towns and cities for work, and in search of work, those controls gradually

loosened. Acuda (1995) noted that at the time these controls loosened, there was a tremendous increase in the availability of alcohol, supported by both aggressive marketing and advertising. In modern day Zimbabwe, easy availability, rapid urbanization, rapid westernization and sociocultural changes, unemployment and economic hardships have led to an escalation of alcohol related problems. Zimbabweans originate from a region with a wide range of alcohol consumption patterns, meaning that some may have experienced conflicting expectations about alcohol use after arrival in the UK.

An article by Chakanyuka in the Sunday News of May 2014 reported that Zimbabwe and South Africa are ranked first in Africa and third in the world as having the "riskiest" drinkers, with men and women in the country ranking among the top 10 heaviest drinkers in the continent. The same article stated that a report in the Washington Post of 25 April 2014 ranked Zimbabwean men and women 6th and 7th respectively as Africa's top drinkers. According to the report, which stated it quoted latest data obtained from the United Nations, Zimbabwe and its southern neighbour have the highest alcohol-attributable disease burdens in the world after Russia and Ukraine. On a scale of one to five, Zimbabwe scored four points, the same points as South Africa, while Russia and Ukraine scored five points to rank first. The same report further suggested that in 2005 Zimbabwean men each consumed 9-7 gallons of alcohol and that 20 percent of women in Zimbabwe binged at least once a week, to rank 7th in the continent beating Senegal, Congo and Chad. According to Delta Beverages' 2012 financial results Zimbabwe consumed 198.1 million hectolitres of lager and 335.4 million hectolitres of opaque (millet) beer (Delta Corporation Limited, 2012).

An article by Zimonte (May 2017) in Democracy, Policy, Prevention, Sustainable Development noted that more than 60% of Zimbabwe's population are under 35 years of age and that most of them are living either in high-density areas or rural areas of the country. He noted that their nearest recreational facilities which everyone living there can reach with the least effort is the bar, and that they are ubiquitous. The Southern African Alcohol Policy Alliance cited an article entitled 'Drug Use, Abuse and Alcoholism in Zimbabwe' published in October 2002 (no named author), which argued that alcoholism is one of Zimbabwe's four top diseases. The report argued that at least three million people in Zimbabwe are

alcoholics and projected that in the year 2022, alcoholism will be the country's number one social problem. Another study entitled 'Culture and choice: lessons from survivors of gender violence', by Armstrong (1998) explored survivors of gender violence in Zimbabwe and found that consumption of alcohol was often involved in cases of domestic violence. To further substantiate this, the Southern African Alcohol Policy Alliance Zimbabwe (2014) stated that more than 1000 people die in alcohol abuse-related accidents every year and that a further 3000 sustain minor to serious injuries. Fritz *et al.* (2002) in a cross-sectional sample of 324 men recruited at beer halls in Harare studied the associations between alcohol use, sexual risk behaviour and HIV infection. The study found that 31% of the men reported having sex while intoxicated in the previous six months. There was also a significant association between having sex while intoxicated and recent HIV seroconversion.

A Zimbabwean on-line newspaper, The Zimbabwe Mail, published in September 2017, reported the government of Zimbabwe as having revived its bid to regulate consumption of alcohol with a Cabinet committee recently approving a draft policy outlawing sale of alcoholic products during certain days, hours and to pregnant women. The push to enforce a host of restrictions on the sale and consumption of alcohol follows Government's concern over increasing cases of abuse of alcohol countrywide.

2.14 Alcohol use in migrant communities

Most research focussing on substance abuse, mental health, and ethnic minorities has taken place in Northern Europe, the US and Canada, societies with a long history of immigration and multiculturalism. (Marsiglia *et al*., 2008). Schiff *et al.* (2005) argued that this has contributed to our understanding of alcohol use and migration but has limited applicability to the UK due to the unique cultural and socio-demographic attributes of its migrant population. Extensive migration between countries with different alcohol consumption patterns may provide an opportunity to examine cultural differences within the country, as well as possible changes in habits within cultures, because of adaptation to the habits of the majority culture. De La Rosa *et al.* (2013) argued that a minority status such as being a migrant is a protective factor for heavy drinking whereas other studies

such as by Tortajada *et al.* (2010) concluded that being a migrant puts one at a higher risk of alcohol problems. Either way, Schiff *et al.* (2005) argued that culture is thought to play a prominent role in influencing the risk or resiliency factors for alcohol use or abuse.

Marsiglia *et al*., (2004) argued that migrants undergo profound changes, losing vital family connections and support structures from the country of origin and facing new languages, customs and loss of social status. Haasen *et al.* (2008) further argued that migrants to industrialised countries are confronted with many difficulties in everyday life that can lead to increased mental stress. These, include language barriers, vocational training deficits and unemployment, social isolation, discrimination, and racism. He gave an example of Afghan migrants in Europe who have to deal with a number of psychological stressors, in that they left their country due to an unstable political environment, that they are faced with a xenophobic climate in most European countries, and that they are confronted daily with news of destruction in their country, limiting any hope of being able to return to their country of origin in the future.

Understanding the patterns of alcohol use among migrant communities is of paramount importance when devising alcohol policies that are cost effective and evidence based. Migrants tend to be healthier or less healthy than the population in their new country. Although the public perception tends to think that they are sicker, the healthy migrant effect is a well-known phenomenon in public health (Constant, *et al.,* 2015; Domnich, *et al.,* 2012). Epidemiological studies among migrant ethnic groups provide insight into the relative importance of cultural and socio-economic factors in the aetiology of substance misuse disorders (Finch *et al*., 2013; Gilman *et al*., 2008; Worby and Organista, 2007). Migrants, like other hard to reach communities, tend to live in closed isolated groups which makes them more prone to ‘slipping through the net’ and not being easily identified for intervention programs despite the problem of alcohol in these communities being at the severe end of the alcohol abuse/misuse spectrum.

2.15 Strategies to reduce the harmful use of Alcohol

The World Health Organization defines screening and brief intervention as practices that aim to identify a real or potential alcohol problem and motivate an individual to do something about it (WHO, 2005). Among other alcohol intervention programs, alcohol screening, followed by brief interventions is considered to be one of the most effective ways of reducing the harmful effects of alcohol (Desy *et al*., 2010; Saitz, 2010; Babor and Higgins-Biddle, 2000). The aim of alcohol screening, brief intervention and referral to treatment is to reduce alcohol use and related injuries, illnesses, and deaths through early identification of, and intervention for, harmful drinking (Desy *et al*., 2010). General practice is a suitable place for screening programs because of the frequency of encounters between doctor and patient (Beich *et al*., 2002). Selway (2006) argued that on an almost daily basis, primary care clinicians have an opportunity to interact with patients who drink too much, but the extent of alcohol use often is not clear until the clinician questions the patient.

A consensus is emerging that screening for excessive alcohol use followed by a brief intervention to modify drinking behaviour should be implemented in general practice and that the research should focus on the implementation of such programs (Babor and Higgins, 2000). Beich *et al*. (2003) argued that General Practitioners and other healthcare professionals are strongly encouraged to identify and intervene with patients whose alcohol consumption is either hazardous or harmful to their health. Desy *et al*. (2010), and Saitz, (2010) have indicated that screening using standardised questioning and brief interventions consisting of a few minutes of feedback, information, and advice are promoted for that purpose. In support of the use of brief interventions, Williams *et al*. (2011) and Selway (2006) also indicated that patients who drink excessively may reduce their alcohol consumption once a practitioner speaks to them.

Preventing and reducing harmful use of alcohol is often given a low priority among policy decision-makers despite compelling evidence of its serious public health effect (Seggie, 2012; Parry *et al*., 2011; Parry, 2010). Alegrı´a *et al.* (2006) acknowledged efforts being made to reduce alcohol misuse. These include both general and targeted approaches which aim to address alcohol misuse in minority

groups through tailored prevention and treatment services. Beyond health consequences, the harmful use of alcohol inflicts significant social and economic losses on individuals and society at large. The harmful use of alcohol also continues to be a factor that has to be addressed to ensure sustained social and economic development throughout the world (WHO, 2014). A report by WHO (2014) concluded that in light of a growing population worldwide and the predicted increase in alcohol consumption in the world, the alcohol attributable disease burden as well as the social and economic burden may increase further. Unless effective policies and measures based on the best available evidence are implemented worldwide, the social and economic burden of alcohol misuse may continue to increase even further (Seggie, 2012; Parry *et al*., 2011).

2.16: Measuring alcohol intake- Methodological challenges

2.16.1 Introduction

Measuring alcohol intake presents alcohol researchers with a difficult conundrum (Greenfield *et al*., 2010; Agrawal *et al*., 2007; Greenfield *et al*., 2000). Despite the large amount of literature on alcohol consumption and drinking behaviours, it appears that the field of alcohol research is yet to reach a consensus on measurement methodology for alcohol use. A lack of consistency in the current methods and tools in use for measuring self-report alcohol intake therefore remains a major challenge in the field of alcohol research. As early as the 1990s, alcohol researchers had already started to acknowledge 'alcohol intake' as a central dependent variable in alcohol research. Del Boca and Darkes (2003) argued that self-report tools offered a valid and reliable approach to measuring alcohol consumption when compared to biochemical assays and sales figures. However, a lack of standard methods or tools for measuring alcohol intake continues to present difficulties for researcher when results of one study need to be compared with another to inform decisions on interventions.

2.16.2 Defining alcohol use and measures of alcohol intake

Besides the difficulties relating to the measurement of alcohol intake, defining what constitutes alcohol use has also raised many debates. The field of alcohol research uses numerous definitions of what comprises an individual who consumes alcohol. Blazer and Wu (2009), defined alcohol use as consuming at least one drink of any type of alcoholic beverage. They excluded the use of only a sip or two from a drink as alcohol consumption and described "a drink" to respondents explicitly as a can or bottle of beer; a wine cooler or a glass of wine, champagne, or sherry; a shot of liquor; or a mixed drink with liquor in it. Fesahazion (2012), defined a current drinker as one who drinks 'now', in contrast to studies which use the AUDIT to measure alcohol intake, which define a current drinker as one who has consumed alcohol in the last 12 months. In contrast to this, Weiser *et al.* (2006) defined alcohol use in four categories, namely no drinking, moderate drinking (1-7 drinks per week for women and 1-14 for men), problem drinking (8-14 drinks per week for women and 15-21 for men); and heavy drinking (≥14 drinks per week for women and ≥21 for men). The term 'sensible drinking' is also commonly used in alcohol research, but like other measures of alcohol intake, is prone to subjectivities. The Department of Health (DoH, 2016) defined sensible drinking 'as drinking in a way that is unlikely to cause oneself or others significant risk or harm'.

To create indicators for different levels of alcohol consumption, Schoenborn and Adams, (2010) scaled the definitions used by Centers for Disease Control and Prevention to the 30-day recall period utilized by the Behavioural Risk Factor Surveillance System (BRFSS). They defined light drinking as 12 or fewer drinks per month, moderate drinking as >12–30 drinks per month for women and >12–60 drinks per month for men, and heavy drinking as >30 drinks per month for women and > 60 drinks per month for men. Using the BRFSS in their study, Schoenborn and Adams, (2010) also asked respondents about the frequency of binge drinking which they defined as the number of episodes in the past 30 days when the individual had five or more drinks on a single occasion (for men) or four or more drinks on an occasion (for women). Unlike Weiser *et al.* (2006), Schoenborn and Adams (2010) introduced the term 'light drinking' as a measure in between 'no drinking' and 'moderate drinking'. Schulenberg *et al*. (1996)

introduced the term frequent binging which they defined as consuming four or more binging episodes during the past 30 days. They created the binge drinking category using the official definition of the National Survey on Drug Use and Health to identify subgroups of individuals who used alcohol and whose drinking pattern may have put them at a greater risk for harm relative to individuals in the other groups.

2.16.3 Standardizing measurement

The main objective of alcohol research is to reduce the harmful effects of alcohol use by addressing its causes and recommending health promotion initiatives that are evidence based (WHO, 2014). A lack of a global standardized tool for measuring alcohol intake presents researchers with the challenge of validity, reliability and comparability presented by each of the tools in current use (Williams and Drummond, 1994). Using different measures of alcohol intake defeats this objective because in that it creates the likelihood of producing conflicting evidence. Not all authors cite the tool they use when measuring alcohol intake, a common weakness in alcohol research studies. Weiss (2008), for example, used two measures, namely 'drank at least once in the previous month' and among drinkers 'drank 3+ times in the previous month', but it is unclear from which alcohol measure these variables were derived from. Some researchers identified in the review used alcohol tools which are incorporated into bigger household surveys, such as by Arfken (2011), who used the National Survey on Drug Use and Health (NSDUH) and Michigan BRFSS to measure alcohol use. Both of these surveys are designed not only to measure alcohol use but other lifestyle indicators related to health. Asbridge *et al.* (2010) also used the AUDIT but only employed three subscales of the AUDIT in making an attempt to measure different dimensions of alcohol use, namely consumption, dependence, and adverse consequences. These subscales are based on the original domains sampled in the development of the AUDIT of which Asbridge *et al.* (2010) argued that these subscales have been confirmed as independent scales in previous studies.

2.16.4 Outcome measures

Rehm (2004) argued that what is common among most self-report measures of alcohol intake is their design to capture quantity, frequency, volume and the variability of drinking. Outcome measures used in alcohol research vary from one study to the other even though the general objective may be similar. The obvious pitfall of this is the potential duplication of studies which may have presented the same outcome if the same measure had been used.

Arfken (2011) used the NSDUH and the Michigan BRFSS to measure alcohol intake. In her study, Arfken (2011) used the NSDUH to measure past year alcohol use, past month alcohol use, binging drinking in past month, heavy drinking in past month; and alcohol abuse and dependence. She also used the BFRSS in the same study to measure past month drinking by looking at past month drinking, and past month binge drinking. Bond *et al.* (2010) further demonstrated disparities which exist in how alcohol intake is measured by examining the frequency of drinking over the past 12 months. They used frequency, rather than usual quantity or volume, because only frequency and not quantity was collected in the surveys. The variables used by Bond *et al*. (2010) are based on the GENACIS Expanded Core questions which assessed frequency of drinking in various contexts by asking: "Thinking back over the *last 12 months,* about how often did you drink in the following circumstances? "*Think of all the times that apply in each situation".* The eight response categories ranged from "every day or nearly every day" through "once or twice a year" to "never in the last 12 months". The obvious weakness of this measure is that it fails to capture the very important dimension of quantity. Categories were converted to the metric of days per year using category midpoints. The values for each of the two constituent contexts were summed to indicate the frequency of drinking in each (public and private) setting. Because it is possible to drink in two settings on a given day, the summed frequencies could exceed 365 days, therefore demonstrating the complexities present in some of the measures available in alcohol research. Becares *et al*. (2011) examined alcohol use as both current drinking and engaging in sensible drinking using the Health Survey England. They measured current drinking by asking respondents whether they drank 'any alcohol nowadays'. Daily sensible drinking limits were assessed by the number of drinks

drunk in the heaviest day of the last week. Some researchers, for example Arciniega *et al.* (1996) used a wide array of alcohol measures incorporated in one study. They used AUDIT to study ethnic differences in alcohol consumption patterns among people presenting for alcohol treatment, alongside the Form-90 interview to obtain detailed drinking information. The Form-90 is a structured interview querying alcoholic consumption (quantity, frequency and patterns) during a prior 90-day window. In a study by Blazer and Wu (2009), survey respondents were asked about their use of alcohol during the past year. Individuals who reported using alcohol also reported "the usual number of drinks" they consumed on a drinking day during the past 30 days and the number of days they consumed five or more drinks on the same occasion. They explicitly defined "same occasion" to respondents as being at the same time or within a couple of hours apart. They used the Geriatric Society's clinical guidelines for low-risk (no more than one drink per day) and at-risk (two or more drinks per day on average) alcohol use and classified respondents into the following four mutually exclusive groups: no use of alcohol in the past year; low-risk use (no more than one drink on a usual drinking day within the past 30 days): at-risk use (two or more drinks on a usual drinking day within the past 30 days); and binge drinking (five or more drinks on the same occasion on at least 1 day within the past 30 days. The definition of alcohol use used in this study differs marginally from most research tools reviewed. Bor *et al.* (2013) assessed alcohol use using five questions obtained from the BBRFSS. Respondents were asked if they had consumed at least one drink of any alcoholic beverage during the past 30 days. Those who had consumed any alcohol were then asked to report the number of days in the month on which they drank (between 1 and 30) and the average number of drinks they consumed on days when they drank, which was censored at 60. The total number of drinks per month was calculated as the product of these two variables and was censored at 450, following Ruhm and Black (2002).

2.16.5 Alcohol intake Thresholds

Cut-off drinking thresholds vary from one measure to the other. Cut-off drinking thresholds also differ in terms of what is sensible drinking for men and women. In the UK, for example sensible drinking limits have been in the last decade defined as not more than 14 units per week for women and 21 units per week for men. These thresholds have since been revised by the GP General who placed a

blanket maximum limit of 14 units for both men and women (Department of Health, 2016). Weiser *et al.* (2006) measured alcohol consumption by asking participants to indicate the number of days per week that they drank as well as the number of drinks per day on the days that they drank. From this information the number of drinks drunk per week is then calculated. In a study by Allen *et al.* (2009) alcohol consumption was measured simply by asking respondents how many drinks they had a week and what type of drink they consumed. Similar to Weiss (2008), the source of the question is not clear. A study by Amundsen (2012) simply asked respondents how often they consumed alcohol in the past year. The responses were divided into four categories: weekly/ monthly/less than monthly/never drank alcohol. This measure has the obvious limitations in that it does not capture the precise nature of drinking behaviour, for example binge drinking or heavy episodic drinking. Bacio *et al.* (2013) on drinking initiation and problematic drinking in US Latino adolescents used frequency of alcohol related problems in the past year to measure problematic alcohol use. Adolescents were asked how many times, as a result of drinking, they "got into trouble with their parents," "had problems at school or with their schoolwork," "had problems with friends," "had problems with someone they were dating," "did something they later regretted," "were hung over," "were sick to their stomach or threw up," "got into a sexual situation they later regretted," and "got into a physical fight." Responses ranged on a 5-point scale from 0 times to 5 or more times in the past year, and were summed for a maximum total of 45 points.

2.16.6 Recall Periods

When making attempts to measure the four dimensions that are routinely used in alcohol research, differences in approaches start to emerge in as far as recall periods and retrospection is concerned. Current literature on alcohol research suggests that recall periods range from a mere 6-hour period to as long as a 24 months. Borges *et al.* (2006) used interviews to inquire about drinking and how it is associated with non-fatal injuries by asking participants if they had consumed alcohol in the last 6 hours prior to an injury. The Alcohol timeline Followback for example, a method for assessing recent drinking behaviour estimates daily alcohol consumption over a time period ranging from 7 days to 24 months prior to the interview (Sobell and Sobell, 1992). As a consequence of the recall

dilemma, differences in methodology and strategy start to emerge with some alcohol researchers choosing current drinking as a more realistic measure of alcohol intake in preference to recent or historical drinking. Other than the difficulties presented to researchers with regards to the recall period, the four dimensions in alcohol measures, namely quantity, frequency, volume and the variability of drinking, also have their individual inherent problems.

2.16.7 Conclusion

This review demonstrated the different approaches used for measuring self-report alcohol intake. Though other approaches in use include collating alcohol sales data to estimate alcohol intake within a specific geographical area, and very rarely, using biological markers to estimate alcohol use, the self-report method remains the only viable option for measuring retrospective alcohol intake, particularly in large population based surveys. The review demonstrate the challenges faced in the field of alcohol research, particularly with regards to the lack of consistency in the current methods and tools used to measure self-report alcohol intake and the unavailability of standard measures to facilitate the comparison of results of one study with another, of which the implications are discussed. Unless a consensus is reached among alcohol researchers, a lack of clarity about which alcohol measure is best suited for which outcome and in what circumstances is likely to continue bringing conflicting evidence on alcohol use patterns at both the local and global level.

2.17 Summary of the literature review findings

This review examined what is known about the current state of alcohol use among migrants in a wide range of geographical locations. It addressed what is known about alcohol use and problem drinking among migrants and highlighted knowledge gaps. The review identified ethnicity, socio-economic status, religiosity, gender, and acculturation as playing multiple roles in influencing patterns, attitudes and beliefs regarding the use of alcohol in immigrant and ethnic minority communities. The review also covered findings from alcohol research in related fields such as alcohol treatment and interventions, alcohol policy, drink and driving, violence and aggression, gender, and HIV.

It represented the intersection of two bodies of literature: alcohol studies focussed on migrant populations and health outcome or health behaviour studies of migrants that include alcohol as a variable.

In addition to the immediate and long term negative health outcomes to which migrants are subject, the review identified the rationale from a public health and cultural perspective for examining alcohol use and its contexts among migrants. The review provided evidence of a growing body of research indicating that many health outcomes for migrants appear to deteriorate after migrating and a live debate about the cause of these changes. Theories on acculturation, ethnic minority health and alcohol use dominated the review. Overall, data on acculturation and alcohol use indicated that acculturation had opposite effects among different ethnic groups, different effects within a single ethnic group and no effect at all for some ethnic groups. The evidence shown from the review regarding acculturation and alcohol use is so inconsistent that it calls for more research, in view of its potential to improve health promotion, reduce harm due to alcohol, and thereby reduce health inequalities.

In light of this, the review justified the importance of understanding the newly arrived and adapting migrants' health behaviours, including alcohol use. It clearly revealed that ethnic minority populations generally experienced more negative consequences of alcohol use compared to the host population and therefore would have greater treatment needs. Despite these inequalities, the review also testified that the quality and appropriateness of alcohol treatment services and interventions for ethnic minorities and migrant populations are ubiquitous and poorly met. The review identified no studies that directly addressed the issue of alcohol use among African migrants in the UK, despite their significant presence. For this reason, information about the population of interest was drawn from studies examining related health issues, including mental health, HIV and stress. For the same reason, the review also drew information from alcohol related research approximating the population of interest and acknowledged a broad range of drinking patterns.

Methodologically, most of the retrieved studies followed a medical model and employed quantitative surveys to collect information on alcohol intake, alongside

questions on demographic, psychosocial and socioeconomic attributes. These studies were insufficiently equipped to explore attitudes, perceptions and beliefs regarding alcohol use because of the inherent subjectivities typifying these domains. Most authors who employed quantitative methods raised both the inherently inconspicuous nature, and suspiciousness of migrant communities as a problem, in view of alcohol use being a sensitive subject. In this respect, the review justified the use of a different approach to exploring the population of interest. The few studies which employed qualitative methods, including ethnography, were able to capture insight into the social processes which shape drinking behaviour. Considering these review findings, the researcher took the ontological decision to employ a pragmatist approach by employing both quantitative and qualitative methods to answer the research question. The logic was that neither quantitative nor qualitative approaches alone were sufficient to develop a complete analysis of the research question at hand, which required integrating 'highly contextualized interpretative findings with quantitative findings that establish empirical generalisations' (Bryman, 2004).

2.18 Justification of Study

"Alcohol is not an ordinary commodity, or 'a run-of-the-mill' consumer substance'' (Babor, 2010). It is a toxic substance in terms of its direct and indirect effects on a wide range of body organs. Epidemiological data has established alcohol as a major contributor to the global burden of disease, disability and death. The mechanisms of toxicity, intoxication and dependence are related to the ways in which people consume alcohol, referred to as 'patterns of drinking'. Epidemiological data has established alcohol as a major contributor to the global burden of disease, disability and death.

Given that some drinking patterns are associated with chronic health consequences, and problems associated with acute intoxication, such as accidents, injuries and violence, alcohol research is pivotal in alleviating the negative effects of alcohol use. With the increasing globalization of alcohol production, trade and marketing, alcohol policy formulation needs to be understood in the context of the ever increasing cultural and ethnic diversity prevalent in many populations, and the UK is an example. The UK is one of many

European countries where cultural diversity has become increasingly prominent in the last 60 years as a result of migration (ONS, 2011). With the heavy cost incurred to the NHS each year because of alcohol harm (Alcohol Concern, 2016; Statistics on Alcohol, England, 2015; NHS, 2011), it is plausible to explore patterns of alcohol use which take into account the demographic changes brought to the UK through migration. Developing an understanding of the intellectual and practical skills to deal effectively with the consequences or benefits of ethnic diversity are essential for the management of effective programs to assist potentially vulnerable members of the community (Refugees Study Centre, 2017).

Given the enormity of harm caused due to alcohol use, and the palpable problems on UK streets, the Police, residents and local authorities have all called for more targeted means to deal with alcohol related behaviour (Alcohol Policy, 2010). Given such calls to have targeted solutions to reduce the harmful effects of alcohol, the available literature points to very limited evidence about alcohol use in UK hard to reach communities, migrants included. Much of the research on alcohol related issues in the UK has been dominated with samples of whites and has ignored the potential influence of cultural factors, such as race and ethnicity, resulting in potentially misleading generalizations. Consequently, it is imperative, from a public health perspective, to better understand ethnic specific drinking patterns and their associated drinking patterns. Unlike the USA which has been administering national alcohol surveys with an emphasis on black and ethnic minorities since 1984 (Caetano *et al.*, 1998), the UK is lacking in these advances.

Migrants make a special case as they are often on the fringes of society. Migrants also tend to have poorer health outcomes. They often live in closed socially isolated groups, which place them at risk of being missed on issues concerning their health and social care, when compared with the host population. There is a substantial body of evidence which indicates that drinking in migrant populations is often associated with risky and illegal behaviours, increasing emotional distress, and other negative psychological outcomes that may impact later life stages (Dillon *et al.*, 2013; Maldonado-Molina *et al.*, 2011; Wong *et al.*, 2011). Concerns have also been raised about alcohol use amongst forcibly displaced persons for reasons relating to both factors prior to and during displacement and

in the post displacement period when people are living in their new areas of settlement (Haasen *et al.*, 2008; Johnson, 1996). (Gonzalez- Lopez *et al.,* 2012; Lindert *et al.,* 2008; Nichols *et al.,* 2012). Studies focused on lifestyles and health determinants have also found that alcohol consumption has distinguishable differences in drinking habits between the host and foreign populations (Arfken *et al.,* 2011; Fierro *et al.,* 2010; Garcia, 2008).

Most research focussing on alcohol use in migrant communities has taken place in the USA and Canada, which have equally long histories of migration, but the research findings have limited applicability to the UK. Given this scenario, the UK Zimbabwean diaspora is a good case as a first step to building an understanding of the patterns of alcohol use in a specific sector of the UK population. This PhD therefore aims to provide new evidence focussed on how alcohol is perceived and consumed among Zimbabwean migrants in the UK. New evidence in this area provides opportunities for predicting patterns of alcohol use and devising appropriate alcohol intervention programs; and policies aimed at reducing the deleterious effects of alcohol consumption. Currently the strongest most cost-effective evidence to reduce the harmful effects of alcohol points to taxation that increases prices, restrictions on the physical availability of alcohol, drink and driving countermeasures, brief interventions with at risk drinkers and treatment of drinkers with alcohol dependence. However, much of this evidence reported from academic publications may have little or no relevance to the emerging cultural diversity in the UK, and in certain UK population groups whose drinking norms, attitudes and perceptions to alcohol use differs from the mainstream population. To address the gap in alcohol research and provide more insight into the relevance of current evidence, alcohol use among Zimbabwean migrants in the UK made a good case to explore.

Zimbabweans are an emerging ethnic group and arguably one of the fastest growing African migrant groups in the UK. Zimbabweans in the UK differ from other migrants in many ways, including their motivations to migrate to the UK, their colonial history and strong socio-economic ties to the UK, their socio-economic attributes and their homogeneity. Caetano *et al.* (1998) noted the methodological difficulties of studying heterogeneous minority populations by giving an example of the history of alcohol research among Hispanics in the USA.

Contrary to this, the Zimbabwean population in the UK is largely homogeneous in its characteristics. For this reason, a study on Zimbabwean migrants offered opportunities for a methodologically sound thesis with the potential to inform new knowledge about the relationship between alcohol and migrants. Consideration of employing an African migrant population sample was given, however, based on Caetano's findings, this idea was rejected as it was felt African migrants in the UK were too heterogeneous to cause methodological and logistical constraints.

Methodologically, alcohol research is dominated with studies which use quantitative surveys to measure alcohol use in relation to specific socio-economic and demographic characteristics. Having established the importance of culture in understanding attitudes, perceptions, and drinking patterns, (Worby and Organista, 2007; Caetano *et al.*, 1998; Eide and Acuda., 1996), the domination of quantitative surveys in alcohol research means that these studies fail to adequately portray the implications of culture in influencing drinking behaviour. As such, a Mixed Methods design using ethnographic methods is justified in the context of its strengths to better understanding ethnic specific attitudes and perceptions about alcohol use. A dominant theme that emerged in the analysis of retrieved studies on alcohol use is the relationship between alcohol and stress (Keyes *et al.*, 2012; Keyes *et al.*, 2011). Taking into light evidence which links stressors related to the social adjustment of migrants to the dominant host culture (Lo *et al.,* 2012; Mulia and Zemore, 2012; Tsai, 2012), the Zimbabwean diaspora in the UK offered a justifiable case to investigate. Key to this investigation was exploring the role of alcohol in managing stresses associated with the migrant experience. I am a Zimbabwean and have worked in the UK as a mental health professional for more than 15 years. Based on my experience working in mental health services, I have witnessed a rising number of Zimbabwean migrants undergoing treatment in healthcare institutions for mental illness, including alcohol related problems. Reports in both the social and more formal media are abound with cases of drink and driving. Zimbabwean social settings where alcohol is consumed have also mushroomed, particularly in the larger cities across the UK, suggesting that alcohol use is key to the day to day lives of Zimbabwean migrants. Members of migrant and ethnic minorities often are unwilling to participate in research because of general distrust of both government and authority (Caetano, 1998). Having an 'insider' taking an active

role in a study which carries a heavy stigma therefore brought its opportunities, in that participants were better placed to open up more than if it was a complete stranger. The implications of this would arguably point to more credible findings.

This study therefore represents an important contribution to and insight into the socioeconomic, psychological and cultural factors that drive migrants into the way they use alcohol by making a specific reference to Zimbabwean migrants in the UK.

Although there is evidence in the literature suggesting efforts in conducting research with minority populations in the UK, research on migrants still lags compared to studies conducted with the majority population. Insights drawn from the findings of this study will therefore help explain and predict drinking behaviours and alcohol related problems among migrant communities. A key impact of this study is the possibility of making inferences from the results to determine what might be happening in other UK migrant communities with a similar background to Zimbabweans. Future patterns on alcohol use can be predicted and used in devising appropriate alcohol intervention programs and policies aimed at saving the NHS millions of pounds every year from the annual 3.5 billion pounds already being spent because of alcohol harm (Alcohol Concern, 2014).

2.19 Conclusions

This chapter provided the literature review relevant to this thesis by demonstrating the strategy used in searching for the relevant literature, and the search results. A review on the major predictors of and factors influencing alcohol use were presented, including a discussion on the consequences of alcohol use. Following this, a narrative on the benefits of alcohol use is provided. An overview situating alcohol use in the context of the UK, Africa in general and Zimbabwe was presented. A global overview of alcohol use in migrant communities was then discussed to provide a wider context of alcohol use in relation to the population of interest. Strategies to reduce the harmful effects of alcohol, at both a global and a local level were discussed. The methodological challenges which researchers face in measuring alcohol intake were also comprehensively

discussed. A summary of the literature review findings, followed by justification of this study closes the chapter.

The next chapter presents the research methodology

Chapter 3: Methodology

3.1 Introduction

This chapter begins by defining the aims and objectives of this study. This is followed by an outline of the rationale for using Mixed Methods (MM), This chapter also addresses the research question, including the philosophical assumptions underpinning this study. The MM research process is separated into a qualitative and a quantitative strand. Included in each of these two strands is an explanation of the philosophical and theoretical perspectives underpinning the research process, the methods employed in the data collection, and the rationale for choosing these methods in line with the research question. Throughout the methodology narrative, theoretical lenses through which this study is anchored are discussed and justified.

3.2 Aims and Objectives

This study aims to:

1. Explore attitudes, perceptions, and beliefs relating to the use of alcohol among Zimbabwean migrants who live in the UK;
2. Investigate the factors associated with increased alcohol intake in Zimbabwean migrants living in the UK.

3.3 Background to Methodology

MM approaches to research are increasingly being used as an alternative to the traditional single-method designs of conceiving and implementing inquiries in research. (Teddlie and Tashakkori, 2009). MM research is also becoming increasingly described, and recognized as the third major research approach or research paradigm (Johnson *et al.,* 2007). Brady *et al*. (2009) argued that MM research is emerging as a dominant paradigm in healthcare research in recent years with an increased use in healthcare research (Brady *et al.,* 2009). A review of research commissioned by the Health Research and Development Program in the UK showed that 17% of the studies commissioned before 1995 were MM in comparison to 30% funded between 2000 and 2004 (O'Cathain *et al.*, 2007). It is clear therefore that researchers in the field of health are increasingly identifying the benefits of using mixed methods designs in their research studies.

Leaders in the field define MM in numerous ways; however, the following definition by Tashakkori and Creswell (2007b, p. 4) is useful in defining the approach in this study.

''MM research is research in which the investigator collects and analyses data, integrates the findings, and draws inferences using both qualitative and quantitative approaches or methods in a single study or program of inquiry.''

3.4 Rationale for using Mixed Methods

The debates surrounding research paradigms have a long history stretching back to the 1980s. Some commentaries on the debate contend that the struggle for primacy of one paradigm over others is irrelevant as each paradigm is an alternate offering with its own merits (Guba, 1990: p 27). Quantitative and qualitative methods are separate paradigms where one is deductive and the other inductive, respectively. At one end of the debate are purists who take the view that quantitative and qualitative methods are based on mutually exclusive assumptions and therefore should not be mixed (Guba and Lincoln, 1989). In direct opposite to purists are pragmatists who argue against a false dichotomy between the quantitative and qualitative research paradigms and advocate for

the efficient use of both approaches (Cameron, 2009). Teddlie and Tashakkori (2009) defined pragmatism as a deconstructive paradigm that debunks concepts such as "truth" and "reality" and focuses instead on "what works" as the truth regarding the research question under investigation. Johnson and Onwuegbuzie (2004) argued that researchers should use whatever methods are needed to obtain the optimum results, even if this involves 'switching between' alternative paradigms.

In an attempt to explore alcohol use among Zimbabwean migrants who live in the UK, this research took the logic of the pragmatist MM position in that neither quantitative nor qualitative approaches alone were sufficient to develop a complete analysis of the research questions at hand, which required integrating 'highly contextualized interpretative findings with quantitative findings that establish empirical generalisations' (Bryman, 2004). To answer the research questions on alcohol use by Zimbabwean migrants in the UK required the researcher to 'hear the voices of participants' in an environment where drinking occurs, followed by the use of inferential statistics to investigate levels of alcohol use and its determinants. Hendricks and Blanken, ((1992) cited in Faugier and Sargeant (1996)) argued that survey studies in the general population that rely on closed questions are inherently limited by the data obtained and may yield poor understanding of the phenomenon under study, which is particularly limiting when exploring new or sensitive areas. In view of alcohol use being a sensitive subject, and for the fact that migrant populations are inherently inconspicuous and 'hard to reach', the researcher adopted a pragmatic approach, using ethnographic methods to capture insight into the social processes that shape drinking behaviours by Zimbabwean migrants. Morgan (2007) argued for pragmatism as a new guiding paradigm for supporting work that combines qualitative and quantitative methods as a way to direct attention to methodological concerns. Central to 'what works' for this study is whether social entities need to be perceived as objective or subjective. Taking into account the research's overall aims and objectives, a pragmatic approach that takes into account both objectivism and subjectivism fits the ontological position of this study. Morgan (2007) supports this position by her claims that any practicing researcher, particularly outside the laboratory has to work back and forth between various frames of reference, and that the classic pragmatic emphasis on an

intersubjective approach captures this duality. Assertions for the application of pragmatism in MM research is further enhanced by the argument that a forced choice dichotomy between post-positivism and constructivism should be abandoned and that a forced dichotomy between subjective and objective is an equally artificial summary of the relationship between the researcher and the research process (Teddlie and Tashakkori, 2009; Morgan, 2007).

This research aims to generate reasons, motives and explanations (Fox, 2010), about alcohol use and its determinants among Zimbabwean migrants in the UK. In order to achieve these aims, including a qualitative approach in the research design is justified. The use of quantitative methods is also justifiable as one of the key aims is to investigate a given set of quantifiable demographic, socio-economic and psycho-social factors and how they are related to increased alcohol use in the population of interest. Based on this dichotomy, the researcher's best available option was adopting a pragmatic approach that took into account both the 'subjective' and the 'objective' by using a combination of qualitative and quantitative methods respectively. The qualitative stage formed the first part of the inquiry and used ethnographic methods, specifically participant observations and field interviews. The second stage was quantitative and used a cross sectional survey in the form of an on-line structured questionnaire. Creswell and Clarke (2012) coin this as an exploratory sequential design which is recognizable 'because the researcher starts by qualitatively exploring a topic before building to a second, quantitative phase'.

The qualitative and quantitative data collection phases were implemented independently and chronologically. However, the analysis stage involved an iterative process whereby the researcher switched from one strand to the other to make inferences. To support the stance employed in this study, Teddlie and Tashakkori (2009) advocated for the use of sequential MM in situations where questions or procedures of one strand emerge from or are dependent on the previous strand, and where the questions of both phases of the MM are related to one another. A mixed method research design also suited the research questions in that it offset the weaknesses of each strand and drew on the strengths of both strands (Bryman, 2006)

3.5 Study design overview

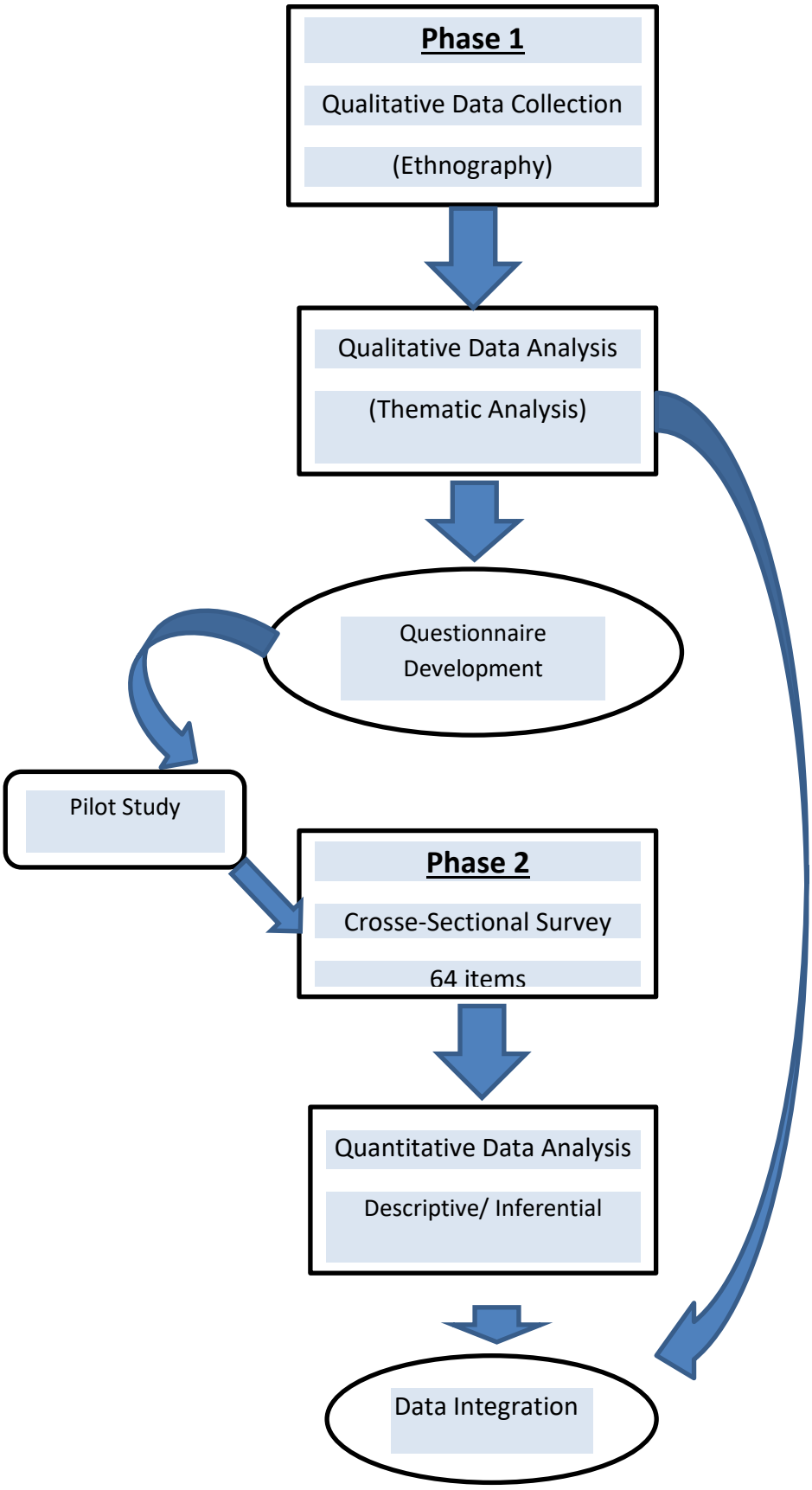
MM was selected on the premise that an exploratory approach is needed for two reasons. Firstly, an exploratory phase was required to establish some unknown variables regarding the use of alcohol. As there was no existing survey instrument available for the study population, an exploratory phase was needed to identify both the dependent and independent variables for the second phase of the MM. Creswell *et al.* (2004) supported the rationale for having an exploratory phase when researchers need to develop and test instruments in instances where they are unavailable. Secondly the researcher found it appropriate to have an exploratory phase for the sake of developing a questionnaire which aimed at investigating the factors associated with increased alcohol use among Zimbabwean migrants living in the UK. Goodson and Vasser (2011) further advocated for the use of qualitative methods in MM designs as a source of determining variables for further research which provides a good launching pad for a larger original data set. Creswell and Clarke (2012) described the type of MM selected for this research as an exploratory sequential design whereby the researcher starts by qualitatively exploring a topic before building to a second, quantitative phase.

Based on these theoretical undertones, this research began by qualitatively exploring attitudes, perceptions and beliefs regarding alcohol use through a focused ethnographic study. The findings emerging from the focused ethnography were used as inputs to inform a questionnaire to collect information on a broad cross-section of Zimbabweans living in the UK. In this study, a survey instrument was developed at the point of interface of the two phases. The qualitative stage, with its inductive theoretical drive (Morse, 2003), generated insights into drinking behaviour, focusing primarily on Zimbabwean migrants living in the UK. The subsequent quantitative stage investigated the factors associated with alcohol use, alongside other measures. This use of quantitative data is consistent with the sequential exploratory design, in which the quantitative component assists in the interpretation of the qualitative findings (Creswell *et al.*, 2003). Morse (2003) illustrated this approach as:

QUAL→ quan

Figure 4 below shows a graphical illustration of a sequential exploratory design adopted in this study.

Figure 4: Graphical illustration of a sequential exploratory design adopted in this study.



3.6 Philosophical Assumptions- Mixed Methods

3.6.1 Overview

Creswell and Plano-Clarke (2012) used Crotty's (1998) conceptualization to position philosophy within a MM study. Likewise, Crotty's framework was adopted to position this MM's philosophical position. Crotty (1998: p3) claimed that the terminology used in both contemporary research and existing research literature is confusing with epistemologies, theoretical perspectives, methodologies and methods ‘’thrown together in grab-bag style as if they were all comparable terms’’. To make more sense of this confusion, Crotty (1998) argued that these terms represent distinct hierarchical levels of decision making within the research design process. According to Crotty (1998), in summarized form, the initial decision making process involves adopting a particular stance towards the nature of knowledge. This particular stance (epistemology) will underpin the entirety of the research process, including the choice or selection of the theoretical perspective. The following table illustrates Crotty’s (1998) hierarchical levels of decision making within the research design process and how it was adopted in this study.

Table 2: Adoption of Crotty’s (1998) hierarchical levels research design process

Paradigm/Worldview	(positivism, constructivism, constructionism)
Theoretical lens	(natural enquiry, social representation theory)
Methodological approach	(mixed methods-ethnography, survey,)
Methods of data collection	(participant observation, interviews, on-line questionnaire)

Constructivist/constructionist and positivist principles were adopted as the underlying philosophical assumptions for this study. Constructivism focusses on the internal, cognitive processes of individuals whereas constructionism focusses on discourse or the joint activities that transpire between people. The two are viewed as similar because of their focus on meaning making processes.

3.6.2 Constructivism

The constructivist approach to this study draws its theoretical perspective from the works of Lincoln and Guba's (1985) conception of Naturalist inquiry, which they later acknowledged as a form of Constructivism (Guba *et al.*, 1998). Constructivist research is relativist, transactional and subjectivist (Guba *et al.,* 1998). Relativism is the philosophical position that all points of view are equally valid and that all truth is relative to the individual (Internet Encylopedia of Philosophy, 2016). This definition suggests the absence of an objective truth, and an emphasis on the diversity of interpretations that can be applied to the world.

Constructivism, often thought to have arisen from the work of Max Weber (1864-1924), looks for culturally derived and historically situated interpretations of the social world. This philosophical position supported the proposed ethnographic methods. Two of Le Compte and Schensul's (2010: p37) seven characteristics of ethnography are that ''it frames all human behaviour and belief within a socio-political and historical context'' and that ''it uses the concept of culture as a lens through which to interpret results.'' Both of these characteristics typify this focused ethnographic study, and are well aligned to a constructivist approach as supported by the work of Max Weber (1864-1924). Realities are better understood in the form of multiple, intangible mental constructions, socially and experientially based, local and specific in nature (although elements are often shared among many individuals and even across cultures) and dependent for their form and content on the individual persons or groups holding the constructions. The investigator and the object of investigation are assumed to be interactively linked so that the `findings' are *literally created* as the investigation proceeds (Guba and Lincoln, 1994: p110-111).

The qualitative design sought to analyze, and interpret individual actions and attitudes and how beliefs, cultural meanings, symbols and social circumstances affect behaviour (Garapich, 2015) and attitudes towards alcohol use. It was anticipated that the ethnography would access accounts by participants regarding attitudes, perceptions and beliefs about alcohol use which would require 'complex' modes of interpretation. This called for a constructivist approach as this, according to Creswell and Plano Clarke (2012) generally works for qualitative studies that value multiple perspectives and deeper understanding of meanings from participants.

3.6.3 Constructionism

Influenced by the social constructionist theory of knowledge, this research utilized focused ethnographic methods of both participant observation and interviews in multi-sited fieldwork to generate data. Social constructionism believes that a great deal of human life exists as it does due to social and interpersonal influences (Gergen, 1985). It takes the view that all knowledge, and therefore all meaningful reality as such, is contingent upon human practices, being constructed in and out of interaction between human beings and their world, and developed and transmitted within an essentially social context. In the constructionist view, as the word suggests, meaning is not discovered but constructed (Crotty, 1998: p42). Social constructionism concentrates on investigating the social influences on communal and individual life. At its core is the recognition that people behave like others around them, similar to Bourdieu's concept of 'habitus'. Habitus is a system of embodied dispositions, tendencies that organise the ways in which individuals perceive the social world around them and react to it (Bourdieu, 1987). Bourdieu (1987) argued that the reproduction of the social structure results from the habitus of individual. He developed a theory of the action, around the concept of habitus, which exerted a considerable influence in the social sciences. The subjects that social constructionism is interested in are those to do with what anthropologists call culture, and sociologists call society.

Apart from the inherited and developmental aspects of humanity, social constructionism hypothesizes that all other aspects of humanity are created, maintained and destroyed in our interactions with others through time (Owen,

1995). The most important elements to the theory are the assumption that human beings rationalize their experience by creating a model of the social world and how it functions and that language is the most essential system through which humans construct reality (Leeds-Hurwitz, 2009). The fact that each race has a different genetic makeup and cultural practice means that constructionists argue that there is no universal human nature.

3.6.4 Positivism

The guiding assumptions of the quantitative stage of the MM design shifted to those of positivism. Positivism is based on the philosophy that our preconceptions need to be set aside in order to identify objective facts observed through empirical observation (McEvoy *et al.*, 2006). A shift in paradigm to positivism was necessary to meet the study aim to investigate the factors associated with increased alcohol use within the population of interest, and to identify statistical associations between alcohol consumption and potential risk factors. Positivism maintains there is a reality external to us. Externalizing reality demands objectivism, a stance which ‘‘portrays the position that social entities exist in reality external to social actors concerned with their existence’’ (Saunders *et al.*, 2009). Put in a different way, objectivism ‘‘is an ontological position that asserts that social phenomena and their meanings have an existence that is independent of social actors (Bryman 2003: p22). The quantitative strand drew its position from Ackroyd's (2004) definition that the goal of positivist research is ‘‘to identify generalizable laws that are based on the identification of statistical relationships between dependent and independent variables’’.

3.7 Methods: Strand 1- Focused Ethnography

3.7.1 Rationale for employing Focused Ethnography

3.7.1.1 Background

Focused ethnography is an applied research methodology that 'has been widely used in the investigation of fields specific to contemporary society which is socially and culturally highly differentiated and fragmented' (Knoblauch, 2005). Focused ethnography can be traced back to the early 50s when researchers such as Goffman (1952) focused on the life of small groups of people. By the end of the 1960's, a number of ethnographers had stopped following the ''old rules'' typical of conventional ethnography - long periods of time in distant field sites to gain exposure to and understanding of settings, cultures and languages not their own (LeCompte and Schenshul, 2010). A number of ethnographers had recognized the limitations of participant observations as the sole means of accumulating and conveying ethnographic knowledge and new, more rigorous approaches to data collection began to evolve (LeCompte and Schenshul, 2010).

As it is known today, the notion of focused ethnography seems to have been introduced by Otterbein (1977) as a type of ethnography designed to focus on culture traits. Knoblauch (2005) stated that focused ethnography is a distinctive kind of sociological ethnography, delineated within the context of other common conceptions of what may be termed conventional ethnography. He identified focused ethnography as particularly, though not exclusively, adopted in applied research, and as being increasingly used in a number of studies. Polit and Beck (2008) categorised ethnography into two main types: 'macro-ethnography', which is 'concerned with broadly defined cultures', and 'micro-ethnography', also known as 'focused ethnography', which focuses on 'more narrowly defined cultures'.
Knoblauch (2005) argued that rather than opposed to, focused ethnography is complementary to conventional ethnography, particularly in fields which are characteristic of socially and functionally differentiated contemporary society. Venzon Cruz and Higginbottom (2013) added that focused ethnography has emerged as a promising method for applying ethnography to a distinct issue or shared experience in cultures or sub-cultures and in specific settings, rather than throughout entire communities.

3.7.1.2 A summary of comparison between conventional and focused ethnography

Conventional ethnography involves studying situations in real-time, thus as they occur in their natural setting, to gain an in-depth perspective of the overt or explicit dimensions of culture that are known and cognitively salient to members of that culture or subculture, and covert or tacit dimensions that may not be articulated by members of the culture or subculture, but nevertheless shared (Fetterman, 2010). On the other hand, focused ethnography focuses on cultures and sub-cultures framed within a discrete community or phenomenon and context, whereby participants have specific knowledge about an identified problem (Higginbottom *et al.*, 2013). Because of its nature, focused ethnography allows the researcher to better understand the complexities surrounding issues from the participants' perspectives ('emic view') while bringing the outsider's framework to the study (Roper and Shapira, 2000). Focussed ethnography still apply traditional forms of observation and description, in addition to what is recorded, however there are several differences that are worthy of note.

First, conventional and focused ethnographies differ with respect to their demands on time (Knoblauch, 2005). Focused ethnography is characterised by short duration of field visits and intense phases of data collection to substitute for the length of data collection common in conventional ethnographies (Knoblauch, 2005). As opposed to the conventional experience based ethnography, focused ethnographies are short ranged and not continual with field visits planned in various intervals, and at times even on specific events. Arguments against the short duration visits typical of focused ethnography are that they are superficial (Knoblauch, 2005), however the short term covered in the field is compensated for their ability to produce a large amount of data in a relatively short space of time.

Second, in addition to the use of field notes typical of conventional ethnographies, focused ethnography has adopted a wide range of technologies for recording data. The argument is that although the use of field notes continue to play an important role in focused ethnography and is subject to personal authorship, technically recorded data is accessible to multiple listeners and viewers at the same time (Knoblauch, 2005)

Third, focused ethnography is characterised by a selected and focused aspect of a field of research. For example, rather than study health related lifestyles of Zimbabwean migrants in the UK, one may want to focus on specific lifestyle behaviour of Zimbabweans in the UK such as attitudes to alcohol use, in a specified geographical setting. Thus, contrary to conventional ethnography, focused ethnography restricts itself to certain aspects of fields with the entities studied not necessarily groups, organisations or milieus but rather situations, interactions and activities (Venzon Cruz and Higginbottom, 2013). For this to be achievable, it is argued that the researcher needs to have reasonable background knowledge of the field they plan to focus on, and that they need the employment of relevant technologies and pragmatic methods for data collection. Goodwin (2002), in an attempt to distinguish the difference between conventional and focused ethnographies, notes:

"Rather than wandering onto field sites as disinterested observers, attempting the impossible task of trying to catalog everything in the setting, we can use the visible orientation of the participants as a spotlight to show us just those features of context that we have to come to terms with if we are to adequately describe the organisation of their action".

Though not entirely exclusive, the tables below show summary comparisons between conventional and focused ethnographies.

Table 3: Comparison between conventional and focused ethnographies

Conventional ethnography	Focused ethnography
Long term field visits	Short term field visits
Experientially intensive	Data analysis intensity
Time extensity	Time intensity
Writing	Recording
Solitary data collection and analysis	Data session groups
Open	Focused
Social fields	Communicative activities
Participant role	Field-observer role
Insider knowledge	Background knowledge
Subjective understanding	Conservation
Notes	Notes and transcripts
Coding	Coding and sequential analysis

(Adapted from Knoblauch, 2005)

Table 4: Comparison of focused ethnographies to traditional anthropologic ethnographies.

Focused ethnography	**Anthropologic ethnographies**
Specific aspect of field studies	Entire social field studies
Closed field of examination as per research question	Open field of investigation as determined through time
Background information usually informs research question	Researcher gains insider knowledge from participatory engagement in field
Informants serve as key participants with their knowledge and experience	Participants are often those with whom the researcher has developed a close relationship
Intermittent and purposeful field visits using particular timeframes or events, or may eliminate observation	Immersion during long term, experiential-intense field-work
Data analysis intensity, often with numerous recording devices including video cameras, tape recorders and photo cameras	Narrative intensity
Data sessions with a gathering of researchers knowledgeable of the research goals may be extensively useful for providing heightened perspective to the data analysis particularly of recorded data	Individual data analysis

(Higginbottom *et al.*, 2013, p. 4)

3.7.1.3 Focused ethnography and its relevance to the population of interest

I now turn to focused ethnography in the context of this study and demonstrate its potential strengths, with a particular focus on discovering the cultural characteristics of Zimbabwean migrants who live in the UK. Focused ethnography suits this study because of its usefulness in discovering values and belief system of Zimbabwean migrants regarding alcohol use and the underlying forces influencing these values and beliefs. I argue that focused ethnography provides a pragmatic strategy for discovering the cultural characteristics of Zimbabwean migrants relevant to this study thorough participant observations and interviews.

In conventional ethnography, researchers are traditionally thought of as neutral, distant, reflective observers and it is assumed that ethnography is best conducted by researchers that are not part of the cultural group to make it easier for the

researcher to see what is happening in the setting (Higginbottom *et al.*, 2013; Morse and Richards, 2002). As a Zimbabwean migrant myself, and therefore a part of the cultural group under study, the underlying assumptions for the use of conventional ethnography did not fit this study. Focused ethnography, on the other hand, is typified by short-term or absent field visits, and an interest in a specific research question (Higginbottom *et al.*, 2013; Knoblauch, 2005; Millen, 2000). To accomplish a high quality ethnography despite relatively brief periods of research time and limited resources, researchers now restrict their studies to a 'topic' or 'lens' through which to view the community they are studying (LeCompte and Schensul, 2010:p6). This characteristic fitted this study as PhD projects have limited time placed on candidates. Also, limited financial resources made it impossible to undertake prolonged field studies and therefore a focused ethnography fitted the aims and objective of this research.

The fact that focused ethnography is best suited for researchers with insider or background knowledge of the cultural group, and intensive methods of data collection and recording made this method the best available option compared to other ethnographic types. A focused ethnography usually deals with a distinct problem in a specific context and is conducted within a sub-cultural group rather than with a cultural group that differs completely from that of the researcher (Knoblauch, 2005; Wall, 2014; Morse and Richards, 2002; Roper and Shapira, 2000). Zimbabwean migrants in the UK are a sub-culture, and exploring their attitudes, norms and belief systems regarding alcohol use is context specific. Because of its nature, focused ethnography allows the researcher to better understand the complexities surrounding issues from the participants' perspectives ('emic view') while bringing the outsider's framework to the study ('etic view') (Roper and Shapira 2000).

Prior to commencing the field visits, I already had a specific research question, which also meant that focused ethnography was best suited for the purpose of this research. Focused ethnography is seen as a pragmatic and efficient way to capture specific cultural perspectives and to make practical use of that understanding (Henzon Cruz and Higginbottom, 2013; Higginbottom *et al.*, 2013; Millen, 2000; Muecke, 1994). Because of the exploratory nature of this study, and for the fact that the subject area is fairly understudied in the UK, focused

ethnography fitted this study. In focused ethnography, the researcher focuses on participants' common behaviors and shared experiences and works from the assumption that the participants share a cultural perspective (Cruz and Higginbottom, 2013; Mayan, 2009; Morse and Richards, 2002). Richards and Morse (2007) argued that focused ethnography is particularly useful in evaluating or eliciting information on a special topic or shared experience. These assumptions fit in well with the population of interest. In general Zimbabwean migrants in the UK share the same cultural orientation, they speak the same languages, and congregate for recreational purposes, with the sharing of experiences binding this group. One of the objectives of this study was to explore the drinking culture and lived experiences of Zimbabwean migrants in the by capturing participants' common behaviours, and focused ethnography fitted this objective.

Focused ethnography is based on the premise that "we no longer need to travel to far-away places to study culture; nor is culture defined only along ethnic or geographical lines" (Mayan, 2009:p37). Rather, cultures and subcultures are everywhere and may be relatively unbounded (Mayan, 2009). The study settings were all within sufficient reach of the researcher with the focused ethnography intended to provide a window through which the Zimbabwean migrants' drinking culture could be captured.

Focused ethnography provides researchers with opportunities to understand the inter-relationship between people and their environments in the society in which they live (Henzon Cruz and Higginbottom, 2013). It has emerged as a useful tool in gaining a better understanding of the experiences of specific aspects of people's ways of life and being (Le Compte and Schensul, 2010). My aim was to better understand realities constructed from subjective experiences of Zimbabwean migrants' use of alcohol that could not be objectively quantified or measured by research driven by the scientific method (Parse 2001; Munhall 2007; Streubert-Speziale and Rinaldi Carpenter, 2007).

3.7.2 Theoretical grounding

This focused ethnography was informed by two theories, namely, the Social Identity Theory and the Social Representation Theory.

3.7.2.1 Social Identity Theory

Social identity theory (SIT) was first coined by Tajfel and Turner in the 1970's and 1980's and refers to the sense of self that a person gains from seeing themselves as part of a relevant social group (Turner & Reynolds, 2011). The premise of SIT is that a social category (e.g., nationality, political affiliation, sports team) into which one falls, and to which one feels one belongs, provides a definition of who one is in terms of the defining characteristics of the category-a self-definition that is a part of the self-concept (Hogg *et al.,* 1995). In SIT, a social identity is a person's knowledge that he or she belongs to a social category or group (Hogg and Abrams, 1990). A social group is a set of individuals who hold a common social identification or view themselves as members of the same social category (Burke, 2000).

McLeod (2008) defined social identity as a person's sense of who they are, based on their group membership. Social identity is the result of a dynamic process of social interactions that comprises understanding, interpreting, and agreeing upon social and individual expectations. Social identity is understood as an interactional, changing and contextual phenomenon and comprises a set of relatively durable features characterizing ways of self-perception and the perception of others formed among members of a community and derived from a culture typical of the community in question (Burke, 1991). Through a social comparison process, persons who are similar to the self are categorized with the self and are labelled the in-group whilst persons who differ from the self are categorized as the out-group (Stets and Burke, 2000).

Tajfel and Turner's (1979) SIT explains that part of a person's concept of self comes from the groups to which that person belongs. Tajfel and Turner (1979) argued that an individual does not just have a personal selfhood, but multiple selves and identities associated with their affiliated groups, and that a person

might act differently in varying social contexts according to the groups they belong to. Tajfel (1979) proposed that the groups which people belonged to were an important source of pride and self-esteem. He argued that groups give a sense of social identity: a sense of belonging to the social world. The central hypothesis of SIT is that group members of an in-group will seek to find negative aspects of an out-group, thus enhancing their self-image (Jackson, 2011; Hewstone *et al.*, 2002). Spears (2011) argued that SIT does not only address the bases for differentiation and discrimination between groups, but that it also views social competition as a means for disadvantaged groups to challenge the status quo, helping to explain social change.

3.7.2.2 Social identity approach

SIT has gone through some changes since its formulation, following criticism of the original theory (Huddy, 2001; Brown, 2000). In response to criticism of SIT, social categorisation theory (SCT) was developed which looked at the self, and group processes using the insights of SIT (Turner & Reynolds, 2011). Nowadays, the theories are grouped together to form the social identity approach, drawing on aspects of both theories. SIT and SCT suggest that people categorize themselves as belonging to certain groups such as nationality, gender, or even sports teams (Trepte and Loy, 2017). Both theories explain self-identity in terms of group processes and intergroup relationships which can account for the complexity of multiple, context specific social identities (Roccas and Brewer, 2002). In addition, Barrett *et al.* (2004) argued that SIT and SCT have proven to be fertile sources of hypotheses for the study of gender and ethnic identity, and national identity development.

Broadly speaking, SIT concerns the affective-evaluative element of intergroup relationships, while SCT comprises the cognitive-perceptual component (Burholt, 2016). Both SIT and SCT constitute the most popular psychological approaches and theoretically advanced explanation of intergroup relations (Schmid and Hewstone, 2011). They also both offer additional insights into the phenomenon of group membership (Turner *et al.*, 1987). These theories assert that people need to simplify their social worlds by creating categories (Lorenzo-Hernandez, 1999). Once a person is categorized as a member of a social group, he or she becomes a recipient of expectations, affects and attitudes held towards members

of that group (Lorenzo-Hernandez, 1999). As predicted by social categorization theories (Tajfel and Turner, 1986; Wilder; 1986), being perceived as members of an out-group may result in rejection.

3.7.2.3 Social identity models relevant to the population of interest

Acculturation, social identity and social cognition

Padilla and Perez (2003) designed a new model of acculturation which posits that acculturation should incorporate contemporary work in social and cognitive psychology. They define psychological acculturation as the internal processes of change that immigrants experience when they come into direct contact with members of the host culture. The model they present builds on previous research in the areas of social cognition, cultural competence, social identity, and social stigma (Padilla and Perez, 2003). This new model, which rests on four pillars, namely social cognition, cultural competence, social identity, and social stigma provides insight and relevance into how both SIT and social categorization theory can be translated to migrant populations. Padilla and Perez (2003) hypothesized that acculturation is more difficult for those persons who must cope with the stigma of being different because of skin color, language, ethnicity, and so forth and argued that their theoretical framework will lead to more productive insights into the adaptation process of immigrants.

Social identity model of identity change

A person's social identity may change as a result of life changing transitions such as when one settles in a new country (Iyer *et al*., 2009). After going through life changing transitions, a person's identity can be replaced by negative self-concepts, which have been associated with poor psychological well-being (Iyer *et al*., 2009; Holme *et al.,* 2008). However, the social identity model of identity change (SIMIC) shows that the effects of life changing transitions and experiences can be reduced or moderated by certain social factors. Whilst a loss of social identity can have negative effects on well-being, social relationships can also have a positive effect on well-being (Iyer *et al*., 2009; Jetten *et al*., 2009; Stets and Burke, 2000). Having the ability to take on new relationships following a life changing transition can be a way of protecting oneself from the harmful

effects of identity change (Jetten *et al*., 2012). Some findings also show that other ways of the self from the effects of identity change, comes from the fact that some people may belong to many different social groups (Jetten *et al.,* 2012). Having different social contacts and maintaining these after the life changing transition, ensuring they are still compatible, has been shown to be associated with life satisfaction scores (Iyer *et al,* 2009; Haslam *et al*., 2008).

3.7.2.4 Social identity in the context of Zimbabweans in the UK

SIT is extensively employed and a relevant explanatory tool in migrant studies (Brettell and Hollifield, 2013). It is concerned with group situations and starts from the assumption that social identity is derived primarily from group membership. It further proposes that people strive to achieve or maintain a positive (thus boosting their self-esteem) and that this positive identity is derived largely from favorable comparisons that can be made between the in-group and the relevant out-groups. The assumption of SIT is that in the event of an unfavourable identity, people may seek to leave their group or find ways of achieving more distinctiveness for it (Brown, 2000).

In this study, a social identity approach is taken to examine the potential for different influences on cultural identity arising from group membership based on cultural heritage, social class, support network, and global citizenship (Roccas and Brewer, 2002). Both anthropologists and social scientists have increasingly noted that migrants live their lives across borders and maintain their ties to home, even when their countries of origin and settlement are geographically distant (Pasura, 2013; Schiller *et al*., 1992). However Adeyanju *et al.* (2011) argued that scholars of international migration have paid scant attention to the phenomenon of bifurcated social identity of African migrants and their efforts to reinvent or re- and deconstruct a certain image of self in their everyday life. A social identity approach is taken to identify factors that are associated with Zimbabwean migrants' sense of belonging in the UK. Burholt *et al*, (2016) argued that a social identity approach allows the testing and exploration of the associations between cultural heritage, social class, social support network types, transnational family relationships and 'cultural identity'. They defined cultural identity as an umbrella term for three identity measures, namely a migrant's sense of belonging to (1) an ethnic group, (2) the family's country of origin and (3) the country of residence.

The extent to which migrants feel they belong to the country in which they reside and/or a country of origin is likely to have an impact on social cohesion (Burholt *et al*, 2016), and consequently migrants' belief systems living alongside members of the host population. Thus, a social identity approach may help to understand identity perceptions of Zimbabweans in the UK and the cognitive processes which involve examining commonalities and differences. In the context of Zimbabwean migrants living in the UK, migration means being in a world in which neighbouring families and the surrounding structures represent a completely different culture with different customs, traditions and lifestyles. Theoretically, this cultural immersion of migrants into the host society implies the construction of new forms of social identity. Niedz'wiedzki (2008) argued that as migrants settle into their new environment, the reconstruction of identity is an essential condition for adaptation in the new place of settlement. He further postulated that the process of identity reconstruction, based on changes in stereotypes, is linked with the acceptance of pluralism as an important feature of the socio-cultural reality.

Zimbabwean migration to the UK may partly fit the picture of what is termed pendulum migration in that they try to retain values, norms, and patterns of behaviour of their country of origin, while at the same time enriching their cultural competencies with new cultural characteristics which mirror the host society. Gudykunst and Schmidt (1987) argued that language is an important symbol of group identity. In the case of Zimbabwean migrants living in the UK, language seems to be an important symbol of national identity. In the context of this study, Zimbabweans in the UK, identify strongly as Zimbabweans. This membership seems to serve to enhance community pride and self-esteem as manifested in activities such the consumption of alcohol, music preferences, barbeques, African food, language through the use of culturally specific vocabulary, and context-sensitive topics.

3.7.2.5 Social Representation Theory

This ethnography was also informed by the Social Representation Theory (SRT). The rationale for choosing SRT was firstly based on its wide usage in the field of anthropology and its ability to connect to different fields of research (Rateau and Lo Monaco, 2013; Wachelke, 2012). Secondly SRT's conceptual framework is flexible, enabling it to adapt to various research areas.

The term ‘social representation’ was originally coined by Serge Moscovici in 1961 in his study on the reception and circulation of psychoanalysis in France. He refers to social representations as system of values, ideas and practices with a twofold function. The functions are, first to establish an order which will enable individuals to orient themselves in their material and social world and to master it, and secondly to enable communication to take place among the members of a community by providing them with a code for social exchange and a code for naming and classifying unambiguously the various aspects of their world and their individual and group history (Moscovici, 1998). Moscovici and Hewstone (1983) suggested social representations as forms of knowledge that are socially constructed, including values, ideas and practices, which enable people to orientate themselves in the social world.

SRT is seen by many researchers as a flexible conceptual framework that enables us to understand and explain the way individuals and groups elaborate, transform and communicate their social reality. For individuals to make sense of their environment, they have to simplify it, construct and reconstruct it in their own fashion (Jodelet, 1991). The process of reconstruction is dynamic and a constantly repeated process. SRT views socially constructed knowledge systems and identities as dynamic, rather than static, and capable of transformation through interaction between people, groups and organizations (Skovdal *et al.,* 2011). At a young age individuals are instilled with a ready-made construction of their world, instilled for example through parents, family members, peers, and the media (Rateau *et al*., 2011). This shaping of ‘reality’ continually reconstructed into later years, is driven by exchanges and communications between the individual and other group members. Rateau *et al.* (2011) summed up the process of reconstruction of reality and how the individual and members of other groups shape this process:

‘‘In this sense, this reconstruction of reality, this representation of reality, is above all social; that is to say elaborated according to the social characteristics of the individual and shared by a group of other individuals having the same characteristics. This last point is important. Not all social groups share the same values, the same standards, the same ideologies, or the same concrete experiences. Yet all construct representations that are closely based on these. It follows that social representations bear on the one hand the mark of the social

membership of the individuals who adhere to them and give them their identity, and on the other allow these same individuals to distinguish “others”, those who do not share the same representations and who appear to them at best as different, at worst as enemies.’’

With the broad knowledge that migrants undergo a process of transformation as they acculturate into their new environment, the researcher posits SRT as a strong basis for informing this study. Social representations forge the way individuals and groups understand the world they live, and in the process, convert these social representations into a particular social reality, for others and themselves.

3.7.3 Research Settings

The research settings were identified by contacting proprietors of Zimbabwean-run social clubs and public houses where Zimbabwean migrants meet for social and recreational purposes through the researcher's network.

This networking process identified three specific settings where Zimbabweans meet for recreational and social activities. All three settings are situated in a large urban area located within the Yorkshire region of the United Kingdom. These three settings offer diverse options for the use of patrons’ leisure time, and provide opportunities for social discourses on alcohol in a way it relates contextually to Zimbabweans.

At the three settings identified, I left participant information sheets for regular patrons to read. A copy of the information sheet is found in Appendix 4. The information sheets provided participants with an opportunity to familiarise themselves with the researcher, the interests of the researcher; and what both the participant observations and the interviews entailed. Below is a description of the three settings identified for the ethnography.

Site A (Matute)

Site A, which has been given the pseudonym ‘Matute’, is located in the outskirts of a large Yorkshire city at a business centre populated by migrants and ethnic minorities from across Europe, Asia, the Caribbean and Africa. The location is

always bustling with activity, well into the early hours of the morning throughout the year. There is a wide range of restaurants specializing in ethnic cuisines, barber shops that specialise in African hair, green groceries, and butchers, to name just a few. In the heart of this business centre there is a rundown arcade comprised of several shops, one of which is Zimbabwean owned and sells canned and bottled lagers, meat; and other food products that are imported mainly from Africa.

At this setting Zimbabweans have congregated for several years for a variety of recreational purposes such as drinking, barbeques, and pool. At this location Zimbabweans also meet to organize activities such as football and pool competitions with other Zimbabweans living in nearby cities such as within the Yorkshire and Midlands regions. This site is the most popular among the three settings being studied, particularly so during the summer months as patrons can choose to socialize either within a built up heated area or outside where they can engage in barbeque activities. Cooked traditional foods such as offal and boiled cow feet are also sold for patrons on a regular basis.

Site B (Rhinos)

Site B which has been given the pseudonym Rhinos is a traditional English pub run by a Zimbabwean migrant, which has been operational over the last 18 months. Despite it being situated in an active industrial area where the local white working class population is dominant, this pub's patron base is purely composed of Africans, with Zimbabweans dominating the scene. It is also situated along a busy bus route connecting the city to another town about five miles east, making it accessible to patrons who do not normally drive. On my initial visits to this site, the proprietor explained that his idea of opening this pub was to capture the more affluent Zimbabwean migrants, who could afford the relatively more expensive products available for sale, namely a wide range of alcoholic beverages, both bottled and dispensed through the tap. His business strategy and mission, he said, was to capture a certain type of Zimbabwean through the provision of a space generally quieter than other Zimbabwean settings, and at the same offering other recreational activities such as satellite sports channels and music. His mission, he said was to also offer spaces where a female patronage felt

comfortable to visit, and where private parties such as birthdays could take place, and where parents and their children could visit during the daytime.

Site C (Wenera)

Site C, where fieldwork was conducted during the third and final phase of the ethnography, was given the pseudonym Wenera. It is based in a large town, in one of the metropolitan boroughs in South Yorkshire. The town is well connected to all areas of the country by its proximity to rail and motorway networks. This town is unique in that asylum seekers were sent to it on a no choice basis by the Home Office as part of the national dispersal program introduced by the Immigration and Asylum Act of (1999). As a consequence of this program, this town provides a hub of migrant communities from across the world and amongst them a relatively large Zimbabwean populace.

The site is a huge dilapidated space comprised of two stories, and was originally a warehouse, situated less than 500 metres from the town centre, making it easily accessible to its patrons. It is managed by a Zimbabwean migrant and has since been open for nearly two years. The amenities there include satellite TV, which provides sports channels, a pool table and board games popular in Zimbabwe such as draughts. A wide range of alcoholic and non- alcoholic drinks are sold in either bottles or cans. Traditional food such as *sadza* and offal are routinely sold at the premises, particularly during busy periods such as when a football match is being shown live. *Sadza* is the Shona word to describe a thickened porridge prepared from any grain with the most commonly used ingredient being white maize meal. Barbeque stands are situated at the end of a driveway that leads to the entrance of the building. A butchery forms part of the premises and patrons can purchase a variety of meat products which can be prepared for consumption at the premises or bought to take away home.

3.7.4 Sampling and Data Collection Procedures

The first phase in the process of selecting and briefing potential participants involved contacting proprietors of Zimbabwean-run social clubs and public houses in the Yorkshire region where Zimbabweans meet for social and recreational purposes. Proprietors of such amenities were identified by my own social network. Initial contact with proprietors was by telephone. During each telephone call, I introduced myself and provided a brief description of the purpose of the research and how I planned to conduct it. If a proprietor expressed willingness to have the research undertaken within their premises, a letter or e-mail explaining the purpose of the research and highlighting consent issues was sent to them (See Appendix 2). The letter or e-mail was accompanied by a 'request for permission return form' that was designed to seek the proprietor's permission to undertake the research within their premises (See Appendix 3). Once the 'request for permission return form' was signed and returned, I then visited the research sites (after an appointment had been made) to formally introduce myself and to further explain the aim of the ethnography and how it would run. On each visit I left participant information sheets for regular patrons (See Appendix 4). I left the information sheets at each of the three research sites for distribution to visiting patrons prior to the data collection. This allowed patrons the opportunity to familiarise themselves with the researcher, the researcher's interest and what both the participant observations and the interviews entailed. A poster was also left at each of the premises indicating my scheduled visits. See appendix 5.

3.7.4.1 Participant Observations

Participant observations were accomplished at the three research settings between March and September 2015. Fieldwork visits to these settings took place at least three times a week, covering days and weekends; and early and late evenings, with the view to capturing a wide spectrum of Zimbabwean migrant lifestyles and preferences.

I observed drinking behaviour as it occurred, including interactions among patrons and other socially constructed attributes which relate to the use of alcohol within the population of interest. Whilst observing and experiencing as a

participant, I continually endeavoured to retain a level of objectivity in order to understand, analyze and explain the social world under study. Each visit took an average of three to four hours during which I repeatedly engaged in conversations with patrons, proprietors and bartenders. In the process of participant observations, I also prepared field-notes for analysis. Topics covered during conversations included the role of alcohol within Zimbabwean diasporic congregations in the UK, its meaning, and how participants constructed the role of these leisure spaces. To capture information arising from the participant observations, and taking into account the nature of the research environment, I utilized a portable computer the size of an I-Pad to collect data. In some cases, particularly in instances where the premises became crowded and there was some underlying evidence of drunkenness, I utilized field-notes to collect data.

3.7.4.2 Interviews

During the process of participant observation, I also carried out informal interviews with patrons. Conversation with participants was either at an individual or group level. I introduced myself as doing a study on alcohol use by Zimbabwean migrants living in the UK. As has already been noted, each visit took on average three to four hours during which I approached a wide range of patrons in an informal way, for example joining into an ongoing conversation about football. My ultimate goal was to capture information related to alcohol use, and other discourses not directly connected to alcohol use as these provided a basis for understanding the population of interest in general, and bring into perspective the socio-cultural orientation of the population of interest. The interviews also included proprietors and bartenders.

As the ethnography ran into its fourth and fifth week, I had identified several key informants who were able to provide some more detailed and focused narratives about alcohol use and Zimbabweans. The interviews were conducted without a formalized interview schedule, however questions asked focused on norms, beliefs, context and behaviour relevant to alcohol use. The questions asked were designed to allow exploration of the respondents' general views regarding alcohol use among Zimbabweans without personalizing the issue, taking into account the

sensitive nature of the subject being studied. An overview of these questions is shown in Appendix 6.

3.8 Ethics

3.8.1 Background

Ethics in ethnographic studies is a complex issue which is heavily debated in many scholarly articles (Tolich and Fitzgerald, 2006; Jokinen *et al.,* 2002). Prior to gaining ethics approval, I held several meetings with my supervisory team as well as other staff members in the Centre of Health and Social Care Research (CHSCR), including the Head of Ethics for CHSCR, to address some of the issues and complexities of conducting ethnographic research in the context of this study. After gaining ethics approval, I continued to have ongoing meetings to address emerging ethical dilemmas with the view to upholding the well-being of my participants. Ethical considerations in the context of this study took into account among other issues, difficulties related to gaining consent, capacity consideration and maintenance of confidentiality when conducting research in an environment where drinking is actively taking place.

Taking into account the complexities related to ethics and ethnographic research, the Ethics Committee requested that I applied for a separate ethics approval to account for some of the anticipated ethical dilemmas related to the ethnographic strand of the MM design. My focus was on developing strategies to navigate through the risks associated with the unknown or emergent aspects typical of ethnographic work. It was important to take into account the fact that the field work involved interacting with potentially inebriated participants. The ethics approval letter for both strands of the MM research is provided in Appendix 7. I now discuss the ethical dilemmas I faced during my fieldwork and will highlight ways in which I made efforts to address these dilemmas. I have focused on the most common ethical issues faced by ethnographers, namely informed consent. However, in the process I have also summarily highlighted my personal experiences of ethical issues related to the researcher-researched relationship, anonymity and confidentiality. I have also focused on the ethical dilemmas of conducting ethnographic research in settings where the consumption of alcohol actively takes place.

3.8.2 Informed Consent

Some researchers have argued that informed consent in ethnographic research is neither achievable nor demonstrable in the terms set by regulatory bodies that take clinical research or biomedical experimentation as their paradigm cases (Murphy Dingwell, 2007). These anticipatory regulatory regimes were developed for governance of clinical and biomedical research, primarily in response to abusive experimentation in Nazi Germany revealed in the Nuremberg Trials (Hazelgrove, 2002; Weindling, 2004) and are not always applicable to ethnographic settings. Tolich and Fitzgerald (2006) argued that the ethics-review processes base their epistemological assumptions aligned with positivistic research, and that they do not always fit qualitative research processes.

Most models of consent in the biomedical ethics literature, and in the regulation and guidelines, identify three key criteria by which the validity of consent might be assessed (Boulton and Parker, 2007). The first of these is that consent is valid only where potential research participants have been provided with all information likely to be relevant to their decision whether or not to participate, and where such information has in fact been understood (Boulton and Parker, 2007). The second criterion for valid consent is that the decision to participate has been made voluntarily, i.e. that it has been free of explicit or implicit coercion (Boulton and Parker, 2007). The third criterion is that to be considered valid such consent has to be given by a person who is competent to do so (Boulton and Parker, 2007). Though not always applicable nor practically possible to achieve in the context of this study, these three criteria formed the guiding principles on which the conduct of my fieldwork was grounded.

To overcome these ethical dilemmas, I developed three levels of gaining informed consent. My first level of consent was that gained from proprietors, which aimed at getting permission to conduct my research in their licenced premises.

Gaining consent at this level was straightforward. The second level of gaining consent involved the use of posters and information leaflets which I left at all study settings some weeks prior to commencing my fieldwork to allow information regarding my research to disseminate to as many patrons as possible. Included in the information sheets was a clear section detailing the right of patrons to raise

any concerns regarding my research. Even though both the posters and information sheets were visibly situated in several strategic areas within the study premises for anyone to see, the difficulty I faced was in determining the level at which this information had been reaching out to its intended audience. The third level of consent, and in my opinion the most challenging of the three, was gaining consent at the individual level. One of the most significant dilemmas I faced during my fieldwork was gaining participant consent in settings where there was a constant movement of people, some regulars, and some visiting for the first time. This dynamic state of affairs was made even more challenging by the fact that some of the visiting patrons were present for hours on end, whilst other patrons were only present at the study settings for a matter of minutes before leaving to go elsewhere. This dynamism created some significant challenges regarding gaining informed consent of participants even though it was clear most of the patrons were willing to participate. I could not be clear to what extent patrons were accessing the information sheets, which is why I had to make it clear at every new interface with a participant that they had a basic knowledge and understanding of what I was doing and that they did not have to participate if they did not wish to.

Unlike other forms of qualitative data collection methods such as focus groups where informed consent can be gained by 'formal' means, gaining consent from every participant in natural settings typical of this study was not practically possible. It was also not always possible to gain verbal consent from participants before my interface with them. It was common for patrons to join their peers in conversations when I was already in the process of interviewing participants. In these circumstances, I felt that stopping the interview process because of consent issues would affect the natural flow of events and arising discourses with the potentials to seriously damage the validity of my findings.

Because of the complex nature of obtaining participant consent within active and dynamic environments involving a continuous movement of people, I had to take the assumption that anyone who wished to share any information regarding my research was in fact consenting. I considered consent as an ongoing continually negotiated and re-negotiated process which occurred as I continued to build trust with patrons over time. Adopting this position required me to constantly make my own personal assessments and judgements on a continual basis to establish if

‘consent’ was being gained. I was well aware that consent is an ongoing process and participants’ willingness to participate may change over time. It was therefore important for me to continually assess the situation by employing my expert insider knowledge of Zimbabwean culture, language, and what I deemed to be socially and ethically in the best interests of everyone involved.

For most, the issue of trust between them (the researched) and I (the researcher) overrode their concerns of participant consent. In fact, it was common for participants to question why it seemed so important to have them understand they had a choice of participating or not participating. This implied that participants’ concern was not in participating but in ensuring that I protected their identities, especially in situations where we would discuss sensitive issues such as immigration problems or drinking and driving. I had this inherent feeling that for most participants, consent to participate or not to participate was a matter of ‘common sense’, and that making such a choice did not necessarily need one to explain. Some participants were open in saying that an overstatement of consent issues was to some extent ‘silly’, and saw it as a matter of common sense. It was common for participants to tell me to ‘just go on with it’ and stop dwelling on what they perceived as unnecessary ‘academic correctness’.

In addition, during my fieldwork, the dilemma I faced was when and how I should disseminate information regarding the nature of my research. When I posed questions regarding the nature of my study in order to assess the level of understanding, some participants would admit that they had seen the information leaflets but did not have the time to go through them in detail. Some would admit that they did not have to read the information sheets because they knew what the research pertained, based on what their peers had informed them. In these circumstances, the dilemma that arises is whether it was ethically right to interview and observe, even though participants were happy to participate based on their own perceptions of understanding. I had to continually remind participants whenever the situation permitted, particularly those who were new to me, that their participation was voluntary. My assessment of whether consent had been gained was obviously subjective, lacked objectivity and lacked clarity because of the presence of many grey areas linked to consent in ethnographic research. Even Dingwell (1980) agrees that there are so many grey areas in ethnography and no clear guidelines as to how issues of consent should be dealt

with. Following on Dingwell's paper, Harriss and Atkinson (2009) argued that current practice of ethical review is itself sociologically and anthropologically impoverished.

3.8.3 Working with drinking/drunk participants.

One of the key areas in ethics is ensuring that participants are well informed of the aims and nature of the research they are being invited to participate. I made the effort to achieve this by using information leaflets as well as discussing this with potential participants prior to the data collection. Though this may sound straightforward, one of the major ethical dilemmas I faced was deciding on the level of detail of the information, which I needed to disseminate to participants. In addition, even if I disseminated information at the right level, there was always a grey area as to whether this amounted to participants' willingness to participate or not. If a participant was visibly inebriated but in control of their faculties, did this imply they required a different level of information when compared to a 'sober' participant? In addition, how was I to judge the extent to which participants were under the influence of alcohol and how this was affecting their level of understanding? The issue of information provision and the level at which it was required was so subjective that each situation required me to make my own personal judgements, grounded in respect of the individual participant. Working as insider in ethnography required me to fit in well with my participants. For this reason, I had to engage in drinking with participants. Questions always arose as to how much I had to drink, when and how often to accept drinks from participants.

The questions I always raised was whether I was the best person to judge participants' capacity to make reasoned decisions and what criteria to use. In addition, even though I had set myself not to use any coercion or undue pressure, my experience with participants was that what constitutes undue pressure or coercion, was always shrouded in subjectivities. Batchelor and Briggs (1994) argued that there are no universal guidelines on how a researcher should behave in these situations when his or her participants are engaged in regular, heavy alcohol consumption. They assumed that each scholar makes their own decisions on the questions raised by these ethical dilemmas.

3.8.4 Maintaining Confidentiality and Anonymity

From my dialog with participants, it appeared that maintenance of confidentiality and anonymity were the more important issues of concern for them rather than informed consent per se. Because participants felt that the British government portrayed drinking in negative terms, I felt that there was an inherent fear among participants of being labelled as deviants or persons of bad character. In fact, some participants I interviewed felt that a perception of Zimbabweans as abusers of alcohol had the potential of damaging Zimbabwean reputation in the eyes of the Home Office. Participants felt that a poor reputation would consequently have the potential of damaging the success of current and future visa applications, therefore making the issue of confidentiality and anonymity a real concern among participants.

Taking into account that some of the Zimbabwean migrants in the UK had fled their country because of political turmoil, it was inevitable that some of my participants would have been asylum seekers and that they needed extra protection due to their vulnerability. Jokinen *et al.*, (2002) argued that the researcher has to respect the informants' humanity and ensure their autonomy, and be sensitive to their expressions and gestures in a reciprocal interaction throughout the research process.

3.8.5 Research dissemination and transparency

Howe (2009) noted that on the one hand, there is a need to transfer knowledge to the academic community, but on the other, this should not occur because of the exploitation of the people under investigation. To promote transparency, I felt that it was important to involve my participants and ensure they were aware of how their contributions went on to influence the academic community. As part of this objective, I invited my key informants of which two managed to attend a Faculty conference where I presented my ethnographic findings. Five other Zimbabweans, three of who had participated in the ethnography also attended the Sheffield Hallam University Health and Sports Conference where I presented a poster. I will also distribute a copy of my thesis to all the ethnography settings and provide information on how they can access the thesis online.

3.8.6 Conclusion

My experiences of ethics in conducting this ethnography clearly demonstrate the need to develop new ethical guidelines for the ethnographic investigation of sensitive subjects such as alcohol consumption. Conducting an ethnography in dynamic environments similar to this study also highlights the implications of folding together the ethical and the empirical in research and supports Parker (2007) that this 'requires the development of new ethico-ethnographic methods for the investigation of ethico-moral objects. Scholarly debates on the complex issue of ethics in ethnographic studies will go a long way in providing evidence on best practice for researchers who may want to investigate drinking in the less understood ethnic populations in the UK, using focused ethnographic methods. My experiences therefore highlight the potential of using negotiational forms of consent by engaging with participants using the concepts of trust, respect, dignity and recognition.

3.9 Methods: Strand 2- Survey

3.9.1 Rationale and theoretical grounding

A survey instrument allowed exploration of the statistical relationship between reported alcohol intake and specified dependent variables. To capture a broad cross section of Zimbabweans living in the UK an on-line questionnaire was used. The questionnaire also allowed findings from the ethnography to be examined in the wider Zimbabwean community.

3.9.2 Survey Instrument

The questionnaire was designed to measure estimates of quantity, frequency and consequences of alcohol consumption, along with potential explanatory variables. Given that alcohol is a very sensitive research subject, complete anonymity was considered a key element in promoting honesty in responses. With limited resources available to the researcher and a dispersed population, an inexpensive method of collecting objective data was required, and an on-line survey fitted this purpose. The survey content was based on validated survey components used in the health and social sciences as well as content derived

from the ethnography. The objective was to design a self-completed survey instrument, worded in such a way it could clearly be understood by respondents.

The survey was piloted with 15 Zimbabwean migrants who live in the UK and five non- Zimbabweans. The 15 Zimbabwean migrants were friends/family of the researcher and selected on the basis of their similarity to the population of interest, and covered a wide range of socio-economic and demographic characteristics. Feedback arising from the pilot study was assessed and used to re-develop the final version of the questionnaire (See Appendix 8) for its launch on 25 October 2015.

3.9.3 Sampling and Data Collection

The strength of any survey lies in its ability to reach as wide the target audience as is possible (Roussel and Touboul, 2011). As postal addresses were not feasibly attainable, postal questionnaires, commonly used in alcohol research and other health and lifestyle surveys were not considered as an option. Survey Monkey (*www.surveymonkey.co.uk/* 2015 version) was used to provide access to the questionnaire via a dedicated web link https://www.surveymonkey.com/r/zim-alcohol. Participants were recruited using a network sampling procedure. Information about this web-link and how to access the questionnaire was distributed using several strategies as described below.

First, the link was distributed via e-mails to key informants who were in turn asked to snowball the link to their own network of Zimbabweans who live in the UK. With the use of internet becoming more and more accessible in Zimbabwean households, the use of an on-line questionnaire distributed through e-mails was considered justifiable. Snowball sampling is a technique that was developed to attempt to include 'hard to reach' and hidden populations (Atkinson and Flint, 2001). The technique relies on a series of referrals that are made within a circle of people who know each other or are loosely connected (Brackertz, 2007).

The key informants are Zimbabweans and were the researcher's family members, friends, work colleagues (both former and current); and former student peers. The researcher ensured that the key informants from these four sources

were varied in their ages, marital status, occupational status and other demographic attributes to further increase the diversity of the sample.

Second, the link was distributed by the same key informants to their Zimbabwean networks across the UK via the 'WhatsApp' mobile app (Version 2.16.60), in a similar fashion to the way e-mails were used. All key informants were kindly asked to forward the link to as many Zimbabweans as they could who met the criteria for inclusion. Given the rising popularity in the use of mobile devices and social media applications, the researcher adopted this mobile phone app to capture a widest possible audience of Zimbabwean migrants. The WhatsApp app is the most commonly used mobile social media software in use by Zimbabweans in the diaspora, and its popularity was augmented by its provision of free text messages and calls, enabling Zimbabwean migrants to have access to their families and friends back in their country of origin, at no cost.

Third, the link was distributed to several Zimbabwean run enterprises and churches popular with Zimbabweans, and to the researcher's current and previous work colleagues in several towns and cities across the UK using printed ''business cards'' with information on how to access the on-line survey.

3.9.4 Outcome measure – Alcohol intake

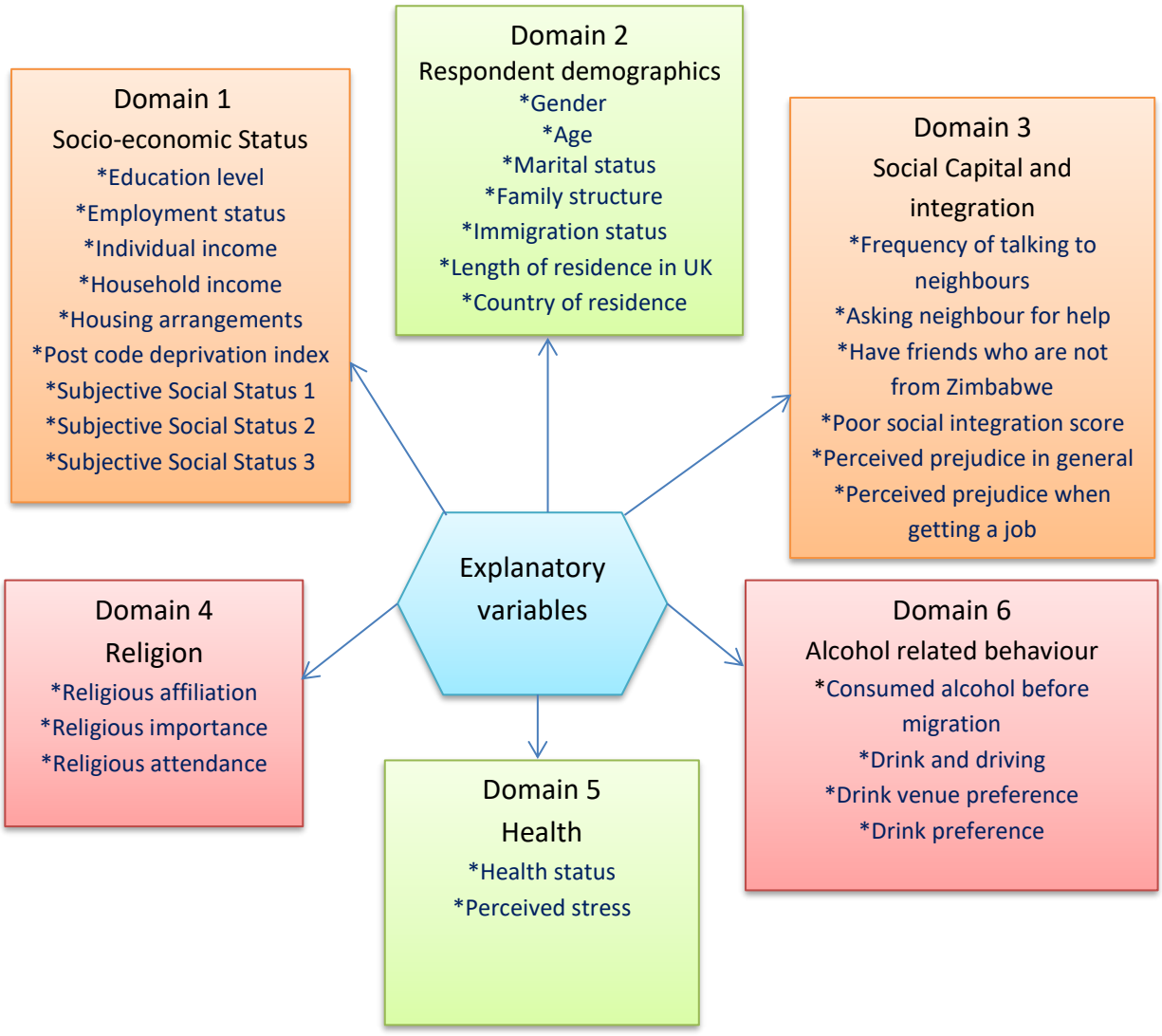
The primary outcome in this study was a composite measure of the quantity, frequency, and consequences of alcohol consumption. The Alcohol Use Disorders Identification Test (AUDIT), a tool developed by the World Health Organization (Babor *et al*., 2001) was asked of respondents who qualified as alcohol users and were immigrants from Zimbabwe. To establish if a respondent qualified as an alcohol user, respondents over the age of 18 were asked if they had consumed alcohol in the last 12 months.

The AUDIT was developed as a simple method of screening for excessive drinking and to assist in brief assessment of alcohol use before alcohol dependence has occurred. It is a 10 item instrument that assesses (1) alcohol consumption level (three items), (2) symptoms of alcohol dependence (three

items), and (3) problems associated with alcohol use (four items). These three components are based on the original domains sampled in the development of the AUDIT and have been confirmed as independent in previous studies (Asbridge *et al.*, 2010). Responses to each item on the AUDIT are rated on a 4-point Likert scale from 0 to 4, which can be summed to a maximum score of 40 to create a continuous index of alcohol use (Pitpitan *et al.,* 2012) with higher AUDIT scores indicating more severe levels of risk. Risk levels (categories) have been created from the AUDIT scores: - a score of 8 or more indicating a tendency to problematic drinking. AUDIT scores were used to classify participants into low/no risk (score = 0-7), increasing risk (8-15), higher risk (16-19) and possible dependence (20+) (Babor *et al.,* 2001).

The survey instrument was designed to capture a range of demographic data and other covariates related to socio-economic and psycho-social factors which are believed to have relevance to alcohol consumption. Figure 5 below shows a visual representation of the explanatory variables grouped into six domains. The following sub-sections provide an overview of all the SES covariates included in the survey.

Figure 5: Visual representation of the explanatory variables grouped into six domains



3.9.5 Explanatory variables

3.9.5.1 Domain 1: Socio Economic Status (SES)

Multiple measures of SES were collected as the socio-economic status of immigrants is difficult to measure as the three usual measures of education; income and occupational prestige are not as strongly correlated as they are in the non-immigrant populations. Also, as noted in the introduction, this is a highly educated cohort that is largely unable to work in the area for which they trained.

Education status was established using a structured question with 7 response options describing different educational levels: no formal education; went to school but did not finish; completed no school no qualifications; completed school with qualifications; further education qualifications; higher education qualifications; and the option 'other- please specify'. This item was adapted from the Measuring Educational Attainment Survey question bank by the Leibniz Institute for the Social Sciences. However, this variable was not regressed due to the low number of respondents in the 'low education category'. In the final analysis, the variable was reduced to two categories, 'lower education' and 'higher education'. The 'lower education' category was comprised of the original categories of 'no formal education'; 'went to school but did not finish'; 'completed no school no qualifications'; 'completed school with qualifications'. The 'higher education' category was comprised of the original categories 'further education qualifications' and 'higher education qualifications'.

Employment status was derived from a series of 12 response options that described different employment situations. The ONS 'Harmonized Concepts and Questions for Social Data Sources' was used to devise this item. The respondent was asked to select as many responses as applied to them. These were: In paid employment-fulltime; In paid employment-part time; Self-employed with employees; Self-employed- working alone without employees; Homemaker; Caring for children or relatives; Unemployed-looking for work; Retired/Pensioner; In education or training; Not working due to illness or incapacity; Volunteer; and the option 'Other' where one was asked to specify. These twelve categories were divided into three, namely 'in paid employment', 'not in paid employment', and 'other/missing' for the final analysis.

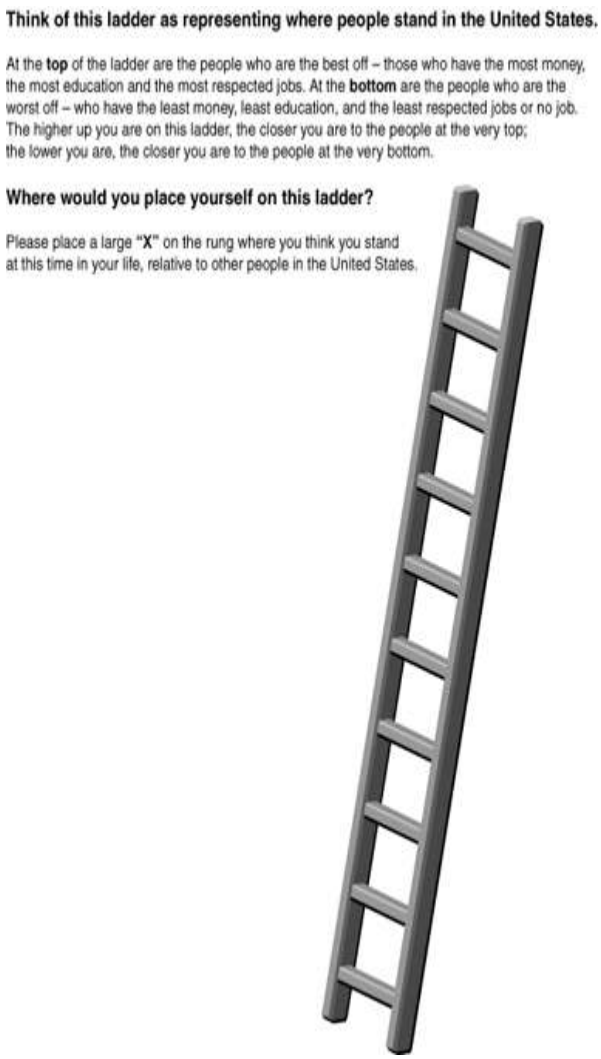
Respondents were asked to choose a category which best corresponded to their individual gross income, and the total gross income of their household. This included pensions, unemployment benefits, and study loans, before any deductions were made for tax, national insurance and/or rent. The ONS 'Harmonized Concepts and Questions for Social Data Sources' was the basis of this item. There were 8 income ranges to choose from ranging from 'under £5 000' to £ '60 000 or more' with an incremental value of £5 000 in between each category. A further option of 'Don't know' was included for those participants that

were not sure. In the final analysis, income was collapsed and measured as a dichotomous variable with respondents reporting if their individual income or total household income was above or below £30 000. Individual income and total household income were analysed separately.

Respondents were asked to choose their housing arrangement from six options which are as follows: Owner occupied, Shared ownership, Housing Association tenant, Local authority, Rent privately; and living with parents/partners/friends. This item was adapted from the Draft Questionnaire for the Survey on Poverty and Social Exclusion. To establish deprivation score, respondents were asked to provide their post code to allow determination of the impact of multiple deprivation scores. Due to poor responses to this question (93% missing), deprivation scores were excluded in the final analysis. Respondents were further asked if they had children under 18, and also the number of people living in their household. This is used to adjust the household income level for the number of people supported.

A section of the questionnaire was designed to elicit information on the subjective social status (SSS) or perceived social status of participants using the MacArthur scale (Adler *et al.,* 2008). This scale was developed to capture respondents' perception of their status in society. In an easy pictorial format shown in Figure 6, the MacArthur scale presents a 'social ladder' and asks respondents to place an 'X' on the rung on which they feel they stand. The ladders were incorporated in this study to assess the contribution of self-reported social status over and above objective measures of SES. In addition to providing a subjective comparison to the objective measures, the ladders also added an element of relative status to the other measures. The anchoring statement was changed for this survey to be less directive in considering what factors should be included in the respondents' assessment of their status. Three versions of the ladder were used. The first elicited the respondent's belief concerning their position on the ladder in relation to the general UK population. The second elicited the respondent's belief concerning their position on the ladder in relation to other Zimbabweans in the UK. And the third and final ladder elicited the respondent's belief concerning the respondent's position on the ladder in relation to other Zimbabweans in the UK. Figure 6 represents the MacArthur scale of Subjective Social Status.

Figure 6: The Original Version of the MacArthur Scale of Subjective Social Status



3.9.5.2 Domain 2: Demographic Characteristics

Gender, age category, marital status, family structure, immigration status, length of stay in the UK, and country of residence in the UK were collected.

Gender was classified as 'male', 'female' and 'prefer not to say' and 'other'. This item was derived from NHS England Diversity monitoring form. In the final analysis, the 'prefer not to say' category was collapsed with 'other' due to the small numbers in both categories. Age was initially categorised as '18-24', '25-34', '35-44', '45-54' and '55 and over'. This item was taken from 'snap survey', a website dedicated to collecting survey demographic information. The '18-24' category had a small number of respondents and hence was combined with the '25-34' category to '18-34' in the final analysis. To establish marital status

respondents were asked to choose from the following: 'single', 'married/civil partner', 'widowed', 'divorced', 'separated'; and 'other- please specify'. This survey item was taken from surveygizmo.com. In the final analysis the categories widowed, divorced and separated were collapsed into one category due to small respondent numbers in each of them. To establish immigration status respondents were asked to choose their immigration status out of the following 5 options: 'Naturalised British', 'Indefinite leave to remain/ Residence Permit', 'Work Permit', 'Student Visa', '5-year asylum/ Refugee visa' and 'other'. This survey item was formulated from the researcher's knowledge of the population of interest. In the final analysis, only 2 categories were used due to low numbers, namely 'Naturalized British/Indefinite leave to remain' and 'Limited leave to remain'. Length of stay in the UK was assessed based on the most recent migration. Respondents were asked how long they have lived in the UK. They were given the following options to choose from; 'less than 5 years', '6-10 years', '11-15 years', and '16 years and over', based on the researcher's knowledge of the migration history of Zimbabweans. The number of years since moving to the UK was included in the analysis as an exogenous variable to estimate the length of the acculturation process. The assumption is that the combined effect of low integration into the host society, low acculturation, and high stress may lead to harmful alcohol consumption. Respondents were also asked to choose the country in the UK in which they were living in. Due to almost all of the respondents choosing England as their country of residence, this variable was not regressed. This item was derived from the Office for National Statistics (ONS).

3.9.5.3 Domain 3: Social Capital and integration

In this study social capital was operationalized by developing questions on the extent to which Zimbabwean migrants participated in their neighbourhood, interacted with their neighbours; and the extent to which they networked with both fellow Zimbabweans and non-Zimbabwean nationals. There is no set and commonly agreed upon definition of social capital, and the particular definition adopted by a study will depend on the discipline and level of investigation (Robinson *et al*., 2002). For the purpose of this study, social capital is about the value of social networks, bonding similar people and bridging between diverse people, with norms of reciprocity (Uslaner, 2001). Inglehart (1997) defined social

capital as a culture of trust and tolerance, in which extensive networks of voluntary associations emerge. Woolcock (1998: p153) defined social capital as the information, trust, and norms of reciprocity inhering in one's social networks.

Two items from the Community Life Survey Questionnaire were used to measure respondents' social capital. Respondents were asked how often they talked to any of their neighbours, and had five options to choose from which are as follows: 'on most days', 'once or twice a week', 'once or twice a month', 'less than once a month' and 'never'. In the final analysis the last two options were collapsed into one due to the low numbers in the 'never' category. Respondents were also asked that 'if suppose you were in bed ill and needed someone, how comfortable are you to send a neighbour to collect your prescription while they did their shopping'. They were given four choices which are as follows: very comfortable, fairly comfortable, fairly uncomfortable, and very uncomfortable. In the final analysis these four items were collapsed into two, namely 'comfortable' and 'uncomfortable' due to low numbers in some of the categories.

The measure of social integration was derived from findings of the ethnography. Clients responded to eight 3 ordered response choices ranging from the degree of adherence to Zimbabwean cultural norms and expectations to the degree to which respondents had adopted mainstream British cultural norms. The list below shows the eight questions used to establish the social integration measure.

1. I find it difficult to develop long lasting friendships with white people
2. I definitely plan to return and settle back in Zimbabwe
3. If I were to die here I would prefer to be buried in Zimbabwe
4. The UK is now my adopted home country
5. I feel more Zimbabwean than British
6. I would prefer my son/daughter to marry a Zimbabwean rather than a white person
7. It would be unacceptable for my son/ daughter to marry a white person
8. I prefer Zimbabwean food to British food

Respondents were asked to choose from three options: 'Yes', 'No' and 'Don't know/ either'. A 'Yes' was coded as 2, a 'No' as 0 and 'Don't know/either' as a 1. An overall poor social integration score was obtained by reverse coding the negative item (item 7) and then summing all the 8 items to provide a social

integration score which ranged from 0 to 16. The higher the score the less socially integrated the respondent was. A factor analysis was conducted using SPSS to look at the inter-correlation between variables and guide the researcher in making decisions about which variables to include in the final analysis.

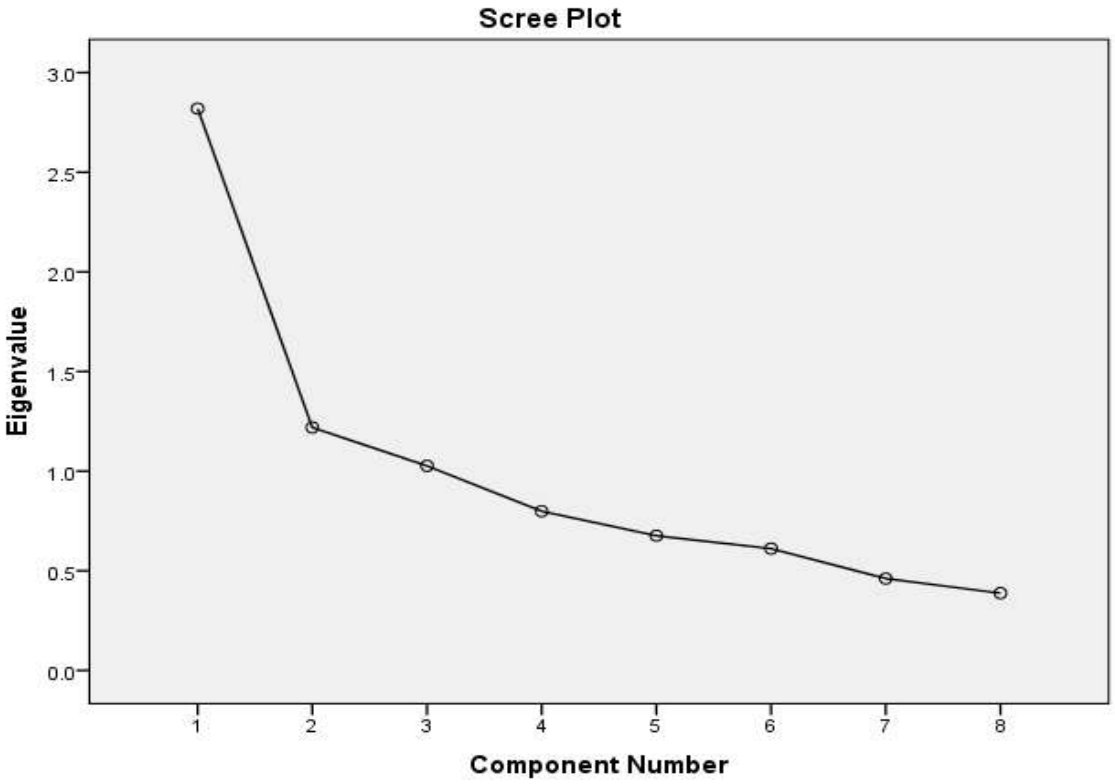
Exploratory factor analysis was used to measure how responses to the eight questions asked related to the ‘social integration’ construct. All eight questions were designed to measure the same underlying dimension of social integration. Hence all the eight questions were included in the analysis as the expectation was that they would all correlate. The factor analysis was run using an orthogonal rotation to create a rotated component matrix of all the eight variables as shown in Figure 7.

Figure 7: Rotated Component Matrix

Component	Questionnaire items	Factor 1	Factor 2	Factor 3
1	I find it difficult to develop long lasting friendships with white people	**0.644**	0.333	-0.029
2	I definitely plan to return and settle back in Zimbabwe	**0.731**	-.0.075	-0.104
3	If I were to die here I would prefer to be buried in Zimbabwe	**0.756**	-0.025	0.229
4	The UK is now my adopted home country	0.233	**0.780**	0.015
5	I feel more Zimbabwean than British	0.328	**-0.667**	-0.059
6	I would prefer my son/daughter to marry a Zimbabwean rather than a white person	**0.712**	-0.098	0.309
7		0.033	0.066	**.0959**
8	It would be unacceptable for my son/ daughter to marry a white person I prefer Zimbabwean food to British food	**0.722**	-0.015	-0.101

SPSS was also asked to produce a scree plot which indicates the point of inflexion and shows the curve to tail off after three factors, thereby justifying the retention of all the three factors. This is shown in Figure 8.

Figure 8: Scree Plot



At this stage, SPSS extracted three factors and the degree of collinearity among and between variables was examined. Highly correlated or perfectly correlated variables cause problems as it becomes impossible to determine the uniqueness of such variables to a factor. The rotated component matrix shows that out of the eight questions under analysis, five loaded cleanly onto factor 1 (i.e. questions 1,2,3,6, and 7). Two of the 8 questions loaded cleanly onto factor 2, (i.e. question 4 and 5). The eighth question (i.e. question 7) loaded highly on factor 3. The five questions that loaded highly on factor 1 all seemed to relate to different aspects of Zimbabwean culture and beliefs. The two questions which loaded highly on factor 2 both seemed to relate to the concept of homesickness and identity. The one question which loaded on factor 3 (i.e. question 7) shared the same content as one of the questions which loaded on factor 1 (i.e. question 6), except for the fact that it was presented on the questionnaire in a negative format. Due to this question having an extremely high q value, (q = 0.959) and for the fact that it shared the same content as question 6 an initial decision was made to discard it. However, before a final decision was made, SPSS was given the command to run a second factor analysis to produce a two-component matrix to determine

how question 7 (which had initially loaded on factor 3) would respond. The two component factor analysis resulted in question 7 loading on factor 2, together with questions 4 and 5, however the loading was very low (q=less than 0.4) and out of sync compared to questions 4 and 5 which remained highly loaded. The other five questions remained cleanly loaded on factor 1. Consequently, question 7 was discarded in the final analysis and the social integration construct was viewed as having two related latent variables, namely 'culture and beliefs', and 'identity and homesickness'. This is shown in Figure 9.

Figure 9: Rotated Component Matrix

Component	Questionnaire items	Factor 1	Factor 2
1	I find it difficult to develop long lasting friendships with white people	0.607	0.316
2	I definitely plan to return and settle back in Zimbabwe	0.724	-0.081
3	If I were to die here I would prefer to be buried in Zimbabwe	0.772	0.109
4	The UK is now my adopted home country	0.163	0.719
5	I feel more Zimbabwean than British	0.380	-0.612
6	I would prefer my son/daughter to marry a Zimbabwean rather than a white person	0.742	0.076
7	It would be unacceptable for my son / daughter to marry a white person	0.108	**0.476**
8	I prefer Zimbabwean food to British food	0.759	-0.024

Perceived racism

Perceived racism, which also is used as a proxy measure of stress, can show the extent to which respondents are integrated, was measured by asking respondents to comment on their feelings and thoughts regarding prejudice and

racism. Perceived racism was measured using the question 'Do you think there is a lot of prejudice in Britain against people of your race?' This item was adapted from the British Social Attitudes Survey. Respondents were asked to choose from four options as to whether they felt there was a lot of prejudice generally speaking, and when it comes to getting a job: The options given are as follows: 'a lot' 'a little' 'hardly any' and 'none'. In the final analysis and for both questions the four categories were dichotomized into 'a lot' and 'less than a lot'.

3.9.5.4 Domain 4: Religiosity

Taking into account the sample size and resource constraints, three measures of religiosity were used in this survey. These were derived from Sethi and Seligman's (1993) Religiousness Measure which incorporates three aspects of religiousness, namely religious influence in daily life, religious involvement, and religious hope. The study used three variables: religious affiliation, religious importance, and religious attendance. Using these three variables is consistent with previous findings that they are associated with both objective and subjective health and wellbeing of individuals and society. In general, religious affiliation, religious attendance and religious importance are positively correlated with wellness and inversely correlated with health-compromising behaviors and illnesses (Koenig, 2012; Seybold and Hill, 2001; Hummer *et al.,* 1999)

When assessing religious affiliation, respondents were asked to choose a category that best described their affiliation with the options: mainstream Christianity, Pentecostal Christianity, African traditional beliefs, not religious at all and 'other'. In the final analysis religious affiliation was collapsed into 'Mainstream Christianity', 'Pentecostal Christianity' and 'other'. 'African Traditional beliefs' and 'not religious at all' were combined with 'other'.

When assessing religious importance, respondents were asked to choose one of the following categories: 'very important', 'somewhat important', 'not really important' and 'not important at all'. Because of small numbers in some categories, the categories 'very important', and 'somewhat important', were collapsed into 'important', and 'not really important' and 'not at all important' combined into 'not important'.

To assess religious attendance respondents were asked how often they attended church or a religious institution. They were asked to choose one option out of nine categories which are as follows: 'Never', 'Less than once a year', 'Less than once a month', 'Once a month', 'Every 2 weeks', 'Once a week', 'More than once a week', and 'Only on special occasions'. 'Less than once a year', 'Less than once a month' and 'Only on special occasions' were combined into 'Rarely'. 'Every 2 weeks' was relabelled as 'Quite often'. 'Once a week' and 'More than once a week' were combined into 'Very often'. 'Never' was left to stand as an independent category. In the final analysis religious attendance was measured using the following categories: 'Never', 'Rarely', Quiet often' and 'Very often'.

3.9.5.5 Domain 5: Health

Health status

Respondents were asked to respond on their perceived general health by using the question: In general, would you say your health is? This was measures using a 5-point Likert response to one of the following options; Excellent; Good; Fair; Poor; and Very Poor. This measure was taken from the SF-12, a commonly utilized, brief assessment of health status (Ware *et al.,* 1996).

Perceived stress

The Perceived Stress Scale-4 Item (PSS-4) was used to measure the levels of stress in the sample population. The scale can be found in an article by Cohen, Kamarck and Murmelstein (1983) entitled 'A global measure of perceived stress'. The scale is composed of four questions which asked respondents about their feelings and thoughts during the last month as listed below.

1. In the last month, how often have you felt that you were unable to control the important things in your life?

2. In the last month, how often have you felt confident about your ability to handle your personal problems?

3. In the last month, how often have you felt that things were going your way?

4. In the last month, how often have you felt difficulties were piling up so high that you could not overcome them?

In each case, respondents were asked to choose from a 5 point-Likert scale how often they felt or thought a certain way, with the following response choices:

0 = Never; 1 = Almost Never; 2 = Sometimes; 3 = Fairly Often; 4 = Very Often

PSS-4 scores were obtained by reverse coding the positive items (2 and 3) and then summing across all 4 items.

3.9.5.6 Domain 6: Alcohol consumption related variables

In addition to the AUDIT, four other items developed from the ethnographic component, related to alcohol use were used in the survey: These were 'drink and driving', 'drink preference', 'drink venue preferences' and 'reason for choosing where they drank'. Respondents were asked if in the last year they had ever driven while intoxicated or rode in a car with a driver who was intoxicated. They were provided with the following options: 'never', 'once in a while', 'often' and 'very often'. Respondents were asked to rank a list of drinks in order of preference, where 1 is the most preferred and 5 the least preferred. The type of drinks respondents were asked to rank were established from the ethnographic findings, and the current UK alcoholic drinks market: 'lager beer', 'wine', 'cider', 'alcopops', and 'spirits'. Respondents were then asked to choose an option that best described where they would prefer to have a drink from the following choices: 'local pub', 'night club', 'Zimbabwean run settings' 'at home' and 'other-please specify'. Respondents were asked to rank their reasons for choosing where they would prefer to drink, where 1 was the most preferred reason and 4 the least preferred out of the following options: 'price', 'atmosphere', 'to meet other people' and 'to meet other Zimbabweans'.

3.10 Data Analysis – Focused Ethnography

3.10.1 Introduction

This study explored the use of alcohol among Zimbabwean migrants who live in one region of the UK. The study utilized focused ethnographic methods of participant observations and informal interviews to explore attitudes, perceptions and beliefs regarding the use of alcohol within this population of interest. The ethnography focussed on three settings where Zimbabwean migrants congregate

for social and recreational purposes. All three settings are situated in a large urban area located within the Yorkshire region of the UK. These three settings offer relatively diverse options for the use of leisure time, and provide opportunities for social discourses on alcohol in a way it relates contextually to Zimbabweans.

A total of 44 participants who were willing to share their stories were interviewed, of which 5 of these were key informants. Participants were identified using judgement sampling in which research subjects are chosen on the basis of the researcher's knowledge of the research population. Judgement sampling is a non-probability sampling technique where the researcher selects units to be sampled based on their knowledge and professional judgement. The main strength of choosing judgement sampling was that no time was wasted and that it gave me the opportunity to use my expertise and knowledge of the population of interest. Johnson *et al.* (2010) argued that one of the most important skills for ethnographers is the ability to enter a field setting, make systematic observations, and hold informal conversations with persons present and screen for persons of interest. In the process of interaction with participants, I gathered data using both a portable computer and paper based field notes, and collated at the end of each visit. I connected and explored patterns across the interconnecting narratives to construct themes that provide insight into attitudes, perceptions and beliefs regarding the use of alcohol by the population of interest and the impact this has on to the individual and the wider community.

3.10.2 Data Analysis Procedure

Braun and Clarke (2006) outlined a series of phases through which researchers must pass in order to produce a thematic analysis. Fielden *et al*., (2011) argued that this procedure of going through a series of phases allows a clear demarcation of thematic analysis, providing researchers with a well-defined explanation of what it is and how it is carried out, whilst maintaining the 'flexibility' tied to its epistemological position. In this study, I have taken a position that acknowledges and incorporates the individual experiences of participants and the meanings they attach to alcohol use. Therefore, I have taken an essentially social constructionist approach that considers both the individual experiences in

constructing meanings attached to alcohol use, and the impact of these meanings to a wider social context. Social constructionism takes the view that all knowledge, and therefore all meaningful reality as such, is contingent upon human practices, being constructed in and out of interaction between human beings and their world, and developed and transmitted within an essentially social context. In the constructionist view, as the word suggests, meaning is not discovered but ‘‘constructed’’ (Crotty, 1998: p 42).

Informed by Braun and Clarke (2006), I used thematic analysis to analyse data arising from the focussed ethnographic field work. Braun and Clarke (2006) defined thematic analysis as ‘‘a method for identifying, analysing and reporting patterns within data’’. Thematic analysis is historically a conventional practice in qualitative research which involves searching through data to identify any recurrent patterns (Braun and Clarke, 2006). Braun and Clarke (2006) have suggested that some qualitative data analysis methods are closely tied to specific theories, however thematic analysis can be employed using any theoretical framework, and through this flexibility is able to allow a rich and detailed description of qualitative data.

3.10.3 Data Transcription

I transcribed field notes from all the three settings in English. I examined the text closely in order to acquire a sense of the various topics embedded in the data, and in the process I made notes on the various issues as they came across.

I read and re-read the transcribed data numerous times, a process called "repeated reading" by Braun and Clarke (2006). This process aimed at increasing "the researcher's closeness with the data" (Fielden *et al.*, 2011). I checked the transcription for accuracy before entering it into Quirkos, a qualitative data analysis software program (Quirkos V1.3). I was careful to remain true to the data and reflect the participants' words. My aim was to retain the context of the interview data, and this "facilitates actually 'hearing' what the data have to say rather than splicing them into arbitrary units before searching for topics, themes or meanings" (Thompson and Barrett, 1997: p60)

3.10.4 Coding

The coding phase involved organizing related data 'items' into categories, or proto-themes using the Quirkos software to aid this process. I chose Quirkos over other packages primarily because it was very new and it had addressed some of the problems of other packages. Quirkos is also relatively simple to use compared to other packages. With Quirkos it is possible to import documents directly from Microsoft word and code these documents easily on screen. Coding stripes can be made visible in the margins of documents so that the researcher can see, at a glance, which codes have been used where. In addition, the time required to become familiar with the package was an important part of this decision making process.

As the data items were being organized into categories, or proto themes, I allowed new categories to emerge freely and existing ones to be modified. Coding involved dividing the text into small units comprising of sentences or small paragraphs. A code is a concept that is given a name that most exactly describes a specific phenomenon. These codes identified features that I considered pertinent to the aim of this study. As is inherent to this data analysis method, the whole data set was given equal attention. This approach ensured that I considered all facets of the data to facilitate the identification of repeated patterns within the data. I used the similarity principle to guide me in searching for and identifying commonalities in the data through a largely inductive process.

The coding was largely data driven because I used the entire data set, giving equal attention to all of its features. As such, the searching for themes was dependent on all the information collected during the fieldwork. Because the coding was largely data driven, I did not identify codes in advance. I collated together extracts from the data set which demonstrated similar patterns within each code and placed them into categories. The coding was open to as many emerging patterns as possible, and if relevant I kept some of the surrounding data on each of the data extracts to maintain context. Some of the data extracts fitted into several categories, or codes, hence I coded them several times into the relevant categories or codes, allowing a more discursive interpretation through cross referencing.

3.10.5 Searching for themes

This phase involved analysing all the coded information in order to identify the initial themes. The process required me to read all the collated extracts which were categorized during the coding phase. The aim was to identify if each of the candidate themes had enough data to support them. Candidate themes that had diverse data were broken down into separate themes and refined whilst those candidate themes that had too little data were either collapsed into related candidate themes or completely disregarded. Braun and Clarke (2006) posited that data within themes should cohere together meaningfully, while there should be clear and identifiable distinctions between themes. Braun and Clarke (2006) also suggested the development of thematic maps to aid the generation of themes. As such these helped me to visualize and consider the links and relationships between themes.

3.10.6 Theme Development and Refinement

A set of five candidate themes emerged based on data extracts which were coded in relation to them. I further analysed all the data extracts that fell within the confines of each of the five candidate themes to ascertain whether the themes held as they were. I concluded that in some respects the thematic map did not exactly fit the data set, and that this required further refining. I made the decision to discard 'benefits and pleasures of drinking' and 'consequences of drinking' and redistribute the feeder sub-themes to the other candidate themes, based on their relevance. The rationale for discarding both of these two candidate themes was due to their very broad and diverse nature and an apparent overlap between their respective sub-themes and the three remaining candidate themes. I refined the candidate theme 'Zimbabwe identity and its preservation' to include the concept of 'social cohesion'. The theme 'stress and coping' held as it was, however, I combined its sub-themes, re-distributed or completely discarded them. At the end of this refinement phase, I was satisfied that the three subsequent themes fitted fairly well together and that they reflected the overall topic on the subjective meaning of alcohol among Zimbabwean migrants living in the UK and the perceived benefits and consequences associated with it. The final phase of

refinement involved renaming the theme 'Identity and social cohesion' to 'Zimbabwean culture and its preservation'. I redeveloped the theme 'stress and coping' to 'stress, coping and social cohesion'. The process of development, re-development and refinement of the themes is shown in Figures 10, 11, 12 and 13. Figure 10 shows the initial thematic mind map which subsequently led to the development of the initial thematic map shown in Figure 11. Figure 12 is a thematic map representing the three re-developed themes. Figure 13 shows a thematic map which shows the final three themes which I believed to be coherent and internally consistent.

Figure 10: Initial theme identification mind map.

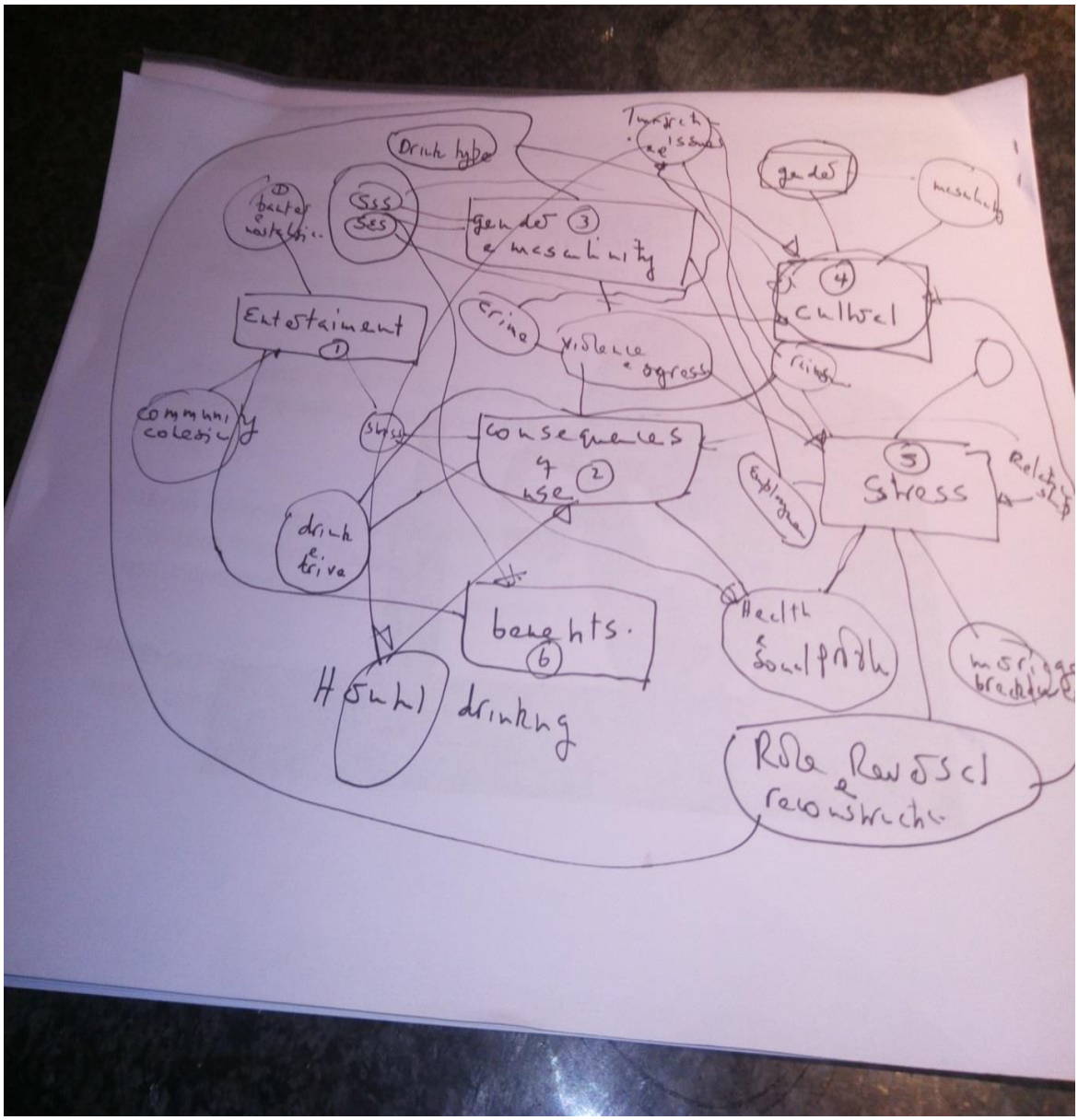


Figure 11: Initial thematic Map, showing five main themes

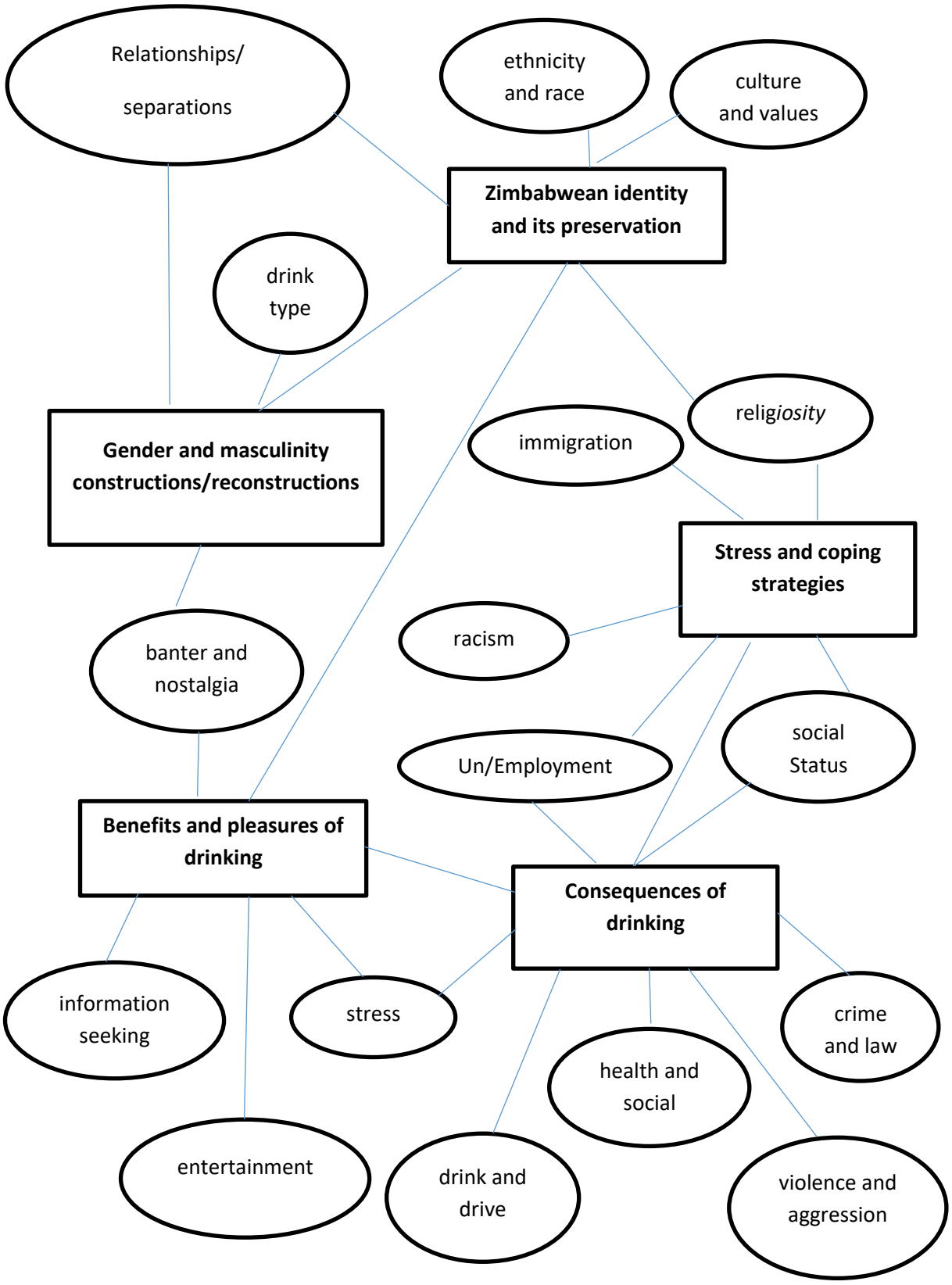


Figure 12: Developed Thematic Map, showing three final themes

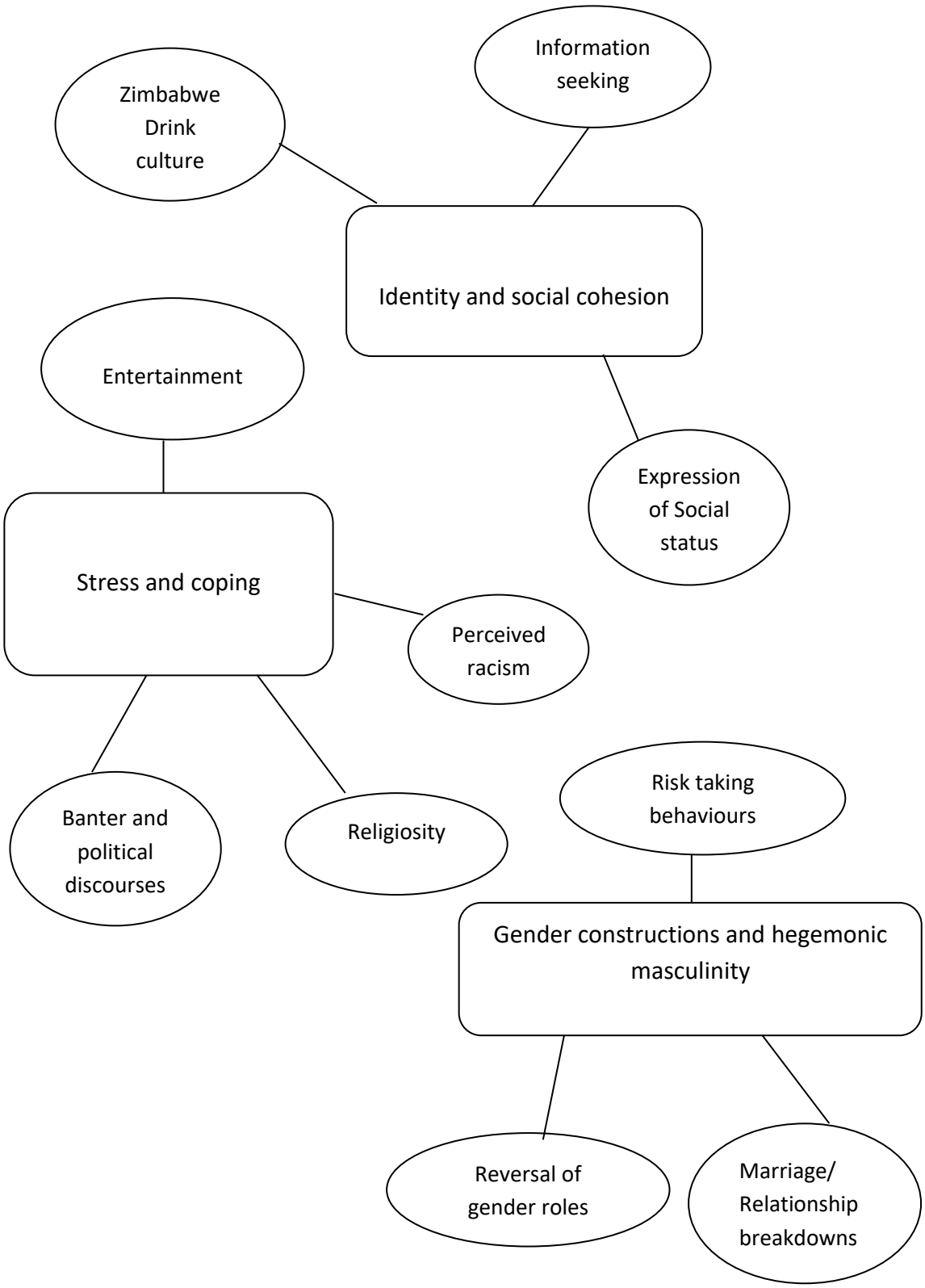
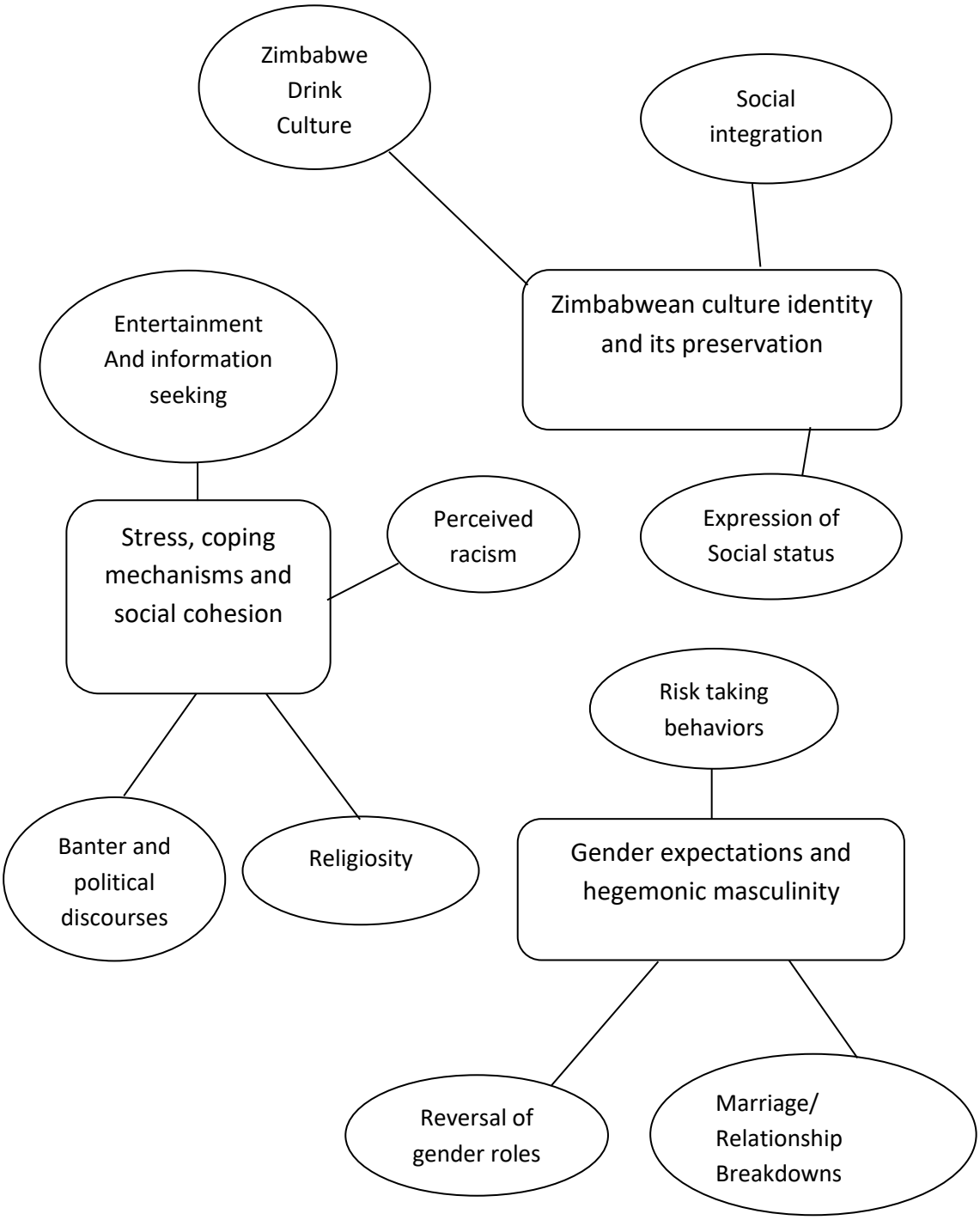


Figure 13: Final Thematic Map, showing three final them



3.11 Data Analysis- Strand 2 -Survey

SPSS version 12 was used to perform exploratory data analysis and descriptive statistics. The crosstab procedure was used to generate the joint frequencies (as percentages) between AUDIT risk levels and the categorical predictor variables. The same procedure was also used to generate the joint means (as a measure of central tendency) and standard deviations (as a measure of dispersion) between all the continuous predictor variables and AUDIT risk levels. A summary of the statistics are presented in Table 5 and Table 6 of the results chapter.

The correlation function was used to examine inter-correlation between variables. This allowed one to see which pairs have the highest correlation and to make decisions on which variables to drop due to high correlation. The diagonal of the table is always a set of ones, because a correlation between a variable and itself is always a one. Table 5 shows the correlation matrix.

Table 5: Correlation matrix

	Risk_F~l	Gende~V3	marStat3	Religi~f	Religi~d	Health~s	Immigr~3	q0002	Percei~l	percei~s	Drink_~e	Comfor~1	q0014	q0012
Risk_Final	1.0000													
Gender_V3	-0.2576 0.0002	1.0000												
marStat3	-0.0488 0.4875	-0.1155 0.0990	1.0000											
Religious_~f	-0.2019 0.0037	0.0942 0.1789	-0.1627 0.0197	1.0000										
Religious_~d	-0.0327 0.6416	0.0974 0.1649	0.1525 0.0291	0.0622 0.3753	1.0000									
Health_sta~s	0.2333 0.0008	-0.0896 0.2012	0.0486 0.4889	-0.1258 0.0722	-0.1457 0.0371	1.0000								
Immigratio~3	0.2421 0.0005	-0.0530 0.4500	0.0135 0.8473	-0.0258 0.7130	-0.0011 0.9877	0.1326 0.0581	1.0000							
q0002	-0.2901 0.0000	0.3971 0.0000	-0.1845 0.0081	0.1875 0.0071	0.0463 0.5095	-0.1521 0.0295	-0.1027 0.1428	1.0000						
Perceived_~l	-0.1438 0.0397	0.1095 0.1180	-0.2253 0.0012	0.1589 0.0228	0.0040 0.9549	-0.0334 0.6341	-0.0874 0.2125	0.0738 0.2929	1.0000					
perceivedp~s	-0.1367 0.0507	0.0434 0.5368	-0.0571 0.4159	0.0539 0.4427	-0.0025 0.9721	0.0448 0.5235	0.0237 0.7358	0.0401 0.5681	0.4619 0.0000	1.0000				
Drink_Drive	-0.0846 0.2277	0.0730 0.2981	0.1239 0.0767	0.2517 0.0003	0.2315 0.0008	-0.0974 0.1649	-0.0074 0.9161	0.3856 0.0000	0.0839 0.2318	-0.0740 0.2916	1.0000			
Comfort_ne~1	0.1427 0.0413	0.0804 0.2518	-0.0424 0.5463	-0.0325 0.6441	-0.0558 0.4266	0.2065 0.0030	0.0851 0.2250	0.0409 0.5601	-0.2244 0.0012	-0.1105 0.1146	0.0595 0.3970	1.0000		
q0014	0.1810 0.0094	0.0607 0.3869	0.0089 0.8994	-0.0441 0.5303	-0.1359 0.0520	0.2996 0.0000	0.2314 0.0008	-0.0845 0.2281	-0.1093 0.1187	-0.0597 0.3952	0.0151 0.8303	0.4929 0.0000	1.0000	
q0012	-0.4537 0.0000	0.2663 0.0001	0.0334 0.6346	0.2012 0.0038	0.2121 0.0023	-0.1747 0.0122	-0.1227 0.0797	0.3788 0.0000	0.0483 0.4912	0.0250 0.7219	0.5396 0.0000	0.0240 0.7324	0.0020 0.9773	1.0000
q0016	0.1027 0.1430	-0.0370 0.5981	0.1408 0.0440	-0.0984 0.1603	-0.0610 0.3852	0.1514 0.0303	-0.0172 0.8062	-0.0524 0.4553	-0.1490 0.0330	-0.1149 0.1009	0.1203 0.0858	0.1820 0.0090	0.2650 0.0001	0.1041 0.1374
q0028	0.1744 0.0124	-0.0290 0.6797	-0.0237 0.7362	0.0352 0.6160	-0.0530 0.4502	0.1470 0.0355	0.2776 0.0001	-0.0683 0.3305	0.0600 0.3924	0.0362 0.6065	0.0006 0.9934	0.0644 0.3592	0.1300 0.0633	-0.0173 0.8055

	q0016	q0028
q0016	1.0000	
q0028	0.1889 0.0067	1.0000

Inferential statistics was used to make judgements of the probability that the observed differences between AUDIT risk levels were dependable ones, or ones that may have just happened by chance. Ordinal logistic regression (OLR) comparing the low/no risk category versus each of the other risk categories was conducted to test for associations with each of the independent variables. Ordinal logistics regression was used in the modelling procedure because the dependent

variable (AUDIT categories) is ordinal in that the AUDIT risk levels are ordered with the real distances between each of the four categories unknown.

The strength of association for each of the independent variables with AUDIT risk levels is expressed as an odds ratio (OR), 95% confidence intervals (CI) and p-values. An OR is a relative measure of risk which tells how more likely it is that someone who is exposed to the factor under study will develop the outcome as compared to someone who is not exposed. An OR is calculated by dividing the odds in group 1 (reference group) by the odds in group 2. For example if you were to calculate the of risk of harmful drinking in males who are over 35 years of age in comparison to males who are 35 years and less (reference group) one gets an OR of 2.00. This means that males over age 35 are twice as likely to engage in harmful drinking compared with males who are age 35 or less. Also, if you were to calculate the risk of harmful drinking in males (reference group) in comparison to females and one gets an OR of 0.70, it would be mean that females are 30% less likely to engage in harmful drinking when compared to males. The confidence interval (CI) is also used alongside the OR to indicate the level of uncertainty around the measure of effect (harmful drinking). OR is statistically significant when the CI does not include 1. Confidence intervals are used in this study because only a small sample of the overall population was recruited and so by having an upper and lower confidence limit it can be inferred that the true population effect lies between these two points. Most studies report the 95% confidence interval (95% CI). In this case, the 95% confidence interval (CI) for the OR of 2.0 with a CI of 1.45,3.80 does not include 1 and so the OR is statistically significant. If the CI did not include 1, it would imply that there is no difference in the risk of harmful drinking between males who are over 35 compared to males who are 35 years and less.

The final model was built in stages. First variables were screened one at a time in OLR. All those which were found to have a screening *p* value of equal to or less than 0.1 were entered together into a logistic regression model. Variables which were found to be the least significant (i.e. greatest *p*-value) were removed one at a time and the model rerun each time. Only statistically significant variables were included in the final model. For verification and cross checking

purposes the removed variables were reverse-tested by entering them into the logistic regression model one at a time, starting with the most significant. The excluded variables were carefully examined before a decision was made to remove them from the regression model. All the regression analysis was conducted in STATA.

3.12 Data Integration

Integration of the qualitative and quantitative data is a key to conducting mixed methods research (Teddlie & Tashakkori, 2009). The integration of quantitative and qualitative data can dramatically enhance the value of mixed methods research (Creswell and Plano Clarke, 2012) with several advantages which can accrue from integrating the two forms of data (Fetters *et al.*, 2013). In this study, the data was integrated at two stages. The first stage of integration was at the design level. Being a sequential exploratory MM design, the intent was to have one phase of the MM study build on the other. In this study, findings from the ethnography were used to develop the questionnaire which was used in the second phase of the MM. At the second stage, findings arising from the focussed ethnography (qualitative stage) level, and the survey were used to make meta-inferences regarding the use of alcohol among Zimbabwean migrants who have settled in the UK. Tashakkori and Teddlie (2008: p 101) describes a meta inference as "an overall conclusion, explanation or understanding developed through and integration of the inferences obtained from the qualitative and quantitative strands of a mixed method study". Quantitative findings were also used to support and/or contradict qualitative findings to show a more holistic picture of the phenomena under study.

3.13 Conclusions

This chapter began by defining the aims and objectives of this study followed by an outline of the rationale for using Mixed Methods (MM), including the philosophical assumptions underpinning this study. The MM research process is separated into a qualitative and a quantitative strand. Included in each of these two strands is a narrative of the philosophical and theoretical perspectives

underpinning the research process, the methods employed in the data collection, the rationale for choosing these methods, and the data analysis procedures employed. Throughout the methodology sections, narratives of the theoretical lenses through which this study is anchored are also discussed and justified.

Chapter 4 presents the ethnographic findings, divided into five sections.

Chapter 4: Qualitative Findings-Focused Ethnography

4.1 Introduction

This study explored themes emerging from narrated accounts of attitudes, motivations, experiences and beliefs shaping alcohol's meaning in UK based Zimbabwean migrants' lives. It further examined how Zimbabwean migrants encounter, express and interpret the social and cultural norms they conceive as constituting their relationship with alcohol in the UK. Some similarities were identified across all three study settings in the reasoning patterns Zimbabwean migrants employed to explain their drinking. Data generated from participant observations was used to further contextualize the themes, identify differences and similarities across the three study settings, and to support the researcher's interpretations. The findings describe the role of Zimbabwean public spaces and alcohol in protecting Zimbabwean migrants from homesickness, isolation and alienation in an environment most perceived as hostile and unwelcoming. Participants threaded narratives between and among issues of gender and masculinity, cultural identity, social cohesion; and stress and coping by constructing frameworks that identified alcohol as playing multiple roles in their lives.

4.2 Overview

At all the three settings studied, regular patrons invariably arrived for drinking and other recreational activities on a daily basis. Drinking was usually from around 4pm into the late hours of the night. A typical evening was rounds of drinks shared among fellow patrons, usually after work or while watching high profile football matches shown live on Sky Sports Channels. Patrons normally stayed together up to the end of the drinking session without adjourning elsewhere for subsequent rounds of drinking. Weekends were significantly busier with some patrons leaving the premises in the early hours of the morning. During weekends, drinking was also infrequently observed as early as mid-day; however, in these circumstances consumption was relatively slow paced and in the voice of participants 'easy going'.

Across all three settings patrons engaged in 'banter', which ranged from discourses on Zimbabwean politics to domestic issues arising in Zimbabwean homes. The atmosphere at all three settings was generally euthymic. Patronage was composed of Zimbabwean migrants from a wide range of socio-economic positions, ranging from professionals to unskilled workers, and to undocumented migrants. Those in employment held occupations in a wide range of sectors such as the healthcare industry whilst some held technical jobs such as in engineering or building.

Despite the wide range of socio-economic positions, the content of conversations was common and independent of social position. The majority of participants across all three settings lived in poor, economically deprived low income neighborhoods; however, a minority described living in the more affluent middle class areas. There was a sense of equity and solidarity among patrons despite the apparent differences in social positions, with the patterns, behaviours and drinking norms exhibiting similarities with the country of origin.

The focussed ethnographic analysis resulted in three themes:

- Gender expectancies and hegemonic masculinity
- Cultural identity and cultural preservation
- Stress management, coping and social cohesion.

4.3 Gender expectancies and hegemonic masculinity

4.3.1 Forging male to male social relationships through banter and drinking

I visited Matute on one Sunday evening in the second week of my fieldwork. This was soon after a football match held between two top English Premier League teams, shown live on Sky Sports TV, There were around fifteen to twenty patrons, all male, mingling in unison as they consumed a variety of lager brands such as Stella, Heineken, Carling and Fosters. There was a heavy smell of burning charcoal and barbequed meat emanating from an outside concrete platform overlooking the main bar and recreational area. Conversations evolved around

Zimbabwean politics, and the new developments with regards to expelled Vice President, Joyce Mujuru, and how the Zimbabwean First Lady was losing support at home.

A male patron, Lazarus, arrived a few minutes after me and warm laughter erupted at the point of his colleagues seeing him. It became apparent that Lazarus and his colleagues had been drinking together at the same site for the last three consecutive evenings. They shook hands vigorously and a conversation erupted about how their drinking was getting out of hand, having been out together for three consecutive days since the Thursday. I took the opportunity to speak to Lazarus as he stood by the bar waiting rather impatiently to be served a round of beer for his colleagues. Whilst I stood next to him, I asked why he so frequently came to Matute. In response to my question, Lazarus gave an insightful account, describing alcohol use as an integral part of his daily life and that of his colleagues and other Zimbabwean males in similar circumstances to him. He described drinking as part of forging and maintaining male friendship, and keeping his connections 'alive'. Lazarus noted:

''After I finish work and before I get home I always come here for a drink and a good laugh. It's the best way to wind down my day with other men, catch up on the latest news about what's happening at home (Zimbabwe) or to just talk about football. You always get to see friends here … and get to know about this and that''

A protracted absence away from other male patrons was interpreted as a sign of pre-meditated disengagement from other men, meaning that male relationships were sustained by frequently seeing each other, with the use of alcohol as a medium for maintaining the male to male relationships. In the late phases of my field work and after a sustained absence from the Rhinos, some of the regular patrons were keen to know why I had been absent for such a protracted period, suggesting that male to male relationships are sustained through a physical presence of other men of the same membership.

In the late phases of my fieldwork, I interviewed David, a recently divorced father of four in his early fifties. David was one of the only few participants I observed

drinking spirits. His preference was Jack Daniels Tennessee whiskey which he would dilute with coca cola. I had met him several weeks earlier, after being introduced to him by Thomas, a male patron who seemed to exhibit alcohol problems as a result of his disinhibited behaviour.

David, who claimed to have worked with Thomas at one of the airports in Zimbabwe, was infamously known by other patrons as never to return rounds of beer. He was also known as never to contribute towards the purchase of meat for barbeque, however he was described by participants as being tolerated by peers on the basis of his age. He was also known to have gone through a marriage breakdown, and that his behaviour was uncharacteristic and most likely to be a consequence of his situation.

I spoke to David who had just finished eating barbequed liver purchased for him by the proprietor. The liver had coloured his entire mouth into a dark unpleasant brown, and as he spoke, some chunks of liver would fly out of his mouth in a way I found disgusting. David was one of those few participants who would approach me and ask if I needed to know anything. He always felt honoured, useful and important during all my encounters with him. Still using his tongue to clean off the chunks of liver gathered on his false top jaw teeth which often fell out of place, David was pleased to share his thoughts with regards to the role of alcohol in forging and maintaining friendships among Zimbabwean men.

‘‘Alcohol unites men. With alcohol men can talk about the important issues, you get advice from other men away from the women…What's the point of drinking from home because drinking is a social thing. You come here to be in the company of other men…I prefer places like this and Zimbabwean gatherings where we can socialise as men… make friends and get to know what’s happening in town…''

As if insinuating his recent experience, he added:

"You can’t be in the house 24hrs. You end up having more and more problems with the wife. So what you do is you leave the wife behind, come here to have a drink with other men so you can get ideas about what's going on …’’

From David's comments, I wondered whether the heavily engrained culture of men leaving their women at home to spend time with other men may in-fact be the reason for causing tensions in matrimonial relationships rather than the drinking itself.

There was this general belief in some male circles that women consult *n'angas* or other sources familiar with black magic to source traditional spells meant to influence the behaviour of their partners when they are in the company of other men away from home. Though Ngoni, one of the few participants in the late sixties light heartedly explained this to me (and I had known about it growing up in Zimbabwe), I had the feeling that this belief ran deep in many Zimbabwean men. For instance, Charles, whom I often spoke to on several occasions during my fieldwork, narrated his belief that women use traditional spells to lure their husbands to get back home before they spend too much on alcohol at the expense of other domestic priorities. Mike also explained that traditional spells cast on men by their women had the power to make men abstain from engaging in outside of marriage relationships with other women. Accompanied with laughter from other men, Charles went on to explain this belief:

"You see; we all know women try all sorts of tricks to get their men to get back home. Some get ingredients sent to them from Zimbabwe to prepare *mushonga* to get it working on their husbands. For example, I know for sure of an African lizard which never leaves the home. It spends its whole day basking in the sun and going round and round the walls of the house. So women get the tail of that lizard, mix it with well-cooked appetizing food. They give the food to their husband…''

At that point, turning the attention on me, Charles added:

" and Professor (meaning myself), once you eat the food you never will leave your wife at home on her own to join us here ever again just like that lizard never leaves the homestead…If she ever choses to use that lizard"

At the Rhinos for instance, late in the night towards the end of my day's fieldwork, I witnessed a case involving a middle aged patron whom I had not met before. His arrival re-enforced what Charles had explained to me regarding the use of *mushonga* by women. An obviously drunk patron welcomed the new arrival by interrogating him as to why he had been absent for so long. He shouted in vernacular:

"Asi wakadyiswa muswe wedzvinyu?!!"

This translates to "were you fed the tail of a lizard?" With an expression of embarrassment, the new arrival proceeded to buy a drink, smirking as he walked towards the inside bar area.

4.3.2 Male perceptions of women drinking in public spaces

At all three study settings, the pervasiveness of alcohol use was invariably male dominated. This was apparent when participants noted the limited opportunities for socializing without alcohol, meaning that alcohol was perceived as a necessary lubricant for the social interactions between and among men. On one of my visits to the Rhinos, I asked Malume, the proprietor, about his thoughts as to why Zimbabwean males seemed to prioritize drinking in the company of other males when socializing. His thoughts to this were simple and plain. Using dry, mocking humour, and having grown up speaking Ndebele, the second most spoken language in Zimbabwe after Shona, Malume's thoughts were that Zimbabwean men copy the behaviours of those before them. Malume described the behaviours of Zimbabwean males as merely a continuation of their behaviours prior to moving to the UK.

Participants across all three settings located men and women in separate spaces with distinct social engagements. In the view of participants, just as norms regarding male and female roles in the household varied widely between the UK and Zimbabwe, so do rules governing Zimbabwean men's and women's drinking in the UK. Based on my observations and the knowledge I have of Zimbabwe, as well as the narratives arising from the numerous conversations with participants,

drinking practices at all three study sites appeared to strongly reflected the norms and values of Zimbabwean history, culture and traditions. Joe, a middle aged male who had been a teacher before moving to the UK was one of the many participants who narrated his sentimental longing and wistful affection of his experiences back in Zimbabwe and how he embraced knowing that there was a place called Matute which resembled a place he used to go for drinking fifteen years earlier. Joe noted:

"Every Saturday and Sunday, we used to play football with teams from elsewhere, even as far as Kwekwe. Then after a match we would got to a place like Mereki where we would buy beers and have barbequed meat with the visiting team. There would be no females whatsoever, so we always spoke what we liked. For that reason, I wouldn't got to Weatherspoon even though the beer might be cheaper there. I would rather come here because it reminds me of Mereki, the things that happen here… and I can meet new friends who might help me one day…"

My question to participants as to why they did not bring their partners or wives for an afternoon or evening of drinking was met with ridicule. For instance, in the third week of my field work I had become close to Gary, who frequented Wenera and with whom we both often bought each other a beer. It was a fairly quiet evening typical of Mondays. Gary was sat around a fire with three other males, who like him were drinking bottled Stella lager. I asked him how long he had been at the site of which he shyly admitted to having started drinking since 3pm, making it nearly four hours of drinking. Soon after my arrival, I bought a 'round' of drinks for the five of us, an expensive round for me but worth spending. Knowing well that he was married, I asked Gary opportunistically why I had never seen him in the company of his wife. His three colleagues waited for his response in anticipation and curiosity, smiling at him as he contemplated how best to put his answer across to me. He stated:

''That would be a silly thing to do. The reason why I come here in the first place is to be away from her (wife). If I have to bring her with me, it means I'm going to be with her 24 hours… And all the gossip, the vulgar stories… the pornographic video clips we share on our phones, you don't want your wife to know that"

Laughter erupted soon after Gary's comments, seemingly in agreement. One of Gary's colleagues, whom I later knew to be Richard, and who appeared intrigued by Gary's comment interjected the conversation by adding that changes were taking place within Zimbabwean circles with regards to alcohol use by women albeit a continued re-enforcement of alcohol uses as a masculine activity. Richard remarked:

"Gone are the days when it was taboo for decent women to be seen drinking in public. It is common to see Zimbabwean women drinking openly now. But the problem is they can't handle drink… it makes them do stupid things"

One of Gary's other colleagues whom I later knew to be Barnabas and who was the quietest of the four gave further insight into how Zimbabwean males perceived women drinking publicly in the company of males. In comparison to others, his comments were slightly liberal with regards to women drinking in public in the company of men. Looking sleep deprived, he noted:

''Decent African women do not come into places like this at this time of the day. It's okay in the afternoon if they have someone else with them, like a friend or a relative"

What I found interesting was the term 'decent' which in the view of Barnabas and other participants whom I interviewed following this encounter, meant that women who drink in public in the company of males, was seen by men in a different light. Barnabas and other participants located 'decent' women as fitting in the 'home' environment, or at church.

Men's consumption of beer with other men was discreetly encouraged while the drinking of beer by women, particularly so in the company of other men was viewed negatively, suggesting the symbolic recognition by males of gender-based expectancies of drinking. All the participants I interviewed viewed the unwritten rules governing restrictions of alcohol use by women in public spaces as embedded in Zimbabwean culture. Contrary to the numerous negative views I had heard from male participants about women drinking in public in the company of other men, Irene appeared notably comfortable in the company of men. She

wore heavy make-up which in the view of Zimbabweans can be perceived as suggesting a sex worker, or a woman of loose morals. She spoke in a loud rustling voice consistent with a seasoned drinker. She also appeared well known among the male dominated patronage and despite being a minority; Irene spoke in confidence when articulating her thoughts and appeared well respected amongst the company of men:

"As a woman growing up in Zimbabwe, I was strongly discouraged from drinking. This was the case with many of my friends and relatives. Though perceptions about drinking are changing, still most men relate women who drink in public as a *hure*. I don't care what others think really because I know who I am. My husband lets me come here so what could be the problem?"

As she spoke about how her own husband would allow her to go out for drinks, I could see the male patrons present shyly avoiding eye contact with each other, suggesting some degree of embarrassment on the part of the men as to why a normal husband would let their wife visit such a place. Irene further remarked that drinking by females in her culture was tolerated more, though unfairly, for women who had past child bearing age.

"If you visit our village and you go out to drink at the traditional bar or at a hosting homestead, it's common to see women in their 50s to 70s drinking the traditional beer. Up to now my mother still does drink so long as she has my father with her. It's not a problem at all. You never see the younger women there; it's always the women that can't bear children anymore."

There was a general agreement among the male patronage to Irene's remark, with those present reflecting upon their past. Most participants I interviewed held very strong views regarding drinking in public in the company of their own women, by stressing that this had the potential to bring unnecessary tensions and frictions among men with the risk of disrupting peace and the natural order of drinking practice. Lazarus, my best guess at 24 years of age, and notably young relative to other patrons, noted:

"Bringing my wife here? What for? I don't see the point and it's never going to happen. I wouldn't like to see your wife here as well (referring to the researcher). It will cause the obvious problems, if you know what I mean. Not in this kind of place"

During my ninth week in the field I was introduced to Maria by Malume, the Rhinos' proprietor. Maria, an occasional female patron at the Rhinos, and arguably gifted at what she did, always brought with her 'imported goods' for sale, such as aftershaves, sun-glasses, watches and other tailor-made merchandise for men. I met Maria again a few weeks later; on a quiet Wednesday afternoon. She vividly illustrated the negative portrayal of women coming to drink in public and her yearning for change in attitudes to female drinkers. The following was her remark:

''I would love to come here with my female friends who regularly visit me from London, because it can get boring having drinks from my house. But I can't bring them out here because when Zimbabwean men see a group of females having drinks in the same place as them, their first impression will be that we are prostitutes hunting for men… The attention is all on you, some good and some bad. But you wish you could be able to enjoy the open space with your mates and not get judged in that way….''

Following up on this, I had the opportunity to interview Cephas; a male patron in his late 30s who regularly visited Matute. In his view, Cephas perceived the domination of drinking by males in Zimbabwean public spaces as signifying an element of insecurity among men. In Cephas' view, the most demeaning experience that could happen to a Zimbabwean man is the embarrassment of their wife forging a relationship with a fellow Zimbabwean. When giving his account, Cephas felt that the safest way to avoid such embarrassment was to locate women well away from the company of other men. He noted:

"I trust my wife so much but I would never bring her to this place, there's no point. Where beer is involved can create unnecessary problems. You know our Thomas for example. He can get really drunk sometimes and what would I do if he or one of these guys slaps my wife's bum right in my face. I would rather she carries on going to her

church…She doesn't drink anyway but if she were to drink I'd prefer this takes place at home or with her own friends…"

In the extremely isolated cases where men brought their wives/partners, it would be for non-drinking purposes and for very brief periods. In these instances, it was common to see other men keeping notable distances away from the female guests. Topic of conversation would also instantly change and men would become more reserved in their demeanours. Cephas' views drew clear similarities with those of other male participants who described the content of discourses taking place as unpalatable to the 'decent female' and young children, and the patterns of behaviour unsuitable for the opposite sex and children. These views clearly justified in the participants' views why women should be excluded. However, contrary to Cephas' fears, it was negatively portrayed and regarded as severely disrespectful for a man to publicly even insinuate interest in another man's partner.

On many occasions I observed patrons either getting dropped or picked up at the study settings by their spouses. In such circumstances, the female spouses invariably abstained from entering the male dominated settings as if there was a rule governing that behaviour. Spouses normally communicated via mobile phone to inform their partners of their arriving time, and in some cases they would send their children to let their father know of their presence. Cephas added on his thoughts with his experience in London:

"Nigerians, unlike Zimbabweans, go out with their women even late into the night. I used to like going to this place in London which is owned by a Zimbabwean who is married to a Nigerian woman. Nigerians liked going there and there would be loads of Zimbabwean men there too. It started to create problems especially late at night when Zimbabwean men would start chatting Nigerian women. You know how Zimbabwean men think… they see a woman drinking in a bar and they start insinuating its easy prey…. [laughter]"

4.3.3 Commensality as a common cultural practice among Zimbabwean males

During my seventh week of fieldwork, on a Saturday evening at Matute, I met Fungai, a male in his mid-forties. Preceding this meeting I had held several conversations with Fungai on various issues related to this study. I had developed a fairly close relationship with him owing to the fact that we shared the same totem called *mhofu.* (A totem is a spirit being, sacred object, or symbol that serves as an emblem of a group of people, such as a family, clan, lineage, or tribe). Based on this common ground, Fungai took me as his own brother. He invited me to join him have some barbequed beef which his colleagues had finished preparing, and just about to be shared amongst a group of five men. I gathered that all the five men present had contributed some money towards the purchase, amounting to fifteen pounds' worth of the meat. All except one of the five men were having medium strength lager from cans, with the other sipping some bottled water. The other man later remarked that he had been drinking till the early hours of the morning and felt that it was a good idea to re-hydrate before he could start on alcohol:

"Always make sure you have plenty of water either during the night or before you start drinking. Also make sure you always have something to eat no matter how small. I won't start drinking till I have had some meat and *sadza*. … Otherwise you end up developing ulcers"

Being a warm sunny day, about eight other patrons were also stood outside, either around or close to the large barbeque stand, made out of a rusty drum, roughly constructed onto four steel legs. Another smaller group of three men and a woman were waiting for space on the barbeque stand so they could start preparing their own meat. With some slight guilt, for not having contributed anything towards the purchase of the meat, we all started to eat. I noted that none of the men, including myself had washed their hands prior to eating; however, no one seemed fazed by this and all were careful to only pick what they would consume. The meat was heavily salted and in my opinion overcooked and near to being burnt. Despite my observation, everyone appeared to enjoy the meal. As we ate, and having noted the presence of a female patron, I took the opportunity to ask Fungai why they were so few female patrons. Chewing a chunk of meat

whilst at the same time rearranging the already prepared meat back onto the fire to warm it before continuing to consume, Fungai made his point heard.

''Going to church is more a social event rather than a belief in God for women…. This is where most Zimbabwean women spend their time to socialise away from home. They can't be seen here … or in pubs because they don't fit.''

The female patron, whom I later got to know as Irene, was drinking a bottled medium strength lager, which had just been bought for her by one of the male patrons present. Based on my observations, this was a rare occurrence to see a woman drinking lager. In the sixteen weeks spent in the field, it was only on three occasions that I had the opportunity to observe and converse with female patrons drinking in the company of men. In light of this, it was a good opportunity to participate in conversation with regards to perceptions and norms about female drinking in the company of men, from the point of view of a woman who drinks. Fungai, who already knew Irene, invited her to join us in the conversation we were having by introducing me as a professor from Sheffield University. She appeared keen to join us, showing a specific interest in me, which raised eyebrows amongst other male patrons. Fungai left the group to buy a further round of lager which included Irene and myself. In the absence of Fungai, Irene, sounding academic, spoke about an article she had read on a Zimbabwean blog which reported Zimbabwean women as among the top most drinkers in Africa. She remarked that she did not entirely agree with the report, by adding that Zimbabwean women in this country were mostly church going. Fungai, on the other hand had agreed with the notion of Zimbabwean women being involved in church activities and attending church more often than men, both in Zimbabwe and the UK. However, he described engaging in church activities as not meaning the absence of alcohol consumption among Zimbabwean women in the UK. He gave an account of two women he had met in a night club in one large city not far from the study setting:

"You see a lot of young women some even as young as 18 or 19 in night clubs. I bumped into 2 in a night club whom I go to the same church with. They tried to 'hide' but I had already seen them and they had seen me too. So at Church we just pretend as if we

never saw each other. So don't be fooled by anyone who says they go to church and then you think they do not drink. They just don't drink in places they think other church members might go to….. You find a lot of Zimbabweans leading two lives.''

4.3.4 Male perceptions of gender roles in Zimbabwean homes

In the second week of my field visits, and late on a Saturday night at Matute, I met Mike, Ernest and Russell who were considering whether to order another round of beers when I joined them for a chat. I knew the three as regular patrons who frequented all three study settings. I had particularly developed a close relationship with Mike, who in the proceeding 14 or so weeks of the ethnography had become one of my key informants. I excused myself from a round of beer on the false premise that I was driving of which Mike insisted that one drink would not do me any harm. Mike instantly bought us a round of beers, including myself, asserting that it was his last for the day as he had to get home to be with the kids in view his wife working a night shift which he said commenced at 10pm. Sat on high stools with beers placed in between our laps, which is typical of drivers who drink while driving in Zimbabwe, I took the opportunity to continue on a topic regarding gender roles in the Zimbabwean homes to establish if the three agreed with the view of participants I had spoken to at the other sites that congregation of males in Zimbabwean spaces played a compensatory role for the loss of status in the household due to a reversal in gender roles. In the process of serving the extremely chilled bottled beers to Ernest and Russell, Mike was the first to air his views and thoughts:

''Look what the pound has done to us now. There's no respect from our women anymore… The way it used to be like back home. Women have now taken control of our homes. In many Zimbabwean homes you find that men now have to cook and do the dishes afterwards to keep their relationships working. Like now I have to leave and Paula (wife) expects me to have done the dishes before she gets back tomorrow. As for me coming here for a drink with other men brings fond memories… It makes me feel like a man again just being around other men''

Ernest, who stated that he had worked as a banker in Zimbabwe after graduating with a degree in Business Studies from the University of Zimbabwe, and who now

worked as a support worker in a nursing home while also doing his Master's degree in Banking and Finance, in the hope of securing 'a more decent job' expanded on Mike's views by adding that in contrast to pre-immigration life in Zimbabwe where most men of working age were invariably breadwinners, the situation in many Zimbabwean homes in the UK was the reverse. He spoke with a degree of emotion about how the current situation had brought immense problems in many Zimbabwean homes. Ernest, expressing some conviction in the way he spoke, conveyed his point strongly:

''I was so content with my life in Zimbabwe, earning six thousand dollars a month. That was in the in the early 90s… a house with a swimming pool and a house maid even though my wife wasn't working at that time. I would have my kids picked up from school by junior work colleagues and get them dropped home. But now look where we have found ourselves''

Because of this reversal in gender roles portrayed by Ernest, informal *dares* often took place where males debated on matters such as matrimonial problems arising in Zimbabwean homes. Following up on this topic, I interviewed Edward at Wenera, on a fairly busy Saturday afternoon, among other participants who were present. Edward had just celebrated his fiftieth birthday the previous week. He described at length how places like Wenera, in his view, played a positive role in promoting and providing solace to men whose marriages or relationships had either collapsed or were on the brink of collapse. In Edward's view, and in the view of the other male participants, matrimonial problems arising in many Zimbabwean homes were a direct consequence of the migrant experience. Edward noted:

''So many Zimbabweans divorce in this country. I guess everyone present here has a friend or a relative whose marriage has fallen apart. Just because women forget what their role is…They feel equal to or above their men simply because they earn the same or have the same job …. it's all gone wrong…. I never heard of a divorce them days back in Zimbabwe. It's gone crazy"

Just by listening to the conversations among patrons, I gathered recurrent narratives shared among men about their experiences of gender reversals taking place in Zimbabwean homes such as women telling their husbands to pack their bags and leave the home, experiences they felt were unheard of in Zimbabwe. Based on my own experience in Zimbabwe, it is the woman who leaves the home with the children in the event of a separation taking place. In the view of male participants, drinking in the company of other men was interpreted as the natural way of socializing and learning from the experience of other men.

It was common practice for men to buy further rounds for their peers without them having to ask for consent. On many occasions I observed patrons drinking for longer periods than planned. It was common for patrons to explain themselves well and show assertiveness when declining offers of drinks for fear of being negatively interpreted as disrespectful, or as disregarding genuine gestures of masculine patriotism. Many participants I spoke to described buying for each other, and very often in 'rounds', as an essential part of the social processes. This often led to men finding it difficult to leave as they felt obliged to return the round which in many cases led to excessive drinking. Those that made the effort to 'run away from the round' prematurely were at the least ridiculed by other men. Speaking to Simon made this clear:

"Buying in rounds is a good idea because it keeps all of us together. No one is left out of what's happening. But it has its problems as well. You cannot just leave without returning the 'round' because you feel obliged. Then sometimes you want your round returned because you can lose out. It becomes a domino effect if you know what I mean"

Across all three settings I often noted some patrons having to be bought beers by others in view of them not being able to afford. Buying beer for other men who could not afford was constructed as a means of fostering male friendships and as a form of collateral for the buying person, in case of future financial hardships. Simon conceded that financial resources for the purchasing of alcohol were not always available. He found buying for others in the 'good times' the sensible thing to do as a guarantee of supply during the 'bad times'. James, a respectable patron at Matute, the eldest I had met and a pensioner in his late sixties was able to explain this to me further. James was always at Matute invariably every time

that I had been there. He would arrive more or less at around six in the evening with a folded newspaper roughly placed in his jacket pocket. He would offer me a drink virtually every time we met. I also observed that he was quite charitable in this respect and often bought others without the expectation to be returned the round. I also noted that he always had a stool reserved for him as a sign of respect by the younger men. He spoke in vernacular and used a Shona proverb I was also familiar with to explain his charitable behaviour.

"Natsa kwawabva nekuti kwaunoenda husiku"

Translated to English this meant that one had to be good to others because where one is heading is all darkness. James strongly felt that men had to look after each other. He also gave an account of how long back during the pre-colonial era in Zimbabwe men would go hunting in groups. He explained that the meat was shared equally among the men without taking into account who had made the most kills.

4.3.5 The role of gender and masculinity on drink choice

Lager and very rarely spirits were the choice of alcoholic beverage. Lager was clearly constructed by Zimbabwean men as the drink for men, with the consumption of wine associated with women. In fact, in the sixteen weeks spent in the field, at no occasion did I observe any of my patrons drinking wine. Based on my observation, I was keen to understand more why this was the case. Tinashe, a male patron, reinforced the constructions and expectancies regarding drink choice. He described the role of lager and its consumption as a masculine activity. He noted:

"You don't expect to see women drinking lager but wine is fine. Lager is a men's drink. It doesn't look good to see a Zimbabwean woman having a lager. Just check the fridges behind the bar. You will not see any wine in stock. In any case it's not expected to see women coming here to drink anyway''

In very isolated cases I observed some men such as David to consume spirits. Though still interpreted as masculine to drink whisky or brandy, the consumption of spirits was constructed by participants negatively, as a sign of ‘‘irresponsibility, alcoholism, or disregard of one’s physical health’’. Ernest, whom I had had several conversations with when he was in the company of Mike explained this to me:

“The good thing about drinking lager is you can get to mingle with others for as long as you want. That’s the whole idea of getting together for a drink…Not with spirits. Imagine drinking Jack Daniels every single day like *Mudhar Diva*. That’s a really bad sign, drinking that way….”

The consumption of cider and alcopops was non-existent at all the three study settings. Participants described both types of beverages as having been non-existent on the Zimbabwean market prior to their immigration to the UK. For instance, James explained his experiences in Zimbabwe and why Zimbabwean men preferred lager as their choice:

"I never heard of alcopops before coming here. Cider…? Yes, I knew there was a beer called cider but never saw it anywhere in Zimbabwe. You probably could have got it in the posh hotels like Sheraton or Monomotapa."

Most of the patrons were observed drinking normal strength lager, with the majority preferring it very cold and some even near to freezing. One participant described this as a ‘home character’, meaning drinkers in Zimbabwe preferred their drinks very cold. Across all three settings, the most commonly observed choice of canned lager was almost invariably Fosters, followed by Carling and Stella Artois, with alcohol contents of 4%, 4.0% and 4.8% respectively. However, a sizeable number of patrons preferred the more expensive bottled brands such as Heineken, with a slightly higher alcohol content of 5%. The consumption of alcopops and cider was invariably absent, a norm which was consistent with modern Zimbabwean drinking culture. Cider and alcopops were not part of Zimbabwe’s share of the beverage market prior to the recent wave of Zimbabwean migration to countries such as the UK, following the unprecedented political turmoil and collapse of the Zimbabwean economy. On the day I met

Lazarus, I also met Mike for probably the eighth time since the start of my fieldwork. He was in the company of someone I later knew to be a medical professional. Mike had this to say:

‘‘I remember Fosters as the first imported canned lager in Zimbabwe… Canned lager became very popular in the 90’s in Zimbabwe and only those with good money could afford them. We brought the idea of drinking Fosters to the UK. Stella is also very popular especially for those that used to drink Castle lager back home in them days. They say Stella has the same taste as our Castle lager. We have always been a lager people…It is cultural to drink lager.

4.3.6 Male perceptions regarding exercise of control after drinking

Male participants perceived remaining in control as a desirable quality and loss of it as a cause of undesirable consequences. As Ernest had explained earlier on, the drinking of low strength lagers meant that men remained in control in order to enhance the sociability of drinking. However, loss of control was deemed a necessary 'evil' in some circumstances. For example, some participants felt that losing some degree of control during events such weddings and secular family celebrations was in many ways acceptable as this made the occasions more fun. Overall, a lack of relative demonstration of control of the mental effects of alcohol in the company of other men was demonised and is labelled in Zimbabwean lingo as *marambadoro*, while being able to drink large quantities over a period of time and remaining sober was treated with respect. Men made comments in respect of how much a colleague the previous night had drunk so much but managed to remain sober. I went to Matute one of the days after most patrons had been away on a football match with a Zimbabwean team from a nearby town. Patrons who had been to the tournament were chatting with bravado about how so much they had drunk and all managed to get home safely. I found Ronnie's account interesting:

"I had an uncle called Ernest. He died within an hour after being stung by a scorpion. Long back in the 80s I always used to spend time with him on weekends. He would drink

all day…a whole case of beer on his own and he would drive like he had never touched any alcohol. It really used to amaze me how he did it. But just at the point of getting to the gates of his house, once he has parked he would then fall asleep on the car seat. You just had to leave him there because there was no way you could wake him up"

Participants I spoke to expected each other to walk without staggering, to drive home responsibly after a drinking session, and to converse intelligibly and engage in debates in a skilful and sober manner while drinking, meaning that demonstrating these attributes promoted one's masculinity. This was in sharp contrast to some participants I interviewed in relation to attitudes about women drinking. They viewed self-control by women who drink in public in the company of other men as a normative moral imperative. Males particularly expressed negative attitudes to females who failed to retain some control while drinking in public. The striking feature of this view is the close link between drinking culture and the conflict surrounding gender expectancies of drinking. During the late phases of my fieldwork, I went to Wenera as a closing visit. There had been a local music festival which I later gathered was an annual event. Patrons who had spent time at the festival were reflecting on the event, some of them in negative terms about how women of all ages would be laid on the pavements without shoes and some on their vomit. One of the patrons whom I had met for the first time in sixteen weeks narrated his experiences to a few others gathered around a barbeque.

"I had never seen anything like that, women everywhere staggering on the streets not caring about cars coming. Some holding each other and walking in groups without a care… without shoes, their clothing ripped, with bottles of wine. You would think you're watching a movie. So deplorable for women to do that…. Mugabe will kill them all, not in Zimbabwe ''

With the history of Zimbabwe pointing to the legacy of male dominance in both public and private spheres and the exercise of control in the household by males, Zimbabwean men who have settled in the UK have and continue to experience cultural conflicts as a result of reversals in gender roles taking place in Zimbabwean homes in the UK. Thus, Zimbabwean men have had to cope with the changes taking place in the hostland by using public spaces as protected time

to express their masculinity through social and recreational activities reminiscent of their experiences in Zimbabwe prior to immigration. Both the interviews and participant observations which took place at all three study settings revealed alcohol use as playing a pivotal role in the constructions and reconstructions taking place in the UK with regards to gendered identities among Zimbabwean migrants. Across all study settings, this ethnography revealed Zimbabwean males as having strong connections and attachments to Zimbabwe and identified alcohol as playing multiple roles in their lives as Zimbabwean migrants.

4.4 Cultural identity and cultural preservation

The cultural context of drinking refers to the ideas, attitudes, social relations and behavior that are related to drinking and shared by individuals in a cultural group. Contrary to the dominant belief in the field of epidemiology where alcohol is heavily medicalised and considered a hazardous psychoactive agent, this ethnography revealed alcohol not just as a social problem, but equally as culturally valued. Participants I spoke to at all the three settings revealed a unique and complex network of culturally driven interactive behaviours, attitudes, and perceptions towards the use of alcohol as Zimbabwean migrants.

4.4.1 Drinking as a culturally defined social activity

I interviewed Moses, a forty-two-year-old man, at the Rhinos one cold Friday evening. I had known Moses for several weeks after initially meeting him at Matute during the early phases of my fieldwork when he claimed to have just moved from the south of England to be closer to his family. He was very keen to share his experiences about Zimbabweans who live in the UK. Moses, with a 'full of I know' character and in a reflective tone, claimed to have managed a small business of his own which was involved in the shipping of household goods and other merchandise to Zimbabwe. Without explaining in full detail, he stated that he had problems with Inland Revenue which led to him having to close his business. Moses described the use of alcohol by Zimbabweans who have settled in the UK as a social activity bound by a shared drinking history dating back to the pre- immigration Zimbabwean era. Among several of his narratives about Zimbabwean drinking behaviour, Moses associated drinking among

Zimbabweans with specific cultural factors, norms and expectancies in the context of a Zimbabwean culture. He gave this account for instance:

"The way we use alcohol is quiet unique. I can easily tell whether a person or a party is Zimbabwean simply by observing drinking behaviour."

When asked to expatiate, Moses continued with his thoughts:

"We like our beer with barbequed meat on the side, the two go hand in hand. And we like our beer very cold, near to freezing. Zambians don't mind warm beer for example. Beer is a men's thing and that's why you don't see women here. They can have some wine once in a while at home… that's fine. Nigerians like to drink with women around them buying expensive brandy and wearing fancy clothes. Zimbabweans don't dress up to go for a drink the way Nigerians do, Zimbabweans are more laid back when it comes to drinking. I can go on forever…."

Participants described drinking culture in the UK as a continuation of Zimbabwean pre-immigration drinking practice, with a specific recognizable Zimbabwean identity. From the view of participants, drinking among Zimbabwean migrants is governed by unwritten culturally driven rules which prescribe what and how much is drunk, in what circumstances and manner, and with what effects. Overall, participants across all study settings described positive culturally driven beliefs and expectancies about alcohol. An account by Tendai was insightful.

"Our whole culture involves alcohol in some way. Whether it's a traditional wedding ceremony, a village exorcism or a traditional thanks giving exercise at harvest time, beer is always used as a ceremonial medium. In modern times drinking is part of any celebratory activity, even at funerals. It's been like this for generations"

4.4.2 Comparing Zimbabwean drinking to the hostland

One specific question posed to participants was how they saw Zimbabwean drinking culture as different or similar to that of the hostland. A wide array of accounts was noted across all three settings. Participants described what I believed were clear differences between them and their hosts in the motives for drinking, the nature of drinking and the benefits or consequences of it. Common among participants' beliefs regarding alcohol use was that Zimbabwean drinking in the UK and elsewhere is a communal largely peaceful activity. This belief was supported by my observations at all the three study settings where Zimbabwean drinking appeared to be largely peaceful and harmonious. Tendai, and other participants alike, described the Zimbabwean drinking culture in this way, contrary to the British way of drinking which they associated with violent and anti-social behaviour. Cashton, a key informant and the proprietor of Matute, summed this belief:

"Beer doesn't make us violent the way it does to the British…the way I see in this country. Yes, we become noisy when drinking but not in an aggressive and intimidating way. And we may have our own internal scuffles sometimes but by nature we are a peaceful people. At another site I manage, I have not had a single problem with the Police in 7 years since I've been running the place''

Some participants gave accounts of 'British' drinking as notably solitary, an observation they described as rare in Zimbabwean circles. Among other participants, Timothy noted that 'British' drinking was avidly one of extreme drunkenness, especially so during weekends and month-ends. Participants also described British drinking as commonly non-communal, that it occurred across a wide range of settings and that it was usually well planned in advance. Even though most of my participants admitted to Zimbabwean migrants occasionally consuming alcohol to intoxication, Timothy noted that in contrast to the British, Zimbabwean inebriation was largely 'controlled' and the behaviors emanating from the inebriation usually kept 'within check'.

Timothy stated:

"We're different because we use beer as a way of communication. For us drinking is a social activity. That's why men find it pointless to drink from home unless you have visitors. And so if you to drink to socialize and to have a laugh and the like…. Yeah it's okay to get drunk but you got to control it and not become an idiot in the company of others"

Discourses arising from those that regularly visit Zimbabwe were marred with negativity about of how the drinking culture has changed in modern day Zimbabwe. They construed the changes taking place as a direct consequence of the ongoing political and economic crisis in Zimbabwe. Gari, a single male in his early thirties, was one of the participants I knew who regularly went to Zimbabwe. When I saw him at Wenera, for probably the fifth time in eight weeks, Gari had just arrived back from Zimbabwe after four weeks of absence. I could easily tell he had been to a hot country such as Zimbabwe in view of the dramatic change in the colour of his skin. Showing other patrons and myself pictures from his Samsung mobile phone, Gari spoke with regret about how ordinary Zimbabweans had started to import cheap illicit spirits and cough syrups from neighbouring countries in order to get drunk. Several other men stood in close proximity to Gari, curiously looking at the images on his phone which showed deteriorating infrastructure in Zimbabwe, with expressions of shock on their faces. After re-convening the discussion on alcohol use, one of the patrons I had not met before but who seemed well known by the other patrons commented that the changes taking place in Zimbabwe contradicted and defeated the cultural purpose for drinking, the way he conceived it. With an expression of disgust, he went on to add that the role of alcohol in shaping the Zimbabwean identity had been getting quickly eroded in the last few years due to changes taking place on the socio-political scene in Zimbabwe. Gari, after placing his phone back into his pocket, made an interesting point when he made the comparison between the drinking cultures of Zimbabwean migrants in the UK with that of Zimbabweans in their homeland. He described the drinking culture of Zimbabwean migrants as remaining consistent with pre-immigration Zimbabwean expectancies, traditions and attitudes towards alcohol.

''If you talk to anyone who has been back to Zimbabwe to visit they'll tell you the situation is sad. You find bars all over the place, everywhere. If a new building is not a bar it will be a church. People drinking to forget their worries, cough syrups, cheap home brews… you name it… It was never the case in the 90s. Drinking then was always a social thing …not to bury your troubles. I guess we have carried on the way we used to drink before we came here because this kind of drinking was unheard of"

4.4.3 Drink and driving among Zimbabwean migrants

Participants also expressed notably positive accounts about British drinkers, for example when it came to respect of the law with regards to driving under the influence of alcohol by their use of taxis when going out drinking. Every single participant I interviewed on this matter agreed that cases of drink and driving among Zimbabwean migrants were rampant in the UK. Majoni, a middle aged man of about fifty, gave valuable insight into the problem of drink and driving among Zimbabwean migrants in the UK. Having a soft drink on the day of the interview, which I felt was out of character for him, Majoni described disrespect of the law by Zimbabwean migrants with regards to drinking and driving. He viewed it as a culturally motivated behaviour with Zimbabwe as its point of origin. Amidst laughter, he described an account of his experience in Highfield prior to moving to the UK. Highfield is the second oldest high-density suburb or township in Harare, Zimbabwe built to house Rhodesians of African origin, the first being Mbare. It is of historical, cultural and political significance to Zimbabwe and is known as *Fiyo* in local slang. Known to other patrons at the Rhino as the 'Proud son of *Fiyo'* Majoni noted:

"This reminds me of my days in Harare in the late 90s when, one day, I was drinking alcohol in Highfield with two junior policemen. After drinking together, they asked me to drive them home though I was equally plastered with alcohol like them"

In the weeks to follow I met Tendai at Wenera in the mid-term of my fieldwork. Tendai, who also claimed to have been born and raised in Highfield, was always willing to provide information on any matter related to my study. He agreed with

Majoni's view that drink and driving was a culturally driven behaviour engrained in Zimbabwean culture. Tendai remarked with confidence:

''Drink and driving is normal in our culture. That's why it's a big problem among us in the UK. My father used to drive us after drinking plenty. It was normal to us. My brother and two sisters would sit in the back of the car and my mother in the front''

Another patron whom I later knew to be Manu and sitting next to Tendai joined the conversation. He agreed that drink and driving was a serious issue among Zimbabwean migrants. An Engineering student at a local university, Manu, like Tendai, held my study in high regard. He was impressed of the fact that a fellow Zimbabwean was in the process of studying for a PhD, and in that respect, he felt that his contribution to my interviews about the various issues pertaining to alcohol was a duty for a fellow countryman rather than a choice. Like several other participants I had spoken to on this matter, Manu felt that drink and driving had caused significant problems for many Zimbabwean migrants, with some ending up in prison, or being deported back to Zimbabwe. He admitted to having been a drink driver himself and claimed he knew several Zimbabweans, including women, who had fallen victim of this. Manu was of the belief that drinking and driving is a culturally driven behaviour learned through generations of exposure to it. He also conferred to having driven his family under the influence of alcohol while still living in Zimbabwe:

''When I was in Zimbabwe I used to drive my family after drinking six or seven pints but they never considered me as an irresponsible father, but here if you're caught drink and drinking, you are perceived as the worst of the worst"

Some patrons also described the changes in attitudes about drink and driving among Zimbabwean migrants. The pervasiveness of driving while under the influence of alcohol was viewed by most patrons as being significantly less compared to the early years of settlement into the UK. Manu's thoughts were congruent with several other participants I had interviewed:

''Zimbabweans are now changing. It was bad the number of people being caught drinking and driving but it's not as bad now…. Most of us have learnt the hard way that this is not Zimbabwe where you can get away with it''

In reflection, some participants found the funny side of things when narrating accounts of their experiences with police as a result of driving while intoxicated. Mike, for example, spoke with both delight and regret of an incident involving him driving down the motorway 'dead drunk' and having to be chased by a helicopter after patrol cars had failed to catch him. He described abandoning his car and eventually being caught in nearby fields, of which ended up getting a six-month prison term. Most participants, however, felt that lessons had to be learnt about Zimbabwean attitudes towards drink and driving in view of the switch in cultural expectancies in the UK of driving while intoxicated. Jackson, a male participant in his early 50s concluded the discussion to the agreement of others stood around him. He noted:

''Just getting a taxi like the British do would be cheaper in the long run, compared to being caught drunk while driving and then ending up having to lose everything you have worked so hard for''

4.4.4 Defining problematic drinking in the context of Zimbabwean culture

Participants commonly perceived alcoholics in negative terms. Problematic drinkers were described by participants as persons of weak character, persons who drank to excess at the wrong time, at inappropriate occasions, and for the wrong reasons. Participants, like William whom I had had lengthy conversations with on various occasions also described alcoholics as persons who failed to keep their family, employment, and matrimonial commitments. He and other participants across all three study settings generally perceived alcoholics as careless persons who disregarded family values and the values of their community in the context of Zimbabwean cultural norms and expectancies. William summed up the perception of Zimbabweans on problematic drinking by describing in his view the differences between responsible and irresponsible drinking:

"You can drink every day the way you like. As long as you continue to go to work, you look after your family by making sure they have food on their plates, you are a responsible drinker. As long as you drink and not cause problems in your community such as fighting, then you don't have alcohol problems"

In his view, William regarded alcohol use as a medium for social engagement. By providing similar accounts to other participants such as Ernest, William portrayed 'moderate alcohol use' in positive terms, even if this happened on a daily basis. He described it as an enjoyable activity which connected Zimbabweans in the UK and other Zimbabwean diaspora communities and by allowing the forging, preservation and perpetuation of Zimbabwean cultural identity, and in the process serving to promote interpersonal and social bonds.

On the basis of accounts provided by William and Ernest I was keen to further explore how other participants perceived excessive drinking and what this meant in the context of Zimbabwean cultural expectancies. I arranged to meet Tafi (who had become one of my key participants) at Matute on his return from a pool competition in a city about sixty miles to the South of the study setting. Like most Saturday evenings, Matute was extremely busy despite the cold breezy weather typical of the UK autumn season. The barbeques appeared freshly lighted. A group of patrons had been waiting patiently in the cold to have the charcoal set before they could start grilling their meat. Beef, ox kidney, chicken wings and occasionally cow intestines were the usual choice. Patrons were drinking the usual brands of lager, which were invariably Heineken, Stella Artois, Carling, and Fosters, in either cans or bottles. Tafi, though a heavy drinker by my standards, portrayed heavy drinking in negative terms unless it occurred during special occasions such as weddings, birthday parties and some anniversaries of high perceived stature. An eloquent, well-spoken and highly educated man, Tafi described with detail how alcohol use had always culturally been a social activity. He explained that even during periods of moaning, relatives and friends of the deceased still consumed alcohol as a social activity, with both the level of consumption and alcohol related behaviour subject to self-imposed social controls. Tafi remarked:

"A funeral is not a funeral without beer. Mourners would leave. Or imagine going to a wedding without beer… Everyone sober and sat on chairs throughout the occasion. That's unheard of. Zimbabwean social gatherings whether here or in Zimbabwe have to have beer. Even meetings by leaders of groups such as burial societies are done with beer. Anything that brings Zimbabweans together involves drinking…. apart from church off-course."

At all the three study settings, participants felt that overall Zimbabwean migrants consumed alcohol responsibly and within generally acceptable levels. In the view of participants, responsible drinking was based on one being able to carry out one's normal family and matrimonial expectations, and abstaining from the consumption of brands with high alcohol content such as brandy and whisky. The majority of participants agreed to the view that as long as one is reasonably able to look after their children and the extended family back home in Zimbabwe and one behaved in public in a way perceived to be socially acceptable, one could not reasonably be construed as neither being irresponsible with alcohol nor experiencing alcohol problems, even if the drinking is copious and on a daily basis. When I asked Malume about his thoughts, this is what he had to say:

"You can drink every day. It doesn't matter. Like a lot of Zimbabwean men, I drink nearly every day. My son is in university now and I give him 150 pounds every single month on top of his bursary. You open my fridge and it's packed with food and nobody at home complains. I send home at least 100 pounds every single month"

Despite the general view of what constitutes responsible drinking, my observation of drinking quantities by many of my participants was way above the UK guidelines on responsible drinking. The following is an excerpt of an interview I conducted to establish the perception of my participants as to how they viewed binge drinking.

Walter: Have you heard of the term binge drinking?

Ronnie: Yeah, I always read about it

Walter: How do you understand it?

Ronnie: It has to do with drinking beer one after the other at a very fast pace. Like seven bottles in an hour.

Walter: So if you drink seven bottles in say three hours when you come here, would you call that binge drinking?

Ronnie: You cannot say that's binge drinking because seven drinks in a three hours while you… that's kind of slow and normal.

Most participants did not 'buy' the concept of binge drinking (defined in a public health context as consuming 6 or more drinks on one occasion) as harmful to their physical health. Rather, what they considered harmful to one's physical health was the consumption of alcohol in quick succession and on an empty stomach. Such mode of drinking was also perceived as defeating the sociability of drinking in terms of forging the Zimbabwean identity. Steady consumption of alcohol was encouraged to allow interactions among each other and to enhance the sociability of drinking. Poor health was not spontaneously referred to by participants when discussing the consequences of drinking to excess, as again the consequences of excessive drinking was viewed as impacting on the social rather than the physical.

From the view of participants, drunken behaviour at the wrong time and in the wrong spaces was socially disapproved of in that it reflected a lack of sharing of both resources and time. In light of these common constructions, drinking of normal strength lager was portrayed in positive terms, because it encouraged peers to have more time to interact with each other due to its low alcohol content. This was also consistent with participants' perceptions of Zimbabwean migrants' drinking culture which placed drinking as both a necessity and a choice which allowed patrons (man in particular) to forge and preserve their social connections, and to individually or collectively embrace strategies in response to challenges faced in their households.

Participants across all three settings, such as Aaron for example, described finding it difficult to express their concerns to those they felt were experiencing alcohol problems. He described the cultural barriers men faced regarding coming out in the open about their problems with alcohol. Aaron noted the culturally driven issues affecting man from opening up about their alcohol problems, from the angle of seeking for help:

''It's very difficult to tell someone they have problems with alcohol. It's very difficult, especially when they're older than you and they are not doing harm to others. I think it's embarrassing too…You have to leave it for someone very close to them. And it's extremely unusual in our culture for a man to come out in the open if they have problems with alcohol.''

4.4.5 The symbolic meanings of sharing through drinking

Participants portrayed drinking in isolation as anti-social, while some perceived it as an indicator of alcoholism. Based on my own knowledge, alcohol in Sub-Saharan Africa is traditionally consumed as a communal activity. Consumption of alcohol was traditionally shared amongst several people and drunk from the same vessel; meaning that the practice of drinking in isolation is considered outside of cultural expectations. At all three study settings, sharing was symbolized in several ways such as the consumption of similar types of lager brand. This concept of sharing was also symbolized by consuming meat from the same plate by groups of patrons and by listening to Zimbabwean music. Social interactions through drinking were perceived by many as a necessary lubricant for the social bonding process among patrons. The reciprocal sharing of resources was constructed as a way of establishing interpersonal and social bonds. John's view was that sharing of the drinking experience is embodied in Zimbabwean culture. He felt that not only are there cultural expectancies regarding sharing the drinking experience but that the sharing should be integrated through banter exchange and friendliness. John cited the late Chinua Achebe, a prolific Nigerian author, as having said:

''A man who calls his kinsmen to a feast does not do so to redeem them from starving. They all have food in their own houses. When we gather together in the moonlight village ground, it is not because of the moon. Every man can see it in his own compound. We come together because it is good for kinsmen to do so. Let us find time to come together physically and enjoy the power of togetherness…''

John, who described having read Chinua Achebe for his 'A' level qualifications, and was confident in citing the author verbatim, felt that the drinking experience

should be enjoyed in a communal sense as did those 'long dead'. John further explained that traditional rituals in Zimbabwe such as *bira* and *maricho* involved the communal sharing of alcohol with those present, and with the ancestors. Sharing with the ancestors was symbolized by the pouring of alcohol into the ground. *Bira* is an all-night ritual, celebrated by Shona people in which members of an extended family call on ancestral spirits for guidance and intercession. Though I knew of this practice from my time growing up in Zimbabwe, I was eager to get the perceptions of participants about what this meant. One Sunday afternoon, during the final phases of my fieldwork, I had the opportunity to discuss among other matters the symbolic meaning of pouring beer into the ground with Cashton, Matute's proprietor. It was an unusually quiet day, with just three other patrons who were all unfamiliar to me. Though of African origin, I could easily tell the other two men were not from Zimbabwe, based on the way they were dressed, the way they spoke English and their complexion etc. I was later informed that most of my participants had gone a few hours earlier to see a fellow patron who had lost his father, to pay their respects. While I sat by the bar opposite him, and him behind the bar, Cashton went on to explain that attendees at ceremonies such as *bira* participate in singing, dancing and hand clapping. He further explained:

"In ceremonies like *bira,* music that was favoured by the ancestors when they were alive is used to summon the spirits to possess living mediums; thus the religious belief system helps to preserve older musical practices. In line with common Zimbabwean traditional rituals, alcohol is poured into the ground as a symbol of sharing and a libation to the dead before drinking amongst those present can take place. If you visit the modern towns and cities of Zimbabwe where drinking is also largely communal, it's common to see drinkers pouring their first drop of alcohol into the ground as a libation to the ancestral spirits"

It was at Matute that I witnessed a patron pour beer into the ground in the way Cashton explained it. It was also common to hear patrons at all the study settings laugh and shout with joy in the event of fellow patrons accidentally dropping their drink. Such accidents were interpreted by patrons as a symbol of the dead yearning to have their own share of alcohol.

Participants described peers who have the habit of accepting drinks from others without returning the gesture in negative terms. They perceived it as anti-social and as defeating the purpose of patriotism as dictated in Zimbabwean culture. Liberty's account was notable.

"We have to buy in rounds. A round also has to include others that may not have money on the day. But it shouldn't be habit to let others keep buying you a drink. You have to sacrifice to return the round even when times are hard for you."

Similarly, buying meat for barbeques was on a communal basis. Financial contributions for the purchasing of meat were on a voluntary basis with each person contributing what they could. This symbolized patriotism, based on the common understanding by patrons that each day of their migrant lives had mixed fortunes and was 'unpredictable'. Participants described having barbeques while consuming alcohol as reflecting Zimbabwean drinking culture.

Drinking on an empty stomach was strongly advised against, and at its worst constructed as sheer disrespect of one's health. It was common for patrons to request the barbeques to be lit in advance, in preparation for afternoons or evenings of drinking. This, in the description of participants, symbolized the unwritten rule that alcohol use should be accompanied by the consumption of barbequed meat. The meat, almost invariably beef, often heavily salted and very well done was consumed communally either prior to or during drinking. Lazarus, whom I had initially met at Matute during the second week of my fieldwork, summed up these beliefs. He was keen to inform me that he was last at Matute more than four weeks earlier and had since been frequenting Wenera instead. He added that he had moved to drinking at Wenera because Cashton had refused to serve him anything alcoholic because of his drunken behaviours. Lazarus had this to say:

"In our culture you can't separate beer from meat…. whether it's at a funeral or at a wedding… or just a family get together…and beer and meat can only be enjoyed through sharing. No one person should enjoy more than the other. Like I don't expect you to buy

a portion of meat here, barbeque it on your own and then start eating without asking others…It's wrong to do that"

In the milieu of all the processes and discourses resulting through alcohol use, communal status played a leading role in influencing behaviour, and controlling behaviour that was deemed anti-social in a Zimbabwean context. For example, during one of my visits at the Rhinos, an extremely drunk Zimbabwean male arrived near to midnight. Despite coercing his friend to buy him a drink, an elderly patron who was usually reserved a seat at Matute made it a point that he was not served anything alcoholic. I later gathered from other patrons that the drunken man did flooring, carpeting and wall decorations for Zimbabweans on cash-in-hand basis and that he would be available to do work for me if needed. I also gathered from fellow patrons during my follow-up visits that the drunken man was called Liberty and he had been struggling to maintain a job in mainstream industry because of recurring mental health issues. From my observations, Liberty was still well respected and welcomed by other patrons despite experiencing chronic mental health problems.

At both Matute and Rhinos it was common to find patrons in their late fifties and even some in their sixties. Respect for older patrons by the younger generations was the social norm. At these settings it was common practice for the younger patrons to offer their seats to their elder peers in situations when the older patrons arrived late and seats were limited.

Across the three study settings, both the interviews and participant observations revealed alcohol as a socially and culturally valued commodity. Participants I spoke to at all the three settings revealed a unique and complex network of culturally driven practices expressed through food, banter, music, and alcohol use. Overall, Zimbabweans used the three study settings as platforms to express culturally driven norms, behaviours and practices reminiscent of their pre-immigration beliefs and experiences with alcohol.

4.5 Stress management, coping and social cohesion.

Zimbabwe's protracted economic crisis of the late 90's to early 00's led to the migration of hundreds of thousands of Zimbabweans to the UK in pursuit of refuge, jobs and education. The pattern of migration to the UK was very age-specific, with the majority of migrants being young to middle aged adults settling in through various legal and extra-legal strategies. Unlike other migrant groups who have settled in the UK, participants across all three study settings viewed their initial migration to the UK as a temporary economic necessity caused by the political turmoil in Zimbabwe, rather than a permanent 'laying down of roots'.

4.5.1 Experiences with UK Immigration officials is a key stressor

Though a sensitive subject to discuss, most participants described having gone through the asylum application process to obtain their residence status in the UK. As my relationship with participants developed so did their revelations of experiences with immigration become more vivid and in my view authentic. On one of my visits to Matute I had the opportunity to interview Tony, a middle aged builder of about forty years of age, meaning that he must have been about twenty-five years of age at the time of migration based on my previous conversations with him when he conferred that he came to the UK in 2001. Tony, a keen pool player who often organised tournaments for patrons at Matute to compete with teams from other nearby UK based Zimbabwean communities, was with three other men, one of whom I had known as Matthew. When I arrived, Tony was in a heated debate about the authenticity of a Honduran herbalist called Dr Sebi regarding his claims that he could cure AIDS, blindness, epilepsy and other serious ailments. At the end of the debate, which had gone on for over 30 minutes and had attracted several other patrons, I had the opportunity to interview Tony at his invitation and as a follow up to earlier conversations we had had on immigration and stress. I bought Tony a drink, on the basis that he had bought me one the last time we met and had then declined a return of my 'round' saying he was in a hurry to pick up his wife from work. Tony explained:

"I came here on a visitor's visa end of 2001, living with my sister in London. They gave me 6 months stay. I thought I would work and work and work! In those 6 months till I

drop, go back home and buy a plot of land to do some farming. Then you could hear stories on the news and from friends and family of Zimbabwe getting really bad, no jobs, people dying of HIV, no food in the shops…no petrol…..Then I thought what's the point of going back. So I claimed asylum and got my stay 2 years later."

Tony's account resonated across all the three study settings. I also heard participants who reported having friends and relatives still waiting for decisions on their asylum applications. Some participants also gave accounts that they were still waiting for their spouses or children to join them in the UK on the basis of family re-union under the United Nations Convention of Human Rights. Participants felt that the uncertainty surrounding the asylum application process which can take 'several years' to obtain eventual refugee status caused significant stresses in their lives. Matthew, a middle aged man, who had just been engaged in a debate with Tony about Dr Sebi, dressed in a camouflage and wearing sunglasses indoors, also described his experience:

"I only got my refugee visa in 2010, after waiting for nearly 8 years. I had to report to Home Office once a week every single week. It all was so embarrassing to start with, you feel like you're a beggar… worthless. But got used to it… Had to survive on some odd cash-in-hand jobs and other ways I can't say… you know what I mean you're a home boy too."

Some participants described the feeling of uncertainty as one of 'intense fear' and 'powerlessness'. I also met Addy at Wenera about two weeks later after having known him from the very first days of my field work. Addy, a middle aged smartly dressed well-spoken male in his early 50s, felt that his experience of waiting for a decision on his immigration status played a significant role in accounting for his drinking. Stood at a distance from others patrons, and drinking Heineken lager from a bottle, Addy remarked:

''I had to deal with my stresses and frustrations of not having papers for so many years…and so I was unable to do what I wanted like going to college… or just walking down the street without watching my back and thinking '*Home Office and the Police will*

get me today and deport me back home'. I felt safe coming here to socialize with others and getting ideas….Imagine ''

He went on to further remark:

"I know of this guy. He comes here quiet often but I won't say names. The bus he was on was involved in an accident. Not a serious accident but some people on it got injured including him. Before the ambulance got to the scene, he had run away limping, everyone looking surprised by it. The guy didn't want to be taken to hospital and risk being deported to Zimbabwe. Because he didn't have the correct immigration papers"

Addy admitted to drinking on a daily basis though he did not view himself as having alcohol problems. He described financial difficulties as the only reason why he did not drink more than he did. In fact he favourably described drinking in the company of peers as having 'saved my life' despite the impact it had been having on his relationship. Tafara, a keen fan of Chelsea football club and in his thirties was happy to share his experiences and described similar experiences to Addy about living in the UK as an undocumented migrant, and the loneliness which accompanied living away from his family. He noted how his situation would drive him to come out and share his time with other Zimbabweans:

"When my wife and kids were still in Zimbabwe, I didn't have much to do through boredom. I was working for an agency that took me on without papers. But sometimes I would go for weeks without getting a shift. I would come out here to drink nearly every day. For most of us it wasn't out of choice…''

4.5.2 Using alcohol as self-medication for loneliness

During a further visit to Matute, I also had the opportunity to talk to Tony, whom I had seen on several occasions during the course of the fieldwork but had not had the opportunity to talk to. Though we had not interacted much before this occasion, I was particularly surprized by his openness in describing what I viewed as very private circumstances. Tony described having heavily cut down on his drinking after taking heed the concerns of his family and that of his GP.

I had gathered from patrons in the preceding weeks that Tony had made a speedy recovery after experiencing hallucinations for over a year after he had been involved in a drink and drive related traffic accident in which one person lost their life. He stated:

''Money used to be a problem. So when you have £10 to spend you want to have as many drinks as possible. Because you just want the company of others. I could forget my sorrows for a while …. Beer helped me relax my mind a bit. If I had enough money, I could have lived here. But it didn't go on well with my wife… getting back home after midnight every-night with a stench of beer all the time"

The feeling of loss as a consequence of the migration experience was raised on several occasions during the numerous discourses among and with participants. It was common and recurring for participants to describe feeling trapped between 'two evils', meaning Zimbabwe and the UK. In the view of several participants I spoke to, the loss of belonging and the feeling of loss led to an inherent need to adopt strategies to cope. I spoke to Gregory, a male participant in his early fifties while conducting field observations at Matute. He was in the company of a younger male in his early twenties whom he had been buying drinks for since my arrival about two hours earlier. The younger male appeared more inebriated than him. This wasn't surprising given the fact that both had admitted to having started drinking from the time Matute was opened five hours earlier. Speaking in a notably composed manner, Gregory for instance, explained his situation:

"I go to Zimbabwe to visit my mother every single year since getting my papers…. around August time every year. My father died before I had got my papers so couldn't even go for the funeral but you got to think of the living and not the dead. I played my part by sending money to contribute towards the funeral…. What I really want to say is when I'm on the flight to Zimbabwe or back to the UK, I'm never sure if I'm going home or coming from home. I don't know where to call home anymore…''

The younger male whom I later knew to be Gregory's nephew, after Gregory introduced him as his uncle's eldest son, kept his head slightly bowed as Gregory spoke. Though obviously drunk, one could tell that he was listening intently to his

uncle's account. As if to help his uncle in making sense of his situation, the younger male also made his point heard:

"As for me home is where I lay my head… For now, the UK is my home''

Slightly out of topic, and as if he wanted to be the last person to speak, Gregory went on to describe a Zimbabwean friend of his who would drink to oblivion on an almost daily basis. He described his friend as experiencing a severe feeling of loss quite similar to 'bereavement'. He went on to explain:

"You know one of my best friend, There's no need to say names… he went to a private school in Zimbabwe. His father had farms and buses and also well known in politics. He had come here to study business in London long back but since then his family back home has lost everything. He has never been to Zimbabwe since, though his parents are dying to see him. I've heard he's been seen at the train station begging for money, I think it's for beer. It makes me feel really sad. So when he drinks I would prefer he does it from here because it's a lot safer… no-one will do him any harm here"

Gregory felt that drinking elsewhere away from other Zimbabweans was too dangerous to even contemplate. His view was similar to several other participants I had spoken to who also felt that drinking in the company of other Zimbabweans was a sub-conscious strategy to cope with the losses which accompany the migrant experience and the fear of living in an alienating environment. Attending church was also a commonly described strategy to cope with the stresses associated with loneliness, alienation and discrimination. Through their discursive participation, participants at all the three settings gave accounts which suggested acculturative stress as playing a significant role in shaping alcohol use among Zimbabwean migrants. Participants conceived the use of alcohol as an effect resulting from stresses which accompany their daily experiences living as migrants whilst some acknowledged alcohol in the company of others as the solution to creating some balance in their lives. Bo, in his late forties and one of the few participants I met at Wenera to admit finding it difficult to live a life without alcohol had this to say:

"I come here for moral support from my countryman…. that's the reason why I do not go anywhere else like Weatherspoon's even though it is said to be cheaper It's so expensive to live here so I ended up sharing a house with strangers; using the same bathroom, and kitchen. What do you do in a house full of strangers… the only place to be is with you guys? People you can talk to and understand and have a drink together… then people from countries like Nigeria have their churches where they spent time…. Instead we congregate for a drink… We are a drinking community''

Unlike Bo, who attributed attending church as a coping strategy used mainly by Nigerian immigrants, most of my participants, who in-fact described themselves as largely Christian, agreed that religion played a prominent role in Zimbabwean lives in the UK, particularly so for women. They felt that attending church played an influential role during difficult life transitions such as those typically faced by Zimbabwean UK based migrants. Though some participants were sceptical about the trustworthiness of some African/Zimbabwean run Pentecostal churches in the UK, most participants agreed that attending regular church services was a sensible thing to do in view of the challenges and stresses facing Zimbabwean migrants in the UK. Taking into light the numerous conversations I had with participants, and the conversations I heard taking place among the general patronage, the accounts revealed the use of alcohol among Zimbabwean migrants as a stress relieving activity. Some participants also gave accounts describing regular church attendance as an alternative platform for managing stress, and providing a sense of purpose, albeit more suitable for women and children.

In attempting to further understand perceptions regarding 'the stresses' which accompanied the migrant experience so commonly described, I took the opportunity to interview participants who had recently been to Zimbabwe. They described Zimbabwean migrants as experiencing a feeling of confusion when they visit Zimbabwe. An account by Tapiwa, a regular patron at the Rhinos provided some insight into participants' experiences when they visit Zimbabwe. His account also echoed a similar note to Gregory's account of his own experiences while visiting Zimbabwe as described.

"I have been to Zimbabwe three times in the last two years… to visit my parents and other close relatives. Last August during the summer break, I went with my whole family, my wife and two daughters. But the thing is I never get to grasp which is my home anymore. My kids can no longer communicate with my parents because they can't speak Shona. Everything is in a mess…"

Participants were very clear with their accounts of places such as Matute, Wenera, and the Rhinos which they described as platforms where largely male patrons used alcohol to 'ease the pain' with regards to the stresses that accompany the migrant experience. When recounting their experiences, most participants described the pressures of managing life in the UK. They perceived the UK as discriminatory, prejudiced against black people, and unwelcoming. Participants generally felt that triggers to their stresses were as a result of communication barriers, difficulties assimilating to beliefs, values and norms of the UK, and feelings of inferiority and discrimination. They rationalized congregating to drink as a means of dealing with the stresses which accompany their daily lives, such as work related stress, institutional racism, and ethnic discrimination. They reported varied reasons for using alcohol and described the challenges of living in a foreign country as black immigrants.

During my earlier visits at Matute, I had a conversation with Cashton. He gave me some insight into a failed project he had embarked on some years earlier. He described having opened up a British style pub with plush interior decorations targeted to cater for Zimbabwean professionals. He informed me that he had envisaged attracting Zimbabwean male professionals by providing them with a plush setting he presumed would be suitable for their spouses and children to enjoy in family friendly surroundings. He went on to describe that he had to 'shut the place' because of lack of business as he could only get one or two patrons for a few hours per day. Looking dejected he stated:

"I once opened this place not far from here. A lovely pub with a warm environment suitable in the winter. This was meant to be for people like you (meaning me) and him (pointing at someone sat next to me). I wanted a place where professionals like you two to come and enjoy the beer and professionally cooked food. My idea was that as

Zimbabwean professionals we ought to meet to share ideas…. I wanted regular customers, who could also be able to bring their families for an evening out. But that never happened because the same professionals I was aiming to capture still continued to come here and to go to other places similar to here... They continued to come here not because it's cheaper or anything like that, but because they relate more with what happens here socially if you know what I mean…. It feels more Zimbabwean here"

Cashton's account provided insight into the irrelevance of class and social position in influencing the way Zimbabwean migrants cohere in the face of what was described as an uneasy relationship with their hosts. Perceived racism, discrimination and a feeling of loss in general meant that unity of purpose, identity and cultural values determined behaviour over class and social position.

Participants across all three settings felt that drinking had significant benefits but also agreed that this did not imply that the practice was invariably beneficial. Among other similar accounts, Ruvimbo, a male patron whom I had known at Matute described his brother as having separated from his wife two years earlier. He acknowledged alcohol use as a cause of matrimonial problems among Zimbabweans who live in the UK.

"There have been so many divorces and separations in this country…it's unbelievable. If you ask anyone here, they would know someone whose marriage has ended. I'm not saying it's always alcohol the problem but in my experience it's certainly playing a role…Some use alcohol to cope with the stress of separation while some relationships have collapsed due to heavy drinking''

Ruvimbo's view was confirmed by other participants who acknowledged alcohol use as a consequence of relationship breakdowns. Across all three study settings, it was commonly viewed by participants that the lack of broad social and family networks made them particularly vulnerable to the collective use of alcohol. It was common to hear participants express a broken sense of belonging which compelled them to congregate to cope with solitude and use alcohol to facilitate the coping process. Some participants also described the role of alcohol in Zimbabwean public spaces as protecting them from homesickness, isolation and

alienation experienced in the UK which they viewed as an unwelcoming and difficult environment. On one visit to Wenera, and this was during the early phases of my field work, I met Prosper, a middle aged male patron who was well known among Zimbabwean circles by virtue of him owning a nursing agency which supplied healthcare professionals to hospitals and nursing homes on a temporary basis. Prosper was well respected for helping Zimbabweans obtain temporary employment contracts in what was described as otherwise white dominated environments. And for that reason, he had been nominated to chair a Zimbabwean social club comprised of about fifty members. From the time I met him, prosper had made several attempts to convince me to join the club as a committee member. When describing the benefits, the club brought to Zimbabweans, prosper was quick to mention the downfalls of living in a western country similar to the UK. He noted:

'It's not easy to get British friends in this country because you don't think the same as them, so you will end up drinking in the house on your own. The alternative, which I think is better, is to come here where you can be in the company other you know to talk to. It's very stressful in this country, you can't plan for big things, you can't go for holidays like the British do, so the money you have you can afford to drink at least all the time. If you don't have money you will always get someone to buy you a drink…. It's very difficult to live here. It's not our country so we just have to live with it and do things together. It's safer that way."

Proper's view was supported by a wide range of participants who noted alcohol use, with its attached cultural norms and values, as a 'social glue' or lubricant for social bonding among Zimbabwean migrants. Participants viewed their life in the UK in polarized terms, which they dichotomized as 'us', meaning Zimbabwean migrants; and 'them', meaning the host populace. In the view of participants, the fear of an uncertain future, coupled with relationship breakdowns, poor social capital and a lack of resources led them to seek for companionships with those they considered as having shared experiences with. It was for this reason that Prosper had made numerous attempts to lure me into joining the social club he chaired, whose vision in his words was 'to bring Zimbabweans together like the Pakistanis and Jews do'. My observations of all the three settings clearly revealed

that both companionship and coping was facilitated through the practice of communal drinking which by many accounts mirrored the norms and values attached to alcohol use in Zimbabwe. Accompanying Prosper on my last meeting with him was one of his committee members, a dreary looking man, probably in his fifties and with all the signs (in my opinion) of a heavy drinker. Adding on to Prosper's account was his colleague whom I never got to know his name.

"Zimbabweans stick together. They may have their individual or personal differences but they are good at sticking together within their local communities, especially in the big cities where most have settled in. But sticking is not always a good thing because it does lead to excessive drinking. Just the way people drink at bottle stores back home (Zimbabwe). In our club we try to do other things. Like other alternative activities to move away from this culture of drinking! Drinking! Drinking! "

4.5.3 Discrimination, racism and prejudice- Perception of participants

Participants felt they faced difficulties in fully integrating into the British society because of experiences with discrimination and obstacles in social mobility. As a consequence, it was the common feeling among participants that they found solace being in the company of other Zimbabweans where opportunities to develop further social networks were available. On one of my group interviews at Matute, Guidance, a male participant who frequented all three settings alike was eloquent in describing the limited opportunities he and others like him had in the UK, which he prescribed to the 'the colour of my skin'. It later came to light that Guidance went to the same University as me in Zimbabwe in the early nineties where he graduated with a degree in Chemistry and was now working as a laboratory assistant at a local school. He spoke with sadness about how he had surrendered to the fact that as a black migrant, opportunities of getting a job as a chemist were limited.

"It's not our country and the fact is we are black…. so we just have to live with it and support each other the best way we can. I can't get the job I used to do before I came here, so I have to do with the best I can with what I've got. It's demeaning and belittling but I've got to get used to it. I have no choice"

Ronnie, a law graduate and a colleague of Guidance, described himself as having completed a law-practicing certificate (LPC) at a local university four years earlier. He reported having given up looking for a job. He confidently attributed his failure to getting a job in the legal fraternity to racism and discrimination. I later knew from sources within his circles that he was working as a care assistant in a nursing home. He also later described "being watched every move I make" and being called for disciplinary hearings 'a countless time for a wide range of 'unwarranted reasons'. Speaking with animated mannerisms, he added:

"I've been finding it difficult to break through due to my colour and my age, and my Zimbabwean ascent doesn't help as well. I think even before I'm called for an interview and they see this weird surname on my CV they just throw the CV into the bin straight away … I can't find how else I could explain it you know?''

Participants felt that the role of alcohol in Zimbabwean spaces is not in drunkenness but in providing platforms which allowed patrons to interact, and in this way deal with common stressors. Participants were eloquent about the virtues of alcohol use in that it decreased inhibition by making people 'open up' and communicate more freely; and that it made them 'happier and 'less worried and less stressed' about their lives as migrants. It was the general view of participants to perceive drinking in isolation negatively and as defeating the purpose of alcohol use with regards to facilitating social cohesion. In the same light, drunken and disorderly behaviour was also socially disapproved of, primarily because in the eyes of participants it defeated the benefits of drinking together as a community.

4.5.4 Coping with the death of loved ones - Experience of Zimbabwean migrants

During the sixteen weeks of my field work, the death of loved ones in Zimbabwe was a common event facing many patrons. Participants described failing to attend funerals of loved ones in Zimbabwe due to either financial constraints or more commonly, problems with their immigration status. The perceived bereavement of family members as a significant stressor which united Zimbabwean migrants in their respective communities. Similar to an account given by Gregory when

describing his failure to attend his father's funeral in Zimbabwe due to limitations with his immigration status, Shaid also sadly shared his experiences:

"You know Professor, (meaning me) there is nothing harder than losing your own mother and being unable to attend the funeral. Like what happened to me. I felt like jumping borders and getting to Zimbabwe through Mozambique. But I thought if I'm caught, my dead mother would have thought in her grave that I'm a fool to lose my future and the future of my kids for her dead body. I have now kind of accepted it but I just don't know how I would have coped without the support of the guys who come here"

Most participants I spoke to described being buried in the UK (which from my own experience is now a common event) as being one of the most frightening potential eventualities which they felt they had to avoid at all costs. However, a few participants also took this in a different light. For example, Patrice, both of whose children were born in the UK, saw no point in getting stressed about where he would be buried and felt that it made more sense for him to be buried in the UK rather than in Zimbabwe. He made an interesting point:

"See, our kids are British. They don't see Zimbabwe as their home at all. Both my parents have passed away and I no longer have any close relatives in Zimbabwe. All my siblings have settled abroad. Two of them are here and one, my sister, is in Australia. So it makes sense that I get buried here. At least my kids and hopefully my grandchildren would always have a place to lay flowers…. I have made my mind"

In instances of death, grief was collectively shared among patrons. Cultural norms and traditions related to mourning were followed such as for example, making monetary donations to the bereaved, and following traditional customs. In circumstances where patrons lost their relatives, the immediate time spent by the bereaved adjusting to their loss was shared. Alcohol played a leading role in facilitating this as has been the case in many African traditions for millennia. On one of my field days at Wenera, I heard that Gota, a male patron in his early sixties, had tragically lost 'his son', through a road traffic accident. The 'son' is said to have been travelling from Zimbabwe to South Africa where he had been

working as a civil engineer. On the day of my visit, patrons had been making monetary contributions which eventually amounted to over one hundred and fifty pounds. A representative had been chosen to submit the donations to the Gota family who lived in a nearby housing estate. Later on in the evening of that day, Gota made an unexpected arrival. His expression was that of a man in sorrow. I later learnt that the dead 'son' was in fact his nephew by virtue of the fact that he was his brother's son.

There were also further recounts of experiences related to the loss of close family members and complications in the grieving process due to failure to attend funerals because of either financial difficulties or a lack of immigration status permitting travel to Zimbabwe. Michael, in his early 50's recounted his friend experiencing severe guilt by not being able to attend both her parents' funerals. He noted:

"My friend's mother died in 2009, followed by his father about six or seven months later. They were in their late 70s and still living in Zimbabwe. He was unable to attend both funerals because he had then applied for refugee status and was still waiting to get his papers, and being the eldest son, this hit him hard. But he seemed to cope well with it. Had it not been for the support he was given by other Zimbabweans whom he used to drink with, we may have been talking a different story now.''

4.5.5 Using alcohol to cope with the stresses accompanying the migrant experiences

Michael's account viewed alcohol use in positive terms, and as protective against the stresses accompanying the migrant experience. His account suggests the importance of social cohesion, with alcohol use as the medium through which men in particular, develop friendships through everyday interactions. Participants also acknowledged that employment and other types of meaningful and productive activities had a therapeutic value when dealing with the stresses that accompany the migrant experience. However, they still maintained the

consumption of alcohol with others who share a similar history played an important role in dealing with the stresses which accompany their daily lives.

Participants acknowledged migration and settlement as being a stressful experience, which required coping strategies. They unveiled a pattern of close connections between stress and alcohol use in relation to their current migrant experiences. They viewed acculturative stress as an important causal explanation of their alcohol use. Tensions related to relationship problems, a lack of, and being separated from close family members, financial difficulties and a loss of social status were viewed as the most common sources of psychosocial stress. Problems linked to matrimonial relationships were the most frequently cited sources of stress among men. Males particularly, described having held 'middle class' occupations and having been bread winners in Zimbabwe and then having to find themselves caught up in humiliating experiences of having to do menial work in the UK to earn a living. One participant, Tony, a regular at the Rhinos gave an account which represented a general view among Zimbabwean men of their experiences since settling in the UK. He stated:

''On the day I arrived in the UK, just by coincidence that's nearly 12 years ago, I saw this guy, once a well-known lawyer in Harare mopping the floor at Heathrow Airport. I could not even dare greet him to save him from the embarrassment… How sad. This has been the case for many guys in the UK, Engineers doing care worker, teachers working on factory lines…''

A sizeable number of participants described having left lucrative occupations in Zimbabwe to join their spouses in the UK in the hope of maintaining their relationships. They gave accounts of having to deal with the stresses accompanying gender role reconstructions taking place in many homes. Very few participants, typically the older patrons and less so the younger generations, accepted with regret the apparent changes in their roles in the home which they felt caused significant problems in maintaining relationship stability.

4.6 Conclusion

This chapter presented findings of the focused ethnography. It drew upon the constructivist, constructionist philosophical approach as its guiding framework. Findings related to the three themes were described in detail. Overall, evidence from all three study settings revealed Zimbabwean migrants as having an uneasy relationship with the UK. In the view of participants, this uneasy relationship with the UK is in many migrants manifesting itself in the use of alcohol to cope with the perceived injustices of racism, discrimination and stigma. A wide range of participants revealed alcohol use as a medium for coping with stresses which accompany the migrant experience. Overall, participants also described alcohol as playing a pivotal role for Zimbabwean migrants through the sharing of public platforms that are protective of Zimbabwean culture and beliefs. With the majority of participants being highly educated individuals who had enjoyed middle class privileges prior to immigration, this focused ethnography revealed Zimbabwean migrants as experiencing a loss of status in their new environment. As such, participants portrayed alcohol as playing multiple roles in their lives, with both benefits and negative consequences attached to its use.

The next chapter presents the quantitative findings.

Chapter 5: Results- Survey

5.1 Descriptive Statistics

331 respondents completed the survey and of these only 214 met the inclusion criteria. The most common reasons for exclusion were:

1. Incomplete questionnaires
2. Duplicate questionnaires (duplicate IP addresses)
3. Respondents not meeting the eligibility criteria

The majority of respondents were classified as low risk: 61.2%, 28.6% as increasing risk, 5.6% as higher risk and 6.5% as possible dependence. The individual AUDIT items which measure frequency of alcohol consumption showed that 21.5% of respondents drank 2 to 3 times a week and 12.1% drank 4 or more times a week. The AUDIT items which measure the quantity of alcohol consumed showed that 19.2% of respondents drank 3 to 4 drinks on a typical day when drinking. Just over 17% of respondents indicated they drank 7 or more drinks on a typical day when drinking, of which 4.2% drank 10 more drinks on a typical day. AUDIT measures of binge drinking indicated that 18.7% of respondents had 6 or more drinks in one sitting on a weekly basis. Only 1.9% of respondents indicated they had 6 or more drinks in one sitting on a daily basis. AUDIT measures of possible dependence indicated that 6.5% of respondents had someone injured as a result of their drinking in the past year. 4.7% of respondents indicated they felt guilt or remorse about their drinking on a daily basis. Nearly 12% of respondents had a friend, relative or doctor being concerned about their drinking in the past year, and 10.7% had a friend, relative or doctor being concerned about their drinking, but not in the past year. Nearly 5% of respondents found they could not stop drinking once they had started, on a weekly basis and 1.7% of needed a drink in the morning, daily or almost daily, to get them going.

The majority of respondents (76.1%) were male and 23% female, and 1.4% preferred not to say or the information was missing. Gender differences in the risk of harmful drinking were found with males demonstrating a greater proportion in all risk categories. About 25% more females than males were classified as low risk. None of the female respondents were classified as possibly dependent in

comparison to 8.6% of males. Nearly half of respondents were between the age of 35 to 44 and just over half were married/in civil partnerships. For both genders, the greatest proportion exhibiting low and no risk were in the 45 to 54 age category. Respondents who reported being single had the highest proportion of those in the increasing risk category (40.9%), followed by those who were widowed/divorced/separated (33.3%). Those exhibiting increasing risk were lowest in those respondents who were married or in civil partnerships. The majority of respondents (73.8%) had children over the age of 18. Over 87% of respondents had naturalized as British or had indefinite leave to remain. Only 6.5% of respondents had limited leave to remain in the UK, and 5.6% either chose the 'other' option or the information was recorded as missing. Over 60% of respondents had lived in the UK between 11 and 15 years, 15.4% for 10 years and less, and just over 20% for 16 years and over. Almost all of the respondents reside in England.

Most respondents reported having achieved higher education (83.6%), with only 8.8% reporting having a lower education status. 7.5% were recorded as missing values. Respondents who had lower education had the greatest proportion of those with possible dependence (10.5%) compared to those with higher education (6.1%). 83.6% of respondents were in paid employment compared to only 16.4% who were not. Of those who were in paid employment, 58.6% were classified as low risk compared to 74.3% of those who were not in paid employment. However, a smaller proportion of those in paid employment were in the possible dependence category (5.6%) compared to nearly twice of those who were not in paid employment (11.4%). Nearly half (47.2%) of respondents had an individual income of less than £29999, with 28% reporting earning an individual income of less than £30 000. 53% of respondents did not report having an individual income, hence this was recorded as missing. Nearly half (49.5%) of respondents reported having a household income of £30 000 and over, with 22.4% reporting having a household income of £29 999 and under. 28% did not report to have a household income, hence this was recorded as missing. Measures of SSS, varied with where, when and with whom respondents were comparing themselves with. Out of all the four risk categories, respondents who had the highest perceived social status were consistently classified as increasing

risk across all three SSS measures. Table 6 below shows a summary of the sample socio-demographic characteristics.

Table 6: Demographic characteristics and distribution of AUDIT Risk Levels by explanatory variables (N=214)

Variable	Category	**N=214 (%)**	Low Risk	Increasing Risk		Higher Risk	Possible dependence
Gender	Male Female Missing/Prefer not to say	162 (76.1) 49 (23.0) 2 (0.9)	89 (54.9) 39 (79.6) 2 (0.9)	47 (29.0) 10 (20.4) -		12 (7.4) 0 (0) -	14 (8.6) 0 (0) -
Age	18 to 34 35 to 44 45 to 54 55 and over Missing	37(17.4) 95 (44.6) 69 (32.4) 13 (6.1)	21 (56.8) 55(57.9) 47 (68.1) 8 (61.5) -	14 (37.8) 28(29.5) 11 (15.9) 4 (30.8) -		1 (2.7 5 (5.3) 6 (8.7) 0(0) -	1 (2.7) 7 (7.4) 5 (7.2) 1(7.7) -
Marital Status	Single Married/civil partner Widowed/Divorced/Sep Other Missing	**44 (17.6)** **128 (51.2)** **36 (16.9)** **6 (2.8)**	21(19.6) 86(67.2) 18(50.0) 6 (100)	18(40.9) 27(21.1) 12(33.3) 0		2(4.5) 6(4.7) 4(11.1) 0	3(6.7) 9(7.0) 2(5.6) 0
Family Structure Children under 18)	Yes No Missing	**158(73.8)** **51(23.8)** **5(2.3)**	97(61.4) 30(58.8) 4(80)	39(24.7) 17(33.3) 1(20)		9(5.7) 3(5.9) 0(0)	13(8.2) 1(2.0) 0(0)
Immigration Status	Naturalized British Indefinite Leave Limited Leave Other/Missing	**88(41.1)** **99(46.3)** **14(6.5)** **12(5.6)**	67(76.1) 51(51.5) 9(64.3) 4(33.3)	16(18.1) 33(33.3) 2(14.3) 6(50.0)		1(1.1) 9(9.1) 1(7.1) 1(8.3)	5(5.7) 6(6.0) 2(14.3) 1(8.3)
Years of residence in the UK	10 years and less 11-15 years 16 years and over Missing	**33(15.4)** **134(62.6)** **43(20.1)** **4(1.9)**	18(54.5) 85(63.4) 27(62.8) 1(25.0)	14(42.4) 32(23.9) 9(20.9) 2(50.0)		1(3.0) 6(4.5) 4(9.3) 1(25.0)	0(0) 11(8.2) 3(7.0) 0(0)
Education Level	Lower education Higher education Missing	**19(8.8)** **179(83.6)** **16(7.5)**	11(57.9) 105(58.6) 15(93.8)	5(26.3) 52(29.1) 0(0)		1(5.2) 11(6.1) 0(0)	2(10.5) 11(6.1) 1(6.3)
Employment Status	In paid employment Not in paid employment Missing	**179(83.6)** **35(16.4)** **-**	105(58.6) 26(74.3) -	52() 5(14.3) -		12() 0(0) -	10() 4(11.4) -
Individual Income	£29999 and under £30000 and over Missing *(Did not have individual income	**101 (47.2)** **60 (28.0)** **53 (24.8)**	64(65.3) 37(61.7) -	26(26.5) 15(25.0) -		4(4.1) 5(8.4) -	7(14.5) 3(5.0) -
Household Income	£29999 and under £30000 and over Missing *(Did not have	**48 (22.4)** **106(49.5)** **60(28.0)**	30(62.5) 66(62.3) -	16(33.3) 26(24.5) -		2(6.7) 6(5.7) -	0(0) 8(7.5) -
Frequency of talking to neighbours (Social Capital)	On most days Once or twice a week Once or twice a month Less than once a month	**52(24.3)** **66(30.8)** **39(18.2)** **45(21.0)**	37(71.2) 44(66.7) 22(56.4) 23(51.1)	14(25.5) 13(19.7) 11(28.2) 14(31.1)		0(0) 4(1.5) 5(12.8) 3(6.7)	1(1.9) 5(7.6) 1(2.6) 5(11.1)

	Never Missing	**12(5.6)**	5(41.7)	5(41.7)		0(0)	2(16.7)
Asking neighbour for help (Social Capital)	Very comfortable Fairly comfortable Fairly uncomfortable Very uncomfortable	**43(20.1)** **44(20.5)** **31(14.5)** **96(44.9)**	33(76.7) 26(59.1) 16(51.6) 56(58.3)	9(21.0) 14(31.8) 9(29.0) 25(26.0)		0(0) 4(9.1) 3(9.7) 5(5.2)	1(2.3) 0(0) 3(9.7) 10(10.4)
Do you have friends who are not Zimbabwean (Social Capital)	Yes No	**157(73.4)** **57(26.6)**	101(64.3) 30(52.6)	40(25.5) 17(29.8)		7(4.5) 5(8.8)	9(5.7) 5(8.8)
Perceived prejudice in general	A lot Less than a lot Missing	**102(48.8)** **105(50.2)** **2(1.0)**	56(54.9) 70(66.7) 2(100)	29(28.4) 26(24.8) 0(0)		7(6.9) 5(4.8) 0(0)	10(9.8) 4(3.8) 0(0)
Perceived prejudice when getting a job	A lot Less than a lot Missing	**115(55.6)** **86(40.2)** **6(2.8)**	65(56.5) 57(66.3) 5(83)	30(26.1) 24(27.9) 0(0)		8(7.0) 3(3.5) 1(16.7)	12(10.4) 2(2.3) 0(0)
Religious Affiliation	Mainstream Pentecostal Other	**131(61.2)** **56(26.2)** **27(12.6)**	68(51.9) 47(83.9) 16(59.3)	42(32.0) 5(8.9) 10(37.0)		12(9.2) 0(0) 0(0)	9(6.9) 4(7.1) 1(3.7)
Religious importance	Important Not important Missing	**194(90.7)** **19(8.9)** **1(0.5)**	121(62.4) 9(47.4) 1(100)	49(25.3) 8(42.1) 0(0)		11(5.7) 1(5.3) 0(0)	13(6.7) 1(5.3) 0(0)
Religious attendance	Never Rarely Quiet often Very often Missing	**14(6.5)** **54(25.2)** **50(23.4)** **69(32.2)** **27(12.6)**	6(42.9) 28(51.9) 34(56.7) 55(79.8) 8(29.6)	6(42.9) 17(51.9) 11(22.0) 10(14.5) 13(48.1)		1(7.1) 7(13.0) 2(4.0) 0(0) 2(7.4)	1(7.1) 2(3.7) 3(6.0) 4(5.8) 4(14.8)
Health Status	Excellent Good Fair/Poor/Very poor Missing	**69(32.2)** **108(50.5)** **36(16.8)** **1(0.5)**	50(72.5) 64(59.3) 16(44.4) 1(100)	16(23.2) 31(28.7) 10(27.8) 0(0)		1(1.4) 9(8.3) 2(5.6) 0(0)	2(2.8) 4(3.7) 8(22.2) 0(0)
Consumed alcohol before migration	Yes No	**150(70.1)** **64(29.9)**	78(52) 53(82.8)	49(32.7) 8(12.5)		11(7.3) 1(1.6)	12(8.0) 2(3.1)
Drink and Driving Frequency	Never Once in a while Often	**86(40.2)** **53(24.8)** **22(10.3)**	60(69.8) 16(30.2) 2(9.0)	20(23.3) 31(58.5) 6(27.2)		4(4.7) 3(5.7) 5(22.7)	2(2.3) 3(5.7) 9(40.9)
Drinking venue preference	Zimbabwean settings At home Local pub Night club Other	**40(18.7)** **75(35.0)** **25(11.7)** **15(7.0)** **5(2.3)**	15(37.5) 45(60.0) 7(28.0) 7(46.7) 4(80.0)	18(45.0) 20(26.7) 11(44.0) 7(46.7) 0(0)		4(10.0) 4(5.3) 4(16.0) 0(0) 0(0)	3(7.5) 6(8.0) 3(12.0) 1(6.7) 1(20)

Primary Demographic Characteristics (Means of continuous variables)		
Perceived stress Scale PSS-4	Continuous	**Mean 9.95 SD 2.822**
Poor Social integration Score High score=poor cohesion)	Continuous	**Mean 8.90 SD 3.391**
Social Status in Zimbabwe relative to others (pre-immigration)	Continuous	**Mean 4.85 SD 2.207**
Social Status (In the UK)	Continuous	**Mean 5.64 SD 2.345**
Social Status in the UK relative to other Zimbabweans	Continuous	**Mean 5.64 SD 2.345**

About 54% of respondents reported talking to their neighbours at least once a week. 5.6% reported never talking to their neighbours. Respondents who were the most comfortable talking to their neighbours had the greatest proportion of those in the low risk category (71.2%), and the smallest proportion of those in the possible dependence category (1.9%). In contrast, respondents who were the least comfortable talking to their neighbours had the greatest proportion in the possible dependence category (16.7%), and the smallest proportion in the low risk category (41.7%). Nearly 4% of respondents found it very uncomfortable asking a neighbour for help compared to only 20.1% who were very comfortable asking a neighbour for help. The greatest proportion of those classified in the possible dependence category (10.4%) reported being very uncomfortable asking their neighbour for help. More than 26% of respondents reported not having any friends who were not Zimbabwean of which the greater proportion (8.8%) were classified as possibly alcohol dependent, compared to 5.7% who reported having friends who were not Zimbabwean. Also, a greater proportion of those who reported having friends who were not Zimbabwean (64.3%), were classified as low risk, compared to 52.6% in the same category who reported not having any friends who were not Zimbabwean.

Just under 91% of respondents considered religion important in their lives of which the greatest proportion (62.4%) were in the low risk category compared to 47.4% of those who considered religion not important. Also, a greater proportion (42.1%) of respondents who reported religion as not important in their lives were classified as increasing risk compared to 25.3% of those who reported religion as important in their lives. More than 60% of respondents reported being affiliated to mainstream Christianity, with 26.2% reporting being affiliated to Pentecostal Christianity. Nearly 13% classified themselves as not being Christian. Just under one third of respondents reported attending religious ceremonies 'very often' of which the majority (79.8%) were in the low risk category, with only 6.5% reporting never attending religious ceremonies. 83.9% of respondents who attended Pentecostal churches were in the low risk category compared to 51% of those who attended mainstream churches.

Over 82% of respondents reported having either good or excellent health. Only 16.8% reported having fair, poor or very poor health. 22.2% of respondents who reported having fair, poor or very poor health were classified as possibly dependent, compared to 3.8% of respondents who had reported having good health. Only 2.8% of respondents who reported excellent health were classified as possibly dependent. Also, the greatest proportion of respondents who were classified as low risk reported having excellent health (72.5%) compared to 44.4% who reported having fair, poor or very poor health. The mean perceived stress score was 9.95 (SD, 2.822). Respondents who had the highest stress levels (PSS-4 Score: $\bar{x}$ =10.33) had the greatest proportion of those classified as increasing risk. Surprisingly, respondents who had the lowest stress levels (PSS-4 Score $\bar{x}$ = 8.71) had the greatest proportion of those classified as possibly dependence.

70.1% of respondents had consumed alcohol prior to migrating to the UK compared to 29.9% who had not. 8% of those who had consumed alcohol prior to migration were classified as possibly dependent compared to only 3.1% of those who had only started to consume alcohol since settling in the UK. Respondents who had consumed alcohol prior to migration also had higher proportions in both the increasing and higher risk categories. 82.8% of those respondents who had not consumed alcohol prior to migration were classified as

low risk, compared to 52% of those who had already been consuming alcohol prior to migration. An alarming 10.3% of respondents reported having 'often' driven while intoxicated or having been driven by someone who was intoxicated. Nearly 25% reported that 'once in a while' they had driven while intoxicated or had been driven by someone who was intoxicated. Over 40% of those who were involved in drink and driving were classified as possibly dependent, with only 2.3% of those who were never involved in drink and driving in the same category. On the other hand, over 69% of respondents who had never been involved in drink and driving were classified as low risk with only 9% of those who were involved in drink and driving 'often' classified as low risk. When asked to rank alcoholic beverages in order of preference out of a choice of lager, wine, cider, alcopops and spirits, most respondents chose lager as their first choice (41.6%). The second most preferred first choice was spirits (12.1%). Alcopops were the least preferred beverage with only 2.8% of respondents choosing it as a first choice. When asked to rank the main reason for choosing where they preferred to drink out of a choice of 'price', 'atmosphere', 'to meet other people', and 'to meet other Zimbabweans'; most respondents chose 'atmosphere' as their main reason (62.4%). Meeting other Zimbabweans as a main reason for choosing where one preferred to drink was ranked higher as a first choice (18.4%) when compared to meeting other people in general (15.4%). When asked to choose an option that best described where they preferred to drink, the greatest proportion of respondents preferred to drink at home (35%) followed by Zimbabwean social settings (18.7%). Only 7% preferred to drink in a night club. When analysed by gender, the greatest proportion of female respondents preferred to drink at home compared to other places (40.8%) whilst 33% of male respondents preferred to drink at home compared to the other options.

5.2 Inferential Statistics

Ordinal logistic regression comparing all risk categories with low/no risk as the reference category was conducted to examine the role of all demographic and psycho-socio factors.

Screening the individual variables one at a time the univariate logistics regression found that being male was significantly associated with a higher risk of hazardous alcohol consumption ($p<0.001$). Females were 71% less likely to be at an increased risk of harmful drinking compared to males (OR= 0.29) (CI 0.13, 0.61). Those participants who consumed alcohol before migration were at a significantly increased risk of harmful drinking when compared to those who had not consumed alcohol before migrating to the UK ($p<0.001$). Age was not significantly associated with an increased risk of harmful drinking. Participants who were married or in civil partnerships were nearly 50% less likely to engage in harmful drinking compared to those who were single ($p<0.1$, OR = 0.53). Employment status was not significantly associated with an increased likelihood of harmful drinking.

All three measures of religiosity appeared to be protective factors against an increased risk of harmful drinking. Religious affiliation was significantly associated with a decreased risk of harmful drinking (p=0.001) as those who attended Pentecostal churches were 78% less likely to be at an increased risk of harmful drinking compared to those who attended mainstream churches (OR=0.22). The other two measures of religiosity, namely religious importance and religious attendance, showed no significant relationship with an increased risk of harmful drinking. The odds ratio for religious attendance showed a gradient of decreasing risk, with those who attended religious services the most often having the least likelihood of engaging in risky alcohol use when compared with those who never attended religious services.

Health status was significantly associated with an increased risk of harmful drinking. Those with good health were nearly twice as likely to engage in harmful drinking compared to those with excellent health (OR=1.84, $p<0.05$). Those with fair/poor/very poor health indicated over four times a greater likelihood of

engaging in risky drinking compared to respondents those whose health was excellent (OR=4.20, $p< 0.001$).

Perceived prejudice 'in general' was not significantly associated with an increased risk of harmful drinking. Respondents who felt more prejudiced were more likely to engage in harmful drinking compared to those who felt less prejudiced. Participants who felt that there was 'less than a lot' of prejudice were 42% less likely to be at an increased risk of harmful drinking compared to those who felt that there was 'a lot' of prejudice. Also, participants who felt that there was 'less than a lot' of prejudice when getting a job were 41% less likely to be at an increased risk of harmful drinking when compared to those who felt that there was a lot of prejudice. Drink and driving was significantly associated with high risk of harmful drinking, with those who drove more often when drunk being over four times more likely to engage in harmful drinking when compared to respondents who never drive while drunk (OR=4.20, $p< 0.001$). Table 7 and 8 below show the univariate ordinal regression of explanatory variables on AUDIT categories, and the multivariate ordinal regression of explanatory variables on AUDIT categories (screening stage) respectively.

Table 7: Univariate ordinal regression of explanatory variables on AUDIT categories

Variable	Category	OR	CI	P Value
Gender	Male Female	1.0 0.29	REF 0.13,0.61	REF **0.001**
Age	18 to 34 35 to 44 45 to 54 55 and over	1.0 1.08 0.77 0.90	REF 0.52,2.24 0.35,1.71 0.26,3.12	REF 0.837 0.528 0.864
Marital Status	Single Married/civil partner Widowed/Divorced/Separated	1.0 0.53 1.00	REF 0.27,1.01 0.44,2.27	REF 0.055 0.999
Family Structure (Children under 18)	Yes No Missing	1.0 0.98 0.36	REF 0.53, 1.82 0.04,3.24	REF 0.951 0.363
Immigration status	Naturalized British Other Indefinite Leave to Remain Limited Leave to remain Missing	1.0 4.06 2.75 2.04 5.88 -	REF 1.07,15.42 1.50,5.07 0.61,6.80 1.05,32.97 -	REF **0.040** **0.001** 0.247 **0.044** -
Years of residence in the UK	10 years and less 11-15 years 16 years and over Missing	1.0 0.87 0.93 2.76	REF 0.42,1.79 0.38,2.24 0.76,16.05	REF 0.705 0.868 0.258
Employment status	In paid employment Not in paid employment	1.0 0.54	REF 0.24,1.23	REF 0.142
Individual Income	£30 000 and over £29 999 and under Missing	1.0 0.92 1.20	REF 0.48,1.75 0.58,2.49	REF 0.800 0.624
Household Income	£30 000 and over £29 999 and under Missing	1.0 0.86 1.21	REF 0.43,1.69 0.65,2.29	REF 0.660 0.543
Frequency of talking to neighbours	On most days Once or twice a week Once or twice a month Less often than once a month Never	1.0 1.41 2.04 2.61 3.49	REF 0.65,3.08 0.88,4.76 1.16,5.90 1.05,11.63	REF 0.379 **0.098** **0.020** **0.041**
Comfortable asking neighbours for help	Comfortable Uncomfortable	1.0 1.79	REF 1.02,3.11	REF **0.041**
Do you have friends who are not Zimbabwean	Yes No	1.0 0.60	REF 0.33,1.09	REF **0.093**
Perceived Prejudice in general	A lot Less than a lot	1.0 0.58	REF 0.33,1.00	REF **0.051**
Perceived prejudice when getting a job	A lot Less than a lot Missing	1.0 0.59 0.28	REF 0.33, 1.03 0.03,2.50	REF **0.066** 0.255
Religious Affiliation	Mainstream Pentecostal Other	1.0 0.22 0.66	REF 0.11,0.48 0.30,1.45	REF **<.001** 0.296
Religious importance	Important Not important	1.0 1.55	REF 0.65,3.70	REF 0.322

Religious attendance	Never Rarely Quiet often Very often Missing	1.0 0.78 0.41 0.22 1.67	REF 0.27,2.31 0.13,1.26 0.07,0.68 0.52,5.39	REF 0.658 0,118 **0.008** 0.390
Health Status	Excellent Good Fair/Poor/Very poor Missing	1.0 1.84 4.20 -	REF 1.11,3.88 2.11,10.37 -	REF **0.023** **0.000** -
Consumed Alcohol before migration	Yes No	1.0 0.23	REF 0.11,0.47	REF **<.001**
Drink and Driving Frequency	Never Once in a while Often	1.0 4.30 36.72	REF 2.15,8.60 12.76,105.6	REF **<0.001** **<0.001**
Drinking Venue Preference	At home Other Local pub Night club Zimbabwean run settings Missing	1.0 0.46 3.34 1.39 2.13 0.03 -	REF 0.046,4.50 1.42,7.84 0.49,3.93 1.03,4.41 0.00,0.20 -	REF 0.501 **0.006** 0.534 **0.042** **<0.001** -
Perceived Stress Scale (PSS-4)	Continuous	1.0 0.99	REF 0.90,1.08	REF 0.756
Social Integration Score	Continuous	1.0 1.06	REF 0.98,1.15	REF 0.162
Ladder 1- SSS	Continuous	1.0 0.92	REF 0.81,1.04	REF 0.179
Ladder 2-SSS	Continuous	1.0 1.18	REF 1.05,1.32	REF **0.006**
Ladder 3-SSS	Continuous	1.0 1.08	REF 0.97,1.20	REF 0.137
Factor 1	Culture and belief system	1.0 0.81	REF 0.59,1.12	REF 0.206
Factor 2	Homesickness	1.0 1.08	REF 0.82,1.42	REF 0.574

Table 8: Multivariate ordinal regression of explanatory variables on AUDIT categories (screening stage)

Variable	Variable categories	OR	P value
Gender	Male Female	1.00 0.15	REF 0.011
Marital Status	Single Married/civil partner Widowed/Divorced/Separated	1.00 0.14 0.11	REF 0.002 0.006
Religious Affiliation	Mainstream Pentecostal Other	1.00 1.68 0.29	REF 0.438 0.189
Religious attendance	Never Rarely Quiet often Very often Missing	1.00 1.90 0.47 0.47 3.06	REF 0.495 0.251 0.283 0.126
Perceived prejudice in general	A lot Less than a lot Missing	1.00 0.36 2.46	REF 0.064 1.000
Perceived prejudice when getting a job	A lot Less than a lot Missing	1.00 1.46 0.89	REF 0.479 0.943
Health Status	Excellent Good Fair/Poor/Very poor	1.00 1.89 3.31	REF 0.214 0.064
Comfortable asking neighbours for help	Comfortable Uncomfortable	1.00 1.29	REF 0.588
How often do you talk to neighbours	On most days Once or twice a week Once or twice a month Less often than once a month Never	1.00 3.09 2.39 2.53 4.08	REF 0.074 0.232 0.194 0.160
Drink and Drive	Never Once in a while Often	1.00 7.57 61.65	REF <0.001 <0.001
Consumed Alcohol before migration	Yes No	1.0 0.94	REF 0.929
Drinking Venue Preference	0ther Local pub Night club Zimbabwean run settings At home Missing	1.00 0.43 0.14 0.18 0.14 0.51	REF 0.679 0.371 0.422 0.354 0.828

Do you have friends who are not Zimbabwean	Yes No	1.00 1.20	REF 0.719
Immigration Status	Naturalized British Indefinite Leave to Remain Limited Leave to remain Other/Missing	1.00 0.72 0.52 1.58	REF 0.524 0.513 0.591
Ladder 2- SSS	Continuous	1.00 1.22	REF 0.956

The final multivariate logistic regression model shows 5 significant explanatory variables at $p<0.05$, namely gender, marital status, religious attendance, health status, and perceive prejudice in general.

Females were 80% less likely to be at an increased risk of engaging in harmful drinking when compared to males (OR=0.20, $p<0.05$). Respondents who were married or in civil partnerships had an 86% less likelihood of being at an increased risk of harmful drinking when compared to respondents who were single (OR=0.14, $p<0.05$). Those who were widowed, divorced or separated were 89% less likely to be at an increased risk of harmful drinking; meaning that being single indicated a greater likelihood of an increased risk of harmful drinking. An increasingly more frequent attendance at religious services was significantly linked to a decreased risk of harmful drinking. Respondents who never attended religious services were nearly three and half times more likely to be at an increased risk of harmful drinking compared to those who attended religious services the most often (OR=3.45, $p= 0.048$). Health status was significantly associated with an increased risk of harmful drinking. Respondents who indicated their health status as fair, poor or very poor were nearly four times more likely to be at an increased risk of harmful drinking when compared to respondents who indicated their health status as excellent (OR=3.82, $p<0.05$). Those who indicated their health status as good were about twice more likely to be at an increased risk of harmful drinking compared to those who indicated their health status as excellent (OR=2.11, $p<0.05$). Finally perceived prejudice (in general) was significantly associated with an increased risk of harmful drinking. Respondents who felt there was 'less than a lot' of prejudice were nearly 50% less likely to be at an increased risk of harmful drinking (OR=0.48, $p<0.05$).

Table 9 below shows a summary of the final logistics regression model.

Table 9: Final Multivariate Logistic Regression Model (OR and p values)

Variable	**Category**	**OR**	**P value**
Gender	Male Female	1.00 0.20	REF <0.001
Marital Status	Single Married/civil partner Widowed/Divorced/Separated	1.00 0.14 0.11	REF 0.002 0.006
Perceived Prejudice In general	A lot Less than a lot Missing	1.00 0.48	REF 0.024
Religious attendance	Very often Never Rarely Quiet often Missing	1.00 3.45 1.87 1.41 5.62	REF 0.048 0.150 0.451 0.001
Health Status	Excellent Good Fair/Poor/Very poor	1.00 2.11 3.82	REF 0.043 0.004

5.3 Conclusion

This chapter 5 drew upon the results of the survey by taking a positivist philosophical approach as highlighted in the methodology chapter. The first section provided detail of the descriptive statistics. The second section provided an account of the inferential statistics conducted using STATA. This was presented in the form of a written account, accompanied by tables depicting explanatory variables in relation to AUDIT risk categories, followed by regression model estimates of odds ratios, confidence intervals and *p* values. Findings from the survey provided additional insight into drinking estimates in relation to specific demographic, socio-economic and psychosocial factors.

Chapter 6: Discussion

6.1 Introduction

This study examined alcohol use among Zimbabwean migrants living in the UK. It aimed to explore attitudes, perceptions and norms with regards to the use of alcohol among Zimbabweans who migrated into the UK from the late 1990's onwards, as a result of the deteriorating political and economic climate in Zimbabwe. It explored themes emerging from narrated accounts of attitudes, motivations, experiences and beliefs shaping alcohol's meaning in UK based Zimbabwean migrants' lives. Employing a social constructionist approach, it further examined how Zimbabwean migrants encounter, express and interpret the social and cultural norms they conceive as constituting their relationship with alcohol in the UK. This study further aimed to investigate the levels of alcohol use using the Alcohol Use Identification Test (AUDIT). Findings from the survey provided additional insight into the factors associated with increased drinking in relation to specific demographic, socio-economic and psychosocial factors. The role of these factors are now explored to demonstrate their influence on the patterns of alcohol use among this migrant community.

6.2 Summary of Results

A fair amount of literature on alcohol focussing on the UK general population is available, but very little examines alcohol use among migrant communities in the UK, even though in 2011 13% (7.5 million) of the resident population in England and Wales were born outside the UK (ONS, 2013). Research which highlights alcohol use among recent migrants into the UK has the potential to provide a rich lens through which key information on the effects of acculturative stress, social capital, religiosity and other factors thought to mediate alcohol use can be understood. This is the first study that attempts to explore and assess the specific impact of demographic, socio-economic and psychosocial factors on alcohol use among an African migrant community in the UK. The study identified a wide range of similarities across all three study settings in the reasoning patterns Zimbabwean migrants employed to explain their drinking. Data generated from participant observations further contextualized the themes, identified differences

and similarities across the three study settings, and supported the researcher's interpretations. The findings describe the role of Zimbabwean public spaces and alcohol in protecting Zimbabwean migrants from homesickness, isolation and alienation in an environment most perceived as hostile and unwelcoming. Participants threaded narratives between and among issues of gender and masculinity, cultural identity, social cohesion; and stress and coping by constructing frameworks that identified alcohol as playing multiple roles in their lives as Zimbabwean migrants. Results from the survey using descriptive statistics and ordinal logistics regression further contextualized the ethnographic findings by showing male gender, low levels of religiosity, engaging in drink and driving, single marital status, and poor health status as demonstrating significant associations with an increased risk of harmful drinking.

6.3 Gender expectancies and hegemonic masculinity

Findings from this study support and extend the current literature that being male is associated with elevated alcohol intake. The gender gap in alcohol use is one of the universal gender differences in human and social behaviour, where males are more often reported to be drinkers, to consume more alcohol and cause more problems from drinking as compared to females (Wilsnack *et al*., 2009). This study demonstrated that alcohol use among Zimbabwean migrants is not only driven by cultural norms and social participation, but that it also reflects international gender norms with drinking strongly informed by masculinity and femininity constructs. Societies have long used alcohol consumption and its effects as important ways to differentiate, symbolize, and regulate gender roles (Joffe, 1998). Better understanding of how men's and women's drinking patterns differ is thus an important key to answering broader questions of how and why societies try to get women and men to behave differently (Murdock, 2001).

Given than nearly 41% of women in this survey indicated they had not consumed alcohol in the last 12 months compared to 19.8% of men, suggests high female abstainer rates within the population of interest. Future research may want to explore why Zimbabwean women abstain from drinking. An international comparison study by Bernard *et al.* (2009) found that regardless of drinking pattern, and abstainer rate of the country, 'having no interest in drinking' was one

of the most common reasons for abstaining. Though the reasons are not clear, high abstinence from drinking by women may reflect either lower exposure to drinking situations, or alternatively it may reflect a 'self-identification' as persons who have no need to drink (Bernard *et al*., 2009) or a social stigma that does not approve of women drinking.

The results of this study further demonstrated that alcohol abuse occurs in some sectors of the Zimbabwean community living in the UK, especially binge drinking among men and that gender norms may be the driving factor in influencing behaviour. The AUDIT scores highlighted that about 55% of males were categorized as low risk compared to nearly 80% of females who were categorized as low risk drinkers. This finding is broadly consistent with narratives emerging from the ethnography about male expectancies of female drinking. One of the main reasons to study how gender and alcohol interact is that some of the gender differences in drinking, and much of the variation in such gender differences, are cultural (WHO, 2005). This study also concurs with several studies which have confirmed stark gender differences in alcohol use due to the additional stigma placed on women drinking in African cultures. An example is a study by Mbatia *et al*. (2009) on the prevalence of alcohol use and hazardous drinking in Tanzania, which concluded that women were significantly less likely than men to report current use of alcohol (OR 0.53, 95% CI 0.37, 0.75, $p \leq 0.001$). Gender specific data generated from this study demonstrated that male Zimbabwean migrants were more likely to drink than their female counterparts, and if they did drink they were more likely to drink more than females; the survey indicated that 80% of males had consumed alcohol in the last 12 months compared to 59% of females.

My observations of Zimbabwean drinking patterns among men who drink was of a community with a tendency to drink heavily, particularly during weekends, and that this pattern of drinking is not confined to celebrations alone. It is possible that this pattern of drinking could be typical of Zimbabwean males both in present day Zimbabwe and in the UK because of cultural connotations and norms that valorise this behaviour. This pattern of drinking can lead to specific and important risks to health as documented by research focussed on the negative health and social consequences of alcohol use (Rehm *et al*., 2014, WHO, 2014; Allamani *et al*.,

2011). The ethnography demonstrated that to control the negative social consequences of alcohol use, drinking by Zimbabwean men is moderated within the same circle of drinkers. Peers can encourage, exonerate or place a ban on continued consumption by anyone seen to be 'crossing the line'. Past research shows that social peers influence substance abuse, suggesting that the social environment may be an effective target for reducing alcohol abuse across a population (Cubbins *et al.,* 2012). Because men define sensible drinking in terms of Zimbabwean perceptions and norms, it is possible that there are heavy drinkers, who consume alcohol in a socially acceptable manner but are at the severe end of the Alcohol use disorder (AUD) pathway.

For male adults, the recommended limits in the UK are three to four units per day. In this study, over 41% of male drinkers reported consuming more than the recommended daily limits of 3-4 units on a typical day when drinking compared to 26.5% of females. This aligns with a study by Greaves (2008) conducted in Canada which reported that black African males and all those from white ethnic groups drank in excess of these recommendations. Males also tended to drink more frequently and more intensively than their female counterparts, a finding which also is consistent of current literature on gender differences in alcohol consumption (Mbatia *et al*., 2009; Nolen-Hoeksema, 2004). For example, 27.2% of males reported drinking 2 to 3 times a week compared to only 4.1% of females, and on average, over 22% of males reported drinking 5-6 units per day on a typical day when drinking compared to the female estimate of 16% on a typical day when drinking; and nearly 6% of male participants estimated they consumed 10 or more units per day on a typical day whereas no females indicated drinking 10 units on a typical day when drinking. Also, a disproportionately higher prevalence of alcohol dependence was found to be present in males (8.6%) compared to females (0%), a finding which is consistent with current literature on gender and hazardous drinking (Bravo *et al.,* 2013; Mann *et al*., 2005; Dawson, 1996).

Gender norms and expectations were reflected in the numerous narratives emerging from the ethnography. Most of the males whom I interviewed were of the belief that female drinking, particularly in public spaces was unacceptable. The more liberal males advocated for females to either drink at home or in the

company of other females, and at special events. Results from the survey concur with these beliefs and expectations in that most females preferred to drink at home compared to other venues. To further contextualize gender differences, males at all study settings found the consumption of lagers by females as unfeminine and a gross departure from the norms and expectations of a proper 'Zimbabwean woman'.

The survey supports the ethnography by its demonstration that 51% of males chose lager as their first drink preference when given five choices whereas only 10% of females chose lager as their first alcoholic drink preference when given five choices. Again, the survey supported this notion in that 16% of females chose wine as their first choice of alcoholic beverage, with only about 5% of males choosing wine as their first choice. Differences in beverage choice between genders may have long term health implications. It is likely that Zimbabwean males construct wine as less 'potent' than lager which therefore places women who drink wine at an elevated risk of harmful drinking due to its higher levels of alcohol by volume compared to lagers.

The ethnography also revealed expectations of drinking behaviour in the attitudes expressed towards intoxication for men and women. Participants generally appeared tolerant of drunkenness in men as long as it fell within what was perceived as acceptable, whereas intoxication in women was always negatively judged. To get intoxicated in public was heavily linked by some participants to women of 'loose character' and described by some of the participants as unfeminine, whereas drinking of large quantities of alcohol was perceived as normal, and in some cases revered by men. These finding resonate with a study by Bobrova (2010) which found that the main reason given by male participants why women should drink less was the traditional role placed on women as a mother and a keeper of the family.

The ethnography showed that women were perceived by some participants as belonging 'in the kitchen' or as role models for taking a leading role in promoting Christian values in children. The notion of male labelling women as belonging in the home environment is contextualized by the fact that though drinking is largely considered to be a recreational activity, I observed fewer women drinking in

public. Only 6% of female respondents chose to drink at Zimbabwean public social environments compared to about 23% of males who preferred these environments. The survey also revealed that only 33% of males chose to drink at home out of five venue choices, in contrast to over 41% of females choosing to drink from home out of the same venue choices. However, participants across all three settings generally agreed that the UK is more permissive of women drinking compared to the Zimbabwean social environment, meaning that Zimbabwean women in the UK are exposed to an increased risk of engaging in elevated drinking as a form of exercising their personal freedoms when compared to the average Zimbabwean woman in Africa. Some studies have reflected this notion by indicating that immigrant women increased their level of alcohol consumption to accommodate to the absorbing society (Schiff *et al.,* 2005), which implies that Zimbabwean women may be exposed to the risks of increased risk of alcohol use. Alternatively, being Zimbabwean may be a protective factor in that the women might be willing to distinguish themselves from the dominant culture by clinging to their former habits of either total abstinence or limited drinking occasions. It may also be plausible that Zimbabwean women drink more at home and therefore their general absence at Zimbabwean social settings may mislead us to believe that alcohol consumption is lower in Zimbabwean women than what it actually is. Because of the sensitive nature of the subject, compounded by the extra stigma placed on women who drink, it is also likely that women may have under-reported their drinking compared to men. However, the difference in alcohol consumption outcomes between Zimbabwean men and women is so high that even if these assumptions were true, the fact remains that Zimbabwean men had more occasions to drink, drank in larger quantities, and some drank strong alcoholic beverages such as brandy whereas very few women drank in public, drank less quantities and preferred to drink wine.

Furthermore, reversal in gender roles among Zimbabwean migrants where men have lost their bread-winner status may have had the effect of creating more opportunities for men to drink more often. The ethnography revealed that some Zimbabwean men congregate to drink with other men in order to share a common platform for the indirect expression of frustrations and stresses associated with changes in gender roles. To support this notion, the SES ladder differences show that men perceive their social status as being lower in the UK compared to the

pre-immigration era. Again this disparity may be explained by the cultural implications and the stigma attached to women drinking in public spaces. Gender reversals in this population of interest contrasts with findings from a study by Schiff *et al.* (2005) which indicated that despite male and female immigrants from the Former Soviet Union to Israel having similar education and occupational status at the time of immigration, wives were found to be giving up or postponing their occupational integration, especially if it implied a temporary loss of income, for the sake of the husbands' occupational achievements. Reversal in gender roles may also explain the high separations and divorce rates among Zimbabwean migrants which male participants attributed to Zimbabwean wives denouncing their cultural expectation of submission to their husbands.

6.4 Cultural identity and cultural preservation

This study demonstrated that alcohol use among Zimbabwean migrants living in the UK is closely intertwined in Zimbabwean culture. This suggests that a change of behaviour to adopt more responsible drinking by Zimbabwean migrants in the UK will pose some challenges as alcohol use strongly reflects this group's social and cultural capital. This study also concluded that alcohol use among Zimbabwean migrants is not only driven by cultural norms and social participation, but that it also reflects gender norms with drinking strongly informed by masculinity and femininity. Zimbabweans originate from a region with a wide range of alcohol consumption patterns, meaning that some migrants may have experienced conflicting expectations about alcohol use after arrival in the UK. Wong *et al.* (2011) argued that social scripts learned in one's culture of origin influence perception and the behaviours in which one subsequently engages, for example gender roles, which are prescribed at birth influence cultural beliefs. These norms and values were then likely to have been modified by the person's migration experience on settling into the UK, which for some individuals may include prolonged hardship. These norms and beliefs are likely to get further modified by the process of acculturation and adjusting to life in the UK.

Unlike studies on Latino migrants into the USA which indicate that the most recent arrivals have lower rates of alcohol consumption when compared to the more

established immigrants; this study did not find this association. This may be because Zimbabwean migrants originate from an environment that is more permissive of alcohol use compared to that of Latino immigrants. Zimbabweans migrated into a society which is arguably equally as permissive of alcohol use, and differences arise in the context of motivations to consume alcohol, and expectancies about alcohol use. Greenfield *et al.* (2000) argued that the setting and context are related to consumption and drinking patterns, given the potential influences of broader cultural and specific group norms.

Participants at all three study settings revealed a unique and complex network of culturally driven interactive behaviours, attitudes, and perceptions towards the use of alcohol as Zimbabwean migrants. The results demonstrated some possible differences between Zimbabwean migrants and their hosts in the motives for drinking, the nature of drinking and the benefits or consequences of it. Common among participants' beliefs regarding alcohol use was that Zimbabwean drinking in the UK and elsewhere is communal and largely peaceful. This notion was supported by findings from the survey which showed that out of a choice of five settings, 23% of male respondents chose to drink at Zimbabwean social settings. Based on the narratives of participants as well as my observations across all three research settings, suggest that that drinking communally is an integral part of Zimbabwean drinking culture. The implications of this is that the pace, nature, frequency and periods spent drinking become a jointly constructed understanding of Zimbabwean migrants as a community rather than an individual's reasoning patterns. It was common for men to ridicule their counterparts for leaving 'too early' to get home with some quarters of the patronage interpreting it as a weakness rather than taking control of one's self.

The findings of this study suggest that drinking norms are socially developed and that ethnic background and the migrant experience have a powerful influence on alcohol consumption practices, related behaviours and belief systems about alcohol. The study also showed that among first generation Zimbabwean migrants, patterns and the belief system about alcohol use in Zimbabwe may be strong determinants of alcohol use in the host country. The results indicate that socio-cultural norms govern drinking levels from the point of view of what is considered as socially acceptable. This view aligns with Russell and Arthur's

(2016) findings that situate alcohol use within the context of personal, social and cultural conditions. Literature on alcohol studies is inundated with data on negative consequences of alcohol use, with only passing mention of its positive consequences (Worby and Organista, 2007).

In Zimbabwean and many other African cultures, alcohol use is part of many social activities with perceived benefits. In the context of this study alcohol was seen as having the benefits of expanding the social network of Zimbabwean migrants, of providing an arena for social bonding and of reducing the stresses which accompany the daily experiences of living as a minority. Worby and Organista (2007) argued that much of the literature highlighting potential protective factors for migrants describe social context variables such as social support, strong family and community connections, and diet. This explains much of the apparent paradox of relatively good physical and mental health among immigrants in the US, despite obvious social and economic disadvantages (Escobar *et al*., 2000; Mehta and Elo, 2012). Another theory argues for the possible role of attitude and outlook toward life from the vantage point of a new or first generation immigrant that is potentially insulating from the stresses and experiences that accompany the migrant's life (Alegria *et al*., 2006). The extent to which there is an established immigrant community as the basis for strong social ties has also been cited as an important protective factor (Painter 2007; Stone and Meyler, 2007). In as much as most of these findings are from US based studies, it is plausible to postulate that culturally led behaviours with alcohol use as a mediator plays an important role in protecting Zimbabwean migrants in the UK from experiencing mental health problems despite the obvious social disadvantages they face.

The survey also failed to demonstrate significant relationships between the gold standard measures of socio-economic status and increased risk of drinking, contrary to several studies which have found relationships between the two. The ethnography may provide insight into the irrelevance of class and socio-economic position as an explanatory variable for alcohol use in certain communities. Zimbabwean migrants cohere in the face of what was described by participants as an uneasy relationship with their hosts irrespective of class. Interestingly, out of all the four risk categories, respondents who had the highest perceived social status were consistently classified as increasing risk across all three SSS

measures, meaning that subjective social position may in fact be a better predictor of risky drinking behaviours or that standard 'objective' social status measures are not as valid in immigrants. Perceived racism, discrimination and a feeling of loss in general meant that unity of purpose, identity and cultural values determined behaviour over class and social position. Results of this study agree with Agic *et al.* (2011) who revealed that on a wide range of migrant communities in Canada, the types and sizes of alcoholic beverages consumed in each community, drinking levels that are considered 'normal' or 'excessive', as well as the perception of alcohol-related problems are largely shaped by thier cultural norms and beliefs, which often differ from those of the dominant culture.

Contrary to studies which link increased alcohol use to younger age groups (Mathiesen *et al*., 2013), this study showed no relationship in that respect. The ethnography revealed most drinkers across all three study settings as males of middle age, with very small numbers in the younger and older generation. This observation concurs with the survey results which indicated that 77% of respondents were between the ages of 34 to 54. There are several reasons why it is hard to situate our current findings within the broader literature on the role of age in influencing alcohol use. This may be explained by the fact that Zimbabwean migration into the UK largely occurred at the turn of the millennium, with most migrants being young men and women in their mid-twenties to early thirties at that time. About fourteen years later, when this study commenced, the same cohort appears to have remained distinct in its perception and attitude to alcohol use.

Broadly, the ethnography revealed Zimbabwean first generation migrants as continuing with the drinking behaviours of their point of origin. The older generation was largely exposed to both the UK and the Zimbabwean drinking cultures whereas most of the younger generation had been exposed largely to the UK drinking culture. The youngest age group captured in the survey were young children at the time of migration. This makes it plausible that the younger generation of respondents would have naturally copied the drinking behaviours of their host peers. Wong *et al.* (2011) argued that the impact of experiences that took place in the home country and during migration would be less significant for those individuals who were young at the time of migration.

This argument is plausible in explaining why significant differences exist between the younger and elder generation of Zimbabwean migrants in attitudes and patterns of alcohol use.

In the US general population, drinking occurs mostly during college years and early adulthood, and then diminishes over time. In contrast to this, several cross-sectional studies have indicated that Mexican immigrants in the USA do not 'grow out' of drinking in the same way the US general population tends to do (Dawson *et al.*, 2007). This is reflected in the ethnographic findings which revealed that the older generation in the UK continued to drink in the same manner as they did prior to migrating. These findings clearly challenge generalizations in the literature that heavy drinking and heavy episodic drinking are habits of reckless youth, habits that decline as people mature and take on more responsibilities. This may explain why the survey found no relationship between age and an increased risk of harmful drinking.

It must be noted that although patrons at all three study settings were predominantly middle aged men meaning that small numbers in older and younger age groups may make inferences from this analysis misleading. Age selection in drinking patterns may possibly be explained by cultural and acculturation processes, in that the younger Zimbabweans tend to drink at parties and night clubs, whereas the older generation prefer to drink in social contexts similar to the pre-immigration Zimbabwean era. This may also explain why there was a low presence of young patrons across all three study settings. Contrary to my experiences and knowledge of drinking behaviour in Zimbabwe where all generations mingle during communal drinking, the ethnography revealed a skewed image of these experiences. In conclusion, these anomalies may explain why the survey demonstrated a non-significant relationship between age and the risk of increased harmful drinking, contrary to a wide array of studies which link increased alcohol use to the younger age groups. Unless the motivations for drinking are well understood, change to more responsible drinking norms will be difficult to achieve as alcohol use strongly reflects the group's historical and cultural context.

The ethnography revealed that among Zimbabwean migrants who consumed alcohol, lager was drunk almost exclusively, with brands available in Zimbabwe such as Carling and Fosters being the preferred choice. Participants noted how they were socialized to consume lager as long as one could afford it, taking into account that lager was traditionally perceived as more superior to the traditional unfiltered beer, commercially produced across the country and perceived as a low budget alcoholic beverage for the less privileged.

Narratives of the benefits of alcohol use as a necessary lubricant for social interactions were common among participants, however it is also worthy to note that some participants felt alcohol use had its negative consequences. While the risks inherent in driving under the influence of alcohol appear to be widely known, the survey found that a substantial percentage of Zimbabwean migrants in the UK engage in this practice. Nearly all interviewed drivers who consumed alcohol admitted to having been arrested at least once for drink and driving, meaning that a culture of permissiveness towards drink and driving exists among Zimbabwean migrants in the UK. However, Harrison *et al.* (1997) argued that trends like this may in fact reflect police enforcement priorities and sentencing bias rather than differences in offending behaviour, and may be related to institutional racism within the British health and criminal justice systems, but the high level of reporting in the survey also suggests cultural acceptance of drink and driving.

An alarming 10% of respondents reported they have either driven while intoxicated or to have been driven by a person who was intoxicated. The association between drink and driving and an increased risk of harmful drinking was unsurprisingly statistically significant. The univariate regression analysis indicated that respondents who reported drink and driving ‘very often’ were 32 times more at risk of harmful drinking compared to those who had never engaged in drink and driving. To contextualize these findings, participants across all the three study settings gave descriptions of their personal experiences of drink and driving, cases that resonated across all three settings. Narratives of participants’ personal experiences of the consequences of drink and driving for Zimbabwean migrants included prison sentences, loss of registration with professional bodies such as the General Medical Council, the Nursing and Midwifery Council, and deportations to Zimbabwe. High drink and driving cases in the UK were

interpreted by participants as a consequence of the socialization process in Zimbabwe where drink and driving is still socially and culturally tolerated, legal penalties for drink and driving are relaxed, and poor governance on the part of the Zimbabwean Police during the pre-immigration era was common.

Considering that lager was the favourite beverage choice of Zimbabwean men, these findings may also partly be explained by Greenfield and Rodger (1999) who argued that individuals' underestimation of beer's intoxicating effects on road safety compared to other alcoholic beverage types, helps explain beer's over-representation in drink driving violation reports. It was common for participants to also underestimate the number of drinks that made them unsafe to drive, overestimate their abilities to drive while under the influence of alcohol, whilst some felt that the law in the UK on drink and driving was way too strict.

The main findings from the body of research on drink and driving are that impaired driving and fatality rates do vary considerably between ethnic groups; the ethnic population with the highest elevated risk for impaired driving is not consistent across studies; and educational and policy initiatives need to acknowledge and be sensitive of the role played by ethnicity (Asbridge *et al*., 2010). As Cheung *et al*. (1999) noted, examination of drinking and driving reveals that ethnicity is "one of the largest areas of disparity in rates of motor vehicle crash (MVC) injuries and fatalities and ethnic minorities are disproportionately affected by alcohol-related MVCs." Findings of this study therefore calls for community based intervention and education programmes which incorporate cultural influences on drink and driving.

Overall, this study showed that Zimbabwean migrants have complex cultural identities that are based on cultural heritage, social class, social support networks, and transnational relationships (Burholt *et al*., 2016). Also, this study showed that the construct of social identity is valid among Zimbabwean migrants as predicted by SIT and that this construct is a dynamic, situated and multifaceted process (Andreouli and Howarth, 2013). Zimbabwean migrants generally situated alcohol consumption within the context of wider cultural practices and reveals social identity and nationalism are all expressed through drinking. The general feeling among participants across all three ethnographic settings was that they

are routinely treated as foreigners and that they do not belong in the UK. Cheryan and Monin (2005) defined this as identity denial, a situation in which an individual is not recognized as a member of an important in-group. They argued that identity denial furthers the understanding of group dynamics by capturing the experience of less prototypical group members who desire to have their common in-group identity recognized by fellow group members. Thus, the Zimbabwean network in the UK is grounded upon some perception of common identity. Their social identity appears to be negotiated at the individual level as well as within and among the group and within social worlds that span more than one place (Vertovec, 2010). This study therefore highlights the dynamic nature of the transnational setting Zimbabweans find themselves in the UK and the effect this has on the construction, negotiation and reproduction of social and cultural identities.

6.5 Stress management, coping and social cohesion.

The pattern of migration of Zimbabweans to the UK was very age-specific, with most migrants being young to middle aged adults settling in through various legal and extra-legal strategies. Unlike other migrant groups who have settled in the UK, most of the participants across all three study settings viewed their initial migration to the UK as a temporary economic necessity caused by the political turmoil in Zimbabwe, rather than a permanent 'laying down of roots'. Though a sensitive subject to discuss, the ethnography revealed that most participants had gone through the asylum application process to obtain their residence status in the UK. Even though the survey revealed that 70% of respondents had British citizenship, the majority of Zimbabwean migrants had passed through the asylum application process prior to obtaining naturalization.

Narratives arising from the ethnography revealed stressful experiences by Zimbabwean migrants from the point of arriving into the UK up to the time this study was conducted. It can be argued that protective factors such as social networks either obtained through church or at Zimbabwean recreational venues, insulate Zimbabwean migrants from the immediate harsh realities of living in a foreign country. In the long term, the use of alcohol as a coping strategy coupled with the ongoing social assimilation which leads to health behaviours

characteristic of the UK, place Zimbabwean migrants at an increased risk of poor physical and mental wellbeing. Although the survey could not establish deprivation levels because too many respondents refused to supply their post code, the ethnography revealed that most of Zimbabwean migrants live in low income housing estates. Environmental factors, coupled with the need to provide financial and emotional support for family members left in Zimbabwe, living in an alien culture with different norms; and significant language barriers further places Zimbabwean migrants in the UK at an increased risk of emotional stresses.

Hondius *et a*l. (2000), identified the long period of uncertainty faced by migrants as a significant variable in psychological health complaints related to post migration stress. The survey showed that respondents who indicated their immigration status as 'other', and these were most likely to be the undocumented migrants, were more than four times likely to engage in harmful drinking when compared to those respondents who indicated that they were naturalized British citizens. Though this survey did not demonstrate a significant association between perceived stress and an increased risk of harmful drinking, findings from the ethnography based on participant narratives indicated that drinking among Zimbabwean migrants is a way of managing the stresses associated with the migrant experience. The survey partly supported this by demonstrating that respondents who had the highest stress levels had the greatest proportion of those classified as increasing risk. To support this further, respondents who were the most comfortable talking to their neighbours had the greatest proportion of those in the low risk category.

Based on research findings that link high social capital to lower level of stress, it may be plausible to suggest that stress plays an important role in influencing drinking behaviours. As expected, respondents who were the least comfortable talking to their neighbours had the greatest proportion of those in the possible dependence category. This study suggests that Zimbabwean migrants who were uncomfortable living in their neighbourhoods were more likely to resort to spending their time with Zimbabwean peers which in turn placed them at an increased risk of alcohol use. The fact that the survey demonstrated 78% of respondents as experiencing discomfort in talking to their neighbours may provide additional reason why Zimbabwean migrants prefer to drink in the

company of other Zimbabweans. The survey also demonstrated that perceived racism, which is considered as a component of stress, was significantly associated with an increased risk of harmful drinking, a finding that further supports the narrated accounts by some participants who perceived the UK as largely hostile and unwelcoming. These finding are profoundly consistent with the view of some participants who felt that drinking in the company of other Zimbabweans was a sub-conscious strategy to cope with the losses which accompany the migrant experience and the fear of living in an alienating environment.

A study by Murphy *et al.* (2014) indicated that, among both men and women, problem drinking is associated with individual-level social isolation. They argued that one possible explanation is that socially isolated individuals are less well equipped to cope, particularly given the shock of the social and economic transition that occurred on settling into the UK. Their argument is based by previous research linking social isolation to psychological stress (Pevalin and Rose, 2003) which may in turn result in harmful drinking as a self-medicating practice. Coupled with males describing having held 'white collar' or 'middle class' occupations and having been bread winners in Zimbabwe and then finding themselves caught up in humiliating experiences of having to do menial work in the UK to earn a living, it is reasonable to conclude that Zimbabwean migrants experience high levels of stress. Participants' social positions prior to migration is supported by a UK report which found that of all groups surveyed, Zimbabweans had the highest level of education, previous work experience and levels of literacy and English language competency, and 57% had worked as professionals, managers or in professional and technical occupations before immigration (Kirk, 2004).

Most participants across all three settings described having had high expectations of the UK, planning to work in their fields of expertise, and then returning back to Zimbabwe 'in a few years'. These findings are supported by Berry's acculturation model (Berry, 2006) in that immigrants must resolve different expectations of their society of origin with that of their host. When these expectation differences are greater and the barrier to acceptance in the society of settlement higher, the process may result in marginalization or segregation.

This study suggests that Zimbabwean migrants faced high barriers on settling into the UK which in turn may have increased their stress levels, resulting in alcohol use and abuse to deal with these stresses. Some of the participants were very clear with their descriptions of the study settings, namely Matute, Wenera, and the Rhinos and other similar Zimbabwean recreational centres as platforms where largely male patrons used alcohol to 'ease the pain' caused by the stresses that accompany the migrant experience. To support this further, some participants described experiencing feelings of inferiority and discrimination which led to them to congregate to drink in order to deal with the stresses which accompanied their daily lives, such as work related stress, institutional racism, and ethnic discrimination. Reversals in gender roles where Zimbabwean men in the UK have lost the traditional role of 'bread winner' were described as causing extra stresses on men to drink in the company of other men. And for some men who had continued to maintain limited responsibilities in the household domestic scene, their leisure time was used to socialize with other men as a means to relieve the stresses linked to menial work through the use of alcohol. The changes in status and social positions due to the unwelcome changes in gender roles which accompanied the migration process, particularly among men may explain the reason why the role of socio-economic status in explaining alcohol consumption behaviours remains inconclusive. It is likely that the migration and settlement experience transformed Zimbabwean migrants in a way that made them defy the standard effects of socio-economic status on behaviour.

The study also demonstrated that religiosity may be important for predicting alcohol related behaviors and that it may reflect other social mediators of drinking. The survey's three religiosity variables detected that religiosity is clearly associated with alcohol use, suggesting that religion serves as a protective factor against alcohol use. The final multivariate regression model estimated that those respondents who never attended church were three and half times more likely to be at an increased risk of engaging in hazardous drinking when compared to those who attended church very often. These findings are supported by a growing number of studies which have found a negative association between alcohol use and religiosity. These findings are also consistent with findings from a study which concluded that not attending church at least monthly is associated with elevated alcohol use in blacks (Bowie, 2006). Luccheti *et al*. (2014) also provided evidence

of the consistent pattern of association found between some elements of religiosity and alcohol consumption.

The finding of this study, however, has to be taken with some degree of caution. The fact that more Zimbabwean women inherently drink less when compared to men (due to cultural expectations and the stigma placed on women who drink), and that Zimbabwean women are more 'religious' than men, should be taken into account when interpreting the association between religiosity and alcohol use. The survey found that 44.9% of females attended church services very often when compared to only 27.7% of males who stated they attended church services very often, meaning that this disparity may explain for the effects of religiosity on alcohol use in the multivariate analysis. The notion of religiosity and gender was also supported by the ethnography which revealed that females 'belonged at home or at church', again supporting a cautious approach to the effects of religiosity in the relationship between alcohol and Zimbabwean migrants. Nonetheless, this study showed that religiosity, being a fundamental characteristic of Zimbabwean migrants in the UK, remains a key explanatory factor of alcohol related behaviours. With only 12% of respondents having stated that religion was not important in their lives, it may be that this group is more likely not to conform to the average Zimbabwean norms about drinking and other high risk behaviours. Also, in some cases religiosity is confused with spirituality, which is a different but related construct. While religiosity relates to religious participation, affiliation, and association, spirituality is defined in terms of one's relationship with God. A clearer understanding of the multidimensional construct of religiosity is therefore important in facilitating a better understanding of its protective effects against alcohol abuse.

The ethnography revealed church attendance as an alternative coping strategy to congregating for drinking purposes. This view can be conceptualized by the stress process model (Pearlin *et al*.,1981) which has become a key theoretical framework for understanding risk and protective factors among minority groups. The basic premise of the model is that health outcomes related to stress such as alcohol use are contingent not only on the extent of stress exposure, but also on social and personal resources, such as attending church and congregating to drink, that serve as moderating influences on the link between stress and health

outcomes (Pearlin, 1989). This is supported by participants who revealed that attending church played an influential role during difficult life transitions such as those typically faced by Zimbabwean UK based migrants. To further support this argument, several participants across all three study settings gave accounts describing regular church attendance as an alternative platform for managing stress, and providing a sense of purpose, albeit more suitable for women and children. Given that many evangelical Christian denominations of African origin such as Forward in Faith Ministries, Christ Embassy, Family of God and Agape which discourage alcohol use have grown in numbers and popularity in the UK, in part because they are attractive to those seeking sobriety, companionship and social networks to cope with the stresses inherent in immigration, it raises concern that there is no discussion in the literature on migrants regarding the relationship between alcohol use and religiosity.

A study by Reijneveld (1998) showed that most first-generation immigrants report a poorer health and greater use of healthcare compared to the host population. Contrary to his findings, over 82% of respondents in this study self-reported their health status as being either good or excellent. Different studies on lifestyles and health determinants have looked at alcohol consumption and results demonstrate distinguished habits between the host and foreign populations. Although studies show that individuals of lower SES are at greater risk of alcohol dependence, there is evidence that members of some disadvantaged minority race-ethnic groups are at a lower lifetime risk (Gilman *et al.*, 2012; Anthony *et al.*, 1994). The contradictions presented here may have relevance in explaining the argument that subjective social status and not the standard measures of SES may be more important in some cultures in predicting alcohol related risks.

The survey revealed that health status was significantly associated with an increased risk of hazardous drinking, with those respondents with poorer health exhibiting an increased risk of hazardous drinking compared to the healthier respondents. This is not uncommon in migrant communities due to the 'healthy migrant effect', a phenomenon characterised by migrants being healthier than the host population. The healthy migrant effect has been reported in several studies, particularly in the USA and Canada, and migrants from the Caribbean to the UK fit this hypothesis. Harrison *et al.* (1997) noted that following the Caribbean

migration of the 1950's and 1960's, rates of death from alcohol use related diseases of migrants from the Caribbean were much lower than among the UK national population. They argue that although they appear to have increased over a 12-year period, the data was still consistent with the 'healthy migrant' hypothesis, as over time the patterns of health and morbidity among migrants will come to resemble that of the host community. Based on this study's portrayal of demographic characteristics of the population of interest, it is highly likely that Zimbabwean migrants fit this general picture. On the other hand, Harrison *et al*. (1997) argued that the Irish and South Asian migrants to the UK did not fit the picture of the 'healthy migrant' as alcohol use related mortality has been consistently elevated when compared to the UK national population. Unlike the case for Zimbabwean and Caribbean migrants to the UK, it is possible that the Irish and South Asian immigrants may have been negatively selected, with the unhealthy making the journey to the UK, therefore possibly resulting in elevated alcohol related mortality when compared with the UK national. The implications of this is that future alcohol harm reduction strategies in migrant communities need to take into account the evidence presented by 'the healthy migrant' hypothesis. It is likely that Zimbabwean migrants' health trajectory will follow the same pathway as Caribbean migrants if health and social care authorities fail to implement policies which address these findings. It is paradoxical that like Zimbabweans in the UK, many migrants come from poor countries with lower socio-economic status and poor access to health services (Domnich, 2012). A study of 500 Zimbabweans which concluded that 97% of Zimbabweans in the UK had a formal qualification and an above average level of education compared to the British population and other exiled groups (Bloch; 2005), may indicate that this migrant group was positively selected by the migration process due to its health and other socio-economic characteristics. In addition, those Zimbabwean migrants of low socio economic status who arrived with the hope of obtaining economic solutions more rapidly than would have occurred in their country of origin may have been more insulated from the effects of certain harsh realities like racism and discrimination. The differences of expectations among the same cohort of migrants may also explain the hazy picture portrayed in this study regarding the link between stress, socio-economic status and alcohol use.

Despite the migration being fairly recent, with 33% of respondents reported having settled in the UK for 10 years or less, it is plausible to postulate that the significant association between poor self-reported health and an increased risk of harmful drinking may be mediated by the perceived stress and discrimination being experienced by Zimbabwean migrants. Narrated accounts of stresses accompanying the migrant experience further contextualized the link between health, stress and alcohol use. Leshem and Sicron (1998) found that most immigrants suffered a real drop in their occupational status due to the immigration, which in turn is likely to increase the level of stress, resulting in an increase in the risk of experiencing alcohol related problems. Cross-sectional studies of adults have documented associations between actual and perceived discrimination, and alcohol use and problem use among several groups, including racial/ethnic minorities (Yoo *et al.,* 2010). Migration entails social stress (post migration stress) with social health and economic implications that are often accompanied by a loss of family structure, representing an important risk factor for drugs consumption (Gonzalez-Lopez *et al.,* 2012). Stress associated with discrimination renders individuals more vulnerable to established psychological processes that confer risk for negative health outcomes (Hatzenbuehler *et al.,* 2011). The combined effect of low integration in to the host society, low acculturation, and high stress may lead to harmful alcohol consumption, and therefore Zimbabwean migrants are likely to be at an increased risk of poorer health outcomes in the long term.

This study provides evidence of the role of social capital in shaping drinking habits and highlights the importance of community effects on behaviour. Most of the participants described feeling some unease when it came to integrating with the host population, the reason being language barriers, perceived differences in values, norms and needs, which they felt were largely alien to them. Migrants face instability of employment, social alienation and discrimination, as well as profound changes in social and cultural context of living (Lin *et al*., 2005) which in turn may increase the likelihood of using alcohol to cope with elevated stress levels. If these participant descriptions can be interpreted as proxy measures of poor integration, it is not surprising that the survey revealed over 20% as talking to their neighbours less than once in a month and nearly half feeling that they would not ask their neighbour for help if it was needed. The poor integration score

with a mean value of 8.90 (on a scale from 0 to 16, though not extremely high, indicates poor integration among Zimbabwean migrants. Particularly if considered in view of the long periods of settlement in the UK. The consequences of poor integration may be one of the strongest factors which drive Zimbabweans to congregate in their own spaces for drinking and other recreational purposes as a mechanism for reducing the stresses which accompanies the migrant experiences.

Haasen *et al.* (2008) argued that psychosocial stressors associated with both the migration and acculturation process can be considered as risk factors in the development of an alcohol use disorder. This study therefore strongly points to the need for supported integration, specific community based education, health promotion initiatives, and early intervention measures that are sensitive of the cultural and psychosocial factors associated with potentially harmful alcohol use. For example, participants across all three settings showed varied knowledge on the concept of units to assess their alcohol intake in relation to government recommendations on responsible drinking. Midanik (1999) noted that some researchers have focused on alcohol intake measures using subjective assessments and have noted that this type of measure can predict adverse consequences associated with alcohol use more efficiently than objective measures of the amount consumed. The findings of this study also suggest the existence of a bidirectional relationship between social drinking and elevated levels of alcohol consumption.

Most of the participants noted the limited opportunities for socializing without alcohol, meaning that alcohol was perceived as a necessary lubricant for the social interactions between men. The social interactions in turn had the potential to lead to drinking more than intended because of the comfort and ease males felt when drinking in the company of their peers. Some peers also encouraged and fomented drinking to levels beyond what was intended by valorising this as what constituted the real African man. Drinking was seen as the motivating factor to patronize these settings, or alternatively a means to another end such as in finding companionship for those who otherwise had limited social capital. Despite the heavy drinking, particularly so on weekends, participants portrayed positive attitudes towards drinking and socializing collectively, whilst men who drank

alone at home were portrayed as ‘antisocial’ and in some cases ‘alcoholics’. The ethnography also noted that collective drink provided the opportunity for patrons to share resources such as job networks, counsel, and the latest news on the political and social scene in Zimbabwe. The findings of this study therefore suggest Zimbabwean recreational settings as potential platforms for the provision of peer education initiatives which aim at addressing the negative effects of irresponsible drinking. General Practitioners may also possibly offer alternative platforms to address the negative effects of alcohol use through brief interventions.

Burholt *et al.* (2016) and others argue that the extent to which migrants feel they belong to the country in which they reside and/or to the country of origin of their family is likely to have an impact on social cohesion, and this seems to apply to Zimbabwean migrants in the UK. Some research suggests that long term exposure to racism (Karlsen and Nazroo, 2013), or being seen less prototypically British because of one’s language, appearance, attitude and behaviour (Cheryan and Monin, 2005), may decrease a sense of British identity, while other authors have argued that an unsatisfactory social identity may lead to engagement in strategies to cope with and overcome the unsatisfactory identity (Mummendey *et al.*, 1999). Such an unsatisfactory identity may therefore place migrants at risk of use of alcohol as a self-medicating practice. On the other hand, possessing strong identity and social networks is described in some epidemiological literature as influencing the relation between perceived discrimination and varying types of substance use in people with a migration background (De Kock *et al.*, 2017).

6.6 Conclusion

Chapter 6 provided the discussion narrative which drew together the findings of both the qualitative and quantitative strands of the Mixed Methods design. When exploring alcohol use among Zimbabwean migrants who live in the UK, this chapter took the logic of the pragmatist MM position in that neither quantitative nor qualitative approaches alone were sufficient to develop a complete analysis of the research questions at hand, which required integrating highly contextualized interpretative findings with quantitative findings that establish

empirical generalisations. Henceforth, participants' narratives between and among issues of gender and masculinity, cultural identity and its preservation, social cohesion, coping; and stress are integrated with results from the survey using descriptive statistics and ordinal logistics regression to further contextualize the ethnographic findings. This chapter also constructed a framework which identifies alcohol as playing multiple roles in the lives of Zimbabwean migrants by showing gender, religiosity, drink and driving, marital status and health status as demonstrating significant associations with an increased risk of harmful drinking.

The next chapter provides conclusions to the thesis and recommendations for future research.

Chapter 7: Conclusions and recommendations for future research

7.1 Introduction

This chapter closes this study. It begins by providing a summary of the contributions of this study to the body of knowledge. Recommendations for further research are then discussed in the context of research, policy and practice, including a description of methodological challenges, and future direction of using mixed methods in alcohol research. Following this is a discussion of the research limitations. The potential use of screening and brief interventions (SBI) to reduce alcohol harm among Zimbabwean migrants is then critically discussed. Closing this chapter and the thesis is a reflexive account of the experiences of the researcher when conducting the focused ethnography, followed by the concluding remarks.

7.2 Contribution to knowledge.

7.2.1 Introduction

The topic of alcohol use, misuse and abuse among migrant and ethnic communities may be a contentious issue in that it can create unwelcome labelling that can obfuscate the wider agenda on health inequalities with the potential to defeat the effectiveness of alcohol policy and potential health promotion initiatives. While this study does not suggest Zimbabwean migrants or members of other immigrant communities in the UK drink more or less heavily compared to the host population, there are several factors worth further consideration.

7.2.2 Contribution to UK diaspora research.

While it is clear that numerous studies have been conducted on the UK based African diaspora, this study highlights the fact that knowledge on alcohol use among African migrants in the UK is profoundly limited with respect to its

availability. With very little known about alcohol use among migrant communities in the UK, even though in 2011 13% (7.5 million) of the resident population in England and Wales were born outside the UK (ONS, 2013), this study provides useful insight into the drinking patterns among one of the fastest growing migrant communities in the UK. Most of the research on alcohol use and migrants has taken place elsewhere with the findings having limited applicability to the UK. The results of this study therefore contribute towards efforts to reduce the harmful use of alcohol by taking into account the cultural diversity prevalent in the UK. The findings add new light into what is already known about the health and social needs of the African diaspora in the UK. In doing so these findings may contribute towards the formulation of policy and health promotion initiatives which aim to address 'problematic' drinking in the less understood and hard to reach migrant communities in the UK.

7.2.3 Contributions to methodology

Surveys of black and minority ethnic drinking practices face a series of methodological problems (Orford *et al*., 2004), and this study was not an exception. The use of self-report measures of alcohol intake also either conceal or exaggerate the levels of alcohol consumption despite guarantees of anonymity (Heim *et al*., 2004) although this is generally true for host populations as well. To date, most studies on ethnicity and alcohol only use standard demographic and socio-economic measures. These measures, though robust in their applicability in western settings, fail to capture some of the characteristics inherent in migrant populations. Of particular concern is the lack of measures designed to capture demographic variables typical of migrant populations who, for example, continue to maintain long distance relationships with their country of origin. Also, most of the current alcohol research has focused on the use of quantitative methods alone. In light of this, the findings of this research have shown that MM research which employ focused ethnographic methods does work in the study of alcohol use in migrant communities. This study therefore calls for more ethnographic research to be incorporated in MM research on alcohol in order to promote further understanding of the link between migration, culture, ethnicity, and alcohol use. More population based research in the area of migration and alcohol use is

therefore called for and any inferences made evaluated to some extent with longitudinal data from adult general population samples, preferably allowing cross-cultural comparisons.

7.2.4 Contributions to understanding cultural influences on drinking behaviour.

The ethnographic findings contributed towards our understanding of how cultural differences can influence the way sensible drinking is defined. What we now know is that Zimbabweans, and possibly other populations of a similar background to Zimbabwean migrants, define 'problematic drinking' on the basis of socially constructed terms and culturally defined views. These findings highlight the need to incorporate the influence of culture in our understanding of the issues relevant to the construction of problematic drinking. This study therefore highlights the challenges healthcare professionals may face from the point of view of delivering harm reduction education which take into account the cultural diversity prevalent in the UK.

7.2.5 Contributions to understanding the role of gender and drinking behaviour

The risk of harmful drinking and its impact to health and to society was found to be high, particularly so in males. Similar to other studies which were highlighted in the literature review, the final multivariate regression model in this study showed that gender was significantly linked to an increased risk of harmful drinking. This study has therefore shed light into the role of gender in the less understood ethnic communities of the UK. This finding adds to what is already known about gender as a mediating factor in alcohol abuse. We now know that similar to other populations across the world, Zimbabwean males in the UK, and possibly males from other African migrant populations in the UK are at an increased risk of alcohol related harm compared to their female counterparts, meaning that similar to other populations across the UK, health promotion initiatives should take into cognisance the role of gender as a mediating factor for alcohol abuse.

7.2.6 Understanding the explanatory factors for drinking behaviours

The evidence from this study suggests that the migration experience, social status, social adjustment issues and the level of acculturation are important factors in understanding attitudes towards alcohol in diverse ethnic communities. The final multivariate regression model also showed that demographic and psychosocial characteristics, namely gender, marital status, health status, religious attendance and perceived prejudice were all significantly linked to an increased risk of harmful drinking in the population of interest. These findings therefore shed further light into and contributed towards a richer understanding of the factors to be considered when developing evidence based health promotion initiatives for Africans in the UK who share a similar background to Zimbabwean migrants. On the same note, these findings also point towards our understanding of the factors which may serve as useful screening tools for health professionals wishing to identify African migrant communities, and possibly other ethnic minorities at greatest risk of alcohol related problems.

7.3 Recommendations for further research and implications to practice

Given the localized nature of the focused ethnography, it is not clear how far the findings relate to Zimbabwean migrants elsewhere in the UK. Nevertheless, it is highly likely that the results of this study have relevance and applicability to the population of interest, and to other black migrants of African descent, who share similar socio-economic and cultural attributes to Zimbabweans. In addition, this study has also provided an increasingly comprehensive view of alcohol issues affecting migrants and minority ethnic communities, and the need to facilitate larger-scale alcohol research in this area.

The problem of drink and driving among Zimbabwean migrants in the UK was found to be pervasive despite effort by the Police to curb this issue across the UK. This suggests that a more targeted and interactive Police intervention program working through collaborative community preventative education may be more effective in reducing the risk of both roads related injuries and traffic accidents related mortality. This strategy has been shown to be effective in peer

delivered interventions in young people who drink heavily (MacArthur *et al.*, 2016; Alcohol Research UK, 2005). It is thought to provide an alternative harm reduction pathway because it has the ability to take into account the sensitive nature of the subject as well as the cultural meanings attached to alcohol use.

Taking into consideration the special needs and challenges faced by Zimbabwean migrants in the UK, the findings of this study calls for targeted programmes which focus on the prevention of alcohol related problems through evidence-based research. Unless these special needs and challenges are understood, alcohol policy and health promotion initiatives will fail to reach this group. Migrants' experiences in the UK, coupled with their perceptions of socially acceptable drinking, calls for an understanding of, and the development of effective intervention and health promotion programs to prevent or reduce the health, social and economic consequences of alcohol use.

The existing UK policies, interventions and programs that reflect the host culture, including public health awareness campaigns about the risks of alcohol misuse may not always be relevant to the needs of Zimbabwean migrants in the UK, demonstrating that health promotion initiatives that are developed for the host population are not always effective for reaching out to people from different cultures. I was unable to find evidence which suggests attempts to test the protective factors which moderate alcohol abuse within migrant communities when devising health promotion harm reduction initiatives which target the host population. This study highlights the need to create partnerships with community based migrant groups and to actively involve members of these groups in the conceptualization and development of messages and strategies about responsible drinking to reflect the cultural diversity prevalent in the UK. This is an effective strategy used in many other aspects of public health.

The results of this study will help to urge the government to develop coherent strategies to reduce preventable illnesses caused by unhealthy behaviour such as drinking outside recommended guidelines. Much of the development in health prevention and health protection strategies is dependent on the health service moving away from predominantly dealing with the sick. The Wanless Report stipulated that National Service Frameworks should be drawn up to raise

standards of healthcare by improving lifestyles (Wanless, 2002). The findings of this study also support the Wanless Report and calls for lifestyle based health interventions as befitting the cultural diversity prevalent in the UK. More population based research in the area of migration and alcohol use is therefore called for and any inferences made evaluated to some extent with longitudinal data from adult general population samples, preferably allowing cross-cultural comparisons.

7.4 Screening and Brief Interventions (SBI) for Zimbabwean migrants in the UK

7.4.1 Introduction

This study revealed that Zimbabwean migrants perceive harmful and irresponsible drinking on culturally defined terms. This is in contrast to the industrialized world which emphasizes frequency, quantity and nature of alcohol intake as important factors in defining harmful or hazardous drinking. Some of the study participants conceptualized negative outcomes of alcohol intake as being associated with an individual's level of social responsibility in line with community expectations. Participants also revealed a wide range of negative outcomes associated with excessive alcohol use, such as the potential for motor vehicle accidents due to driving while intoxicated, relationship problems, self-neglect; and financial problems.

In view of these findings, a comprehensive public health measure such as targeted intervention and prevention program in high risk communities similar to Zimbabwean migrants is warranted to reduce the impact of alcohol related harm. The increasingly diverse population composition prevalent in the UK underscores the importance of understanding patterns of alcohol use by race and ethnicity and the extent to which interventions may need adaptation for different racial and ethnic groups. The findings from this study offer some suggestions for strategies to prevent alcohol related harm among Zimbabwean migrants in the UK. The findings also raise important questions for future research to inform such strategies.

7.4.2 Screening and brief interventions (SBI): An introduction

Alcohol misuse (at a level below diagnostic criteria for alcohol abuse or dependence) is associated with significant health and social harms (WHO, 2014, NHS, 2011). In order to reduce levels of alcohol consumption and negative impacts of drinking, screening and brief interventions (SBI) are being delivered with individuals that have been identified as positive for alcohol misuse as defined by alcohol screening tools (Heather e*t al.*, 2006). In recent years, there has been a shift in the delivery of substance use assessment and treatment interventions with SBI becoming a popular model, and a growing body of evidence supporting the use of this approach with diverse ethnic and cultural groups (Manuel *et al.*, 2015; Williams *et al.*, 2011; Field *et al.*, 2013). Hyman (2006) argued that the defining characteristics of screening and brief intervention are that a non-specialist is able to explore a potential problem and negotiate healthy lifestyle options with the patient in order to motivate behaviour change. A systematic review by Johnson *et al.* (2010) concluded that adequate resources, training and the identification of those at risk without stereotyping are the main facilitators for successful SBI in primary care.

7.4.3 SBI in the context of Zimbabwean migrants in the UK - Background

An increasingly diverse population composition underscores the importance of understanding patterns of alcohol use by race and ethnicity and the extent to which interventions may need adaptation for different racial and ethnic groups (Manuel *et al.*, 2016). On the basis of the literature reviewed, and results of this study, SBI provide the most realistic framework for reducing the potential impact of harmful drinking in the population of interest. A wide range of studies have concluded that SBI can work for diverse ethnic and cultural groups (Manuel *et al.*, 2016; Williams *et al.*, 2012; Field *et al.*, 2010). Using SBI to reduce risky drinking has the potential to help improve the health of Zimbabwean migrants living in the UK by preventing the range of negative outcomes associated with excessive alcohol use. Brief interventions only take about five to fifteen minutes and their purpose is to increase the person's awareness of his or her alcohol use and its consequences and then motivate the person to either reduce risky drinking or seek treatment, if needed (Kaner *et al.*, 2007;).

Past research shows that social peers influence substance abuse, suggesting that the social environment may be an effective target for reducing alcohol abuse across a population (Cubbins *et al.,* 2012). Because SBI are designed for use by service providers who do not specialize in addiction treatment, Zimbabwean social platforms similar to this study's ethnography setting provide appropriate environments for peer led brief interventions. Because SBI use motivational approaches based on how ready the person is to change behaviour, volunteer peer educators trained to deliver brief interventions (BI) have the potential to provide low cost and effective strategies to reduce harm due to alcohol use (NIAAA, 2005). The ethnography showed that respect to elders by the younger generations is a cultural imperative. For this reason, special attention should be given when choosing screeners and peer educators for any intervention. It is recommended that peer education is delivered by those members of the Zimbabwean community identified as commanding a high level of respect in their respective communities.

Bearing in mind that Zimbabwean migrants are generally well educated, it is also imperative that the peer educators possess at least the same level of education, and a good command of English and Shona or Ndebele. Narratives of mistrust of and perceived discrimination of the host population and its institutions were common among participants. System factors potentially contribute to underutilization in behavioural health care, including socioeconomic status, stigma, and distrust of providers, poor identification, and lack of culturally competent services (Alegria *et al*., 2002). For this reason, incorporation of peers in the SBI program will enhance trust building that in turn will increase capacity utilization to enhance SBI acceptability and effectiveness (Derges *et al*., 2017). Patrons, who regularly visit these social environments, where alcohol use is the norm, can be given feedback about their drinking and appropriate information. The potential which lies in peer led SBI is that those using the service will not feel either judged or accused. BIs which are respectful of and responsive to the beliefs, practices and cultural needs of Zimbabwean migrants can help bring about positive changes in attitudes towards alcohol use. A study by Murphy *et al.* (2014) concluded that higher interpersonal trust was associated with lower odds of episodic heavy drinking among men at the community level. However, they also found a positive association between community level civic participation and

problem drinking among men and women, a finding which both challenges and supports the use of peer support in BI intervention initiatives.

Like in many hard to reach communities, including migrants, alcohol use remains a sensitive subject. For this reason, there is a strong likelihood that Zimbabweans in the UK may feel wrongly targeted by service providers. This can in turn lead to poor response to SBI participation due to fears inherent in Zimbabwean migrants as revealed in this study. Provision of SBI at Zimbabwean social platforms, through a process of peer education, can bring about a sense of trust which can in turn be effective in reducing alcohol use and alcohol-related adverse consequences. The aim is to enhance participants' motivation to reduce their alcohol intake and drink more responsibly and not abstinence.

7.4.4 Implementation of SBI program to Zimbabwean migrants in the UK

The intervention will begin by screening willing patrons at the specific Zimbabwean social settings where alcohol use is a key activity to identify which individuals may have an alcohol use disorder or at risk of experiencing problems associated with alcohol use. Manuel *et al.* (2015) argued that appropriate screening questions are key to accurate identification of substance use problems. The AUDIT will be appropriate for the population of interest as those who participated in the survey did not seem to encounter problems when completing it. It is important that those willing to participate in the intervention are screened using the AUDIT, rather than assuming an individual may have alcohol problems. This study survey revealed that over 80% of respondents had at least a higher education. For this reason it not expected that patrons will have difficulties understanding what a unit is once it is described to them, and therefore the use of pictures is not necessary. An AUDIT score of 8 or more indicates a hazardous or harmful pattern of drinking, and in this case the screening would indicate that brief interventions are needed. Zimbabwean migrants have an above average education compared to the host population, and it is therefore not anticipated that the AUDIT would hinder validity. The AUDIT was in-fact developed with the intent of creating an instrument that would be useful in many countries and cultural groups for detecting risky drinking (Babor *et al*., 1989). With 41% of male respondents reporting drinking above the recommended limits of 3 to 4 units a

day, it would be rational to conclude that risky drinking is present and therefore the AUDIT would be a suitable tool for detecting this.

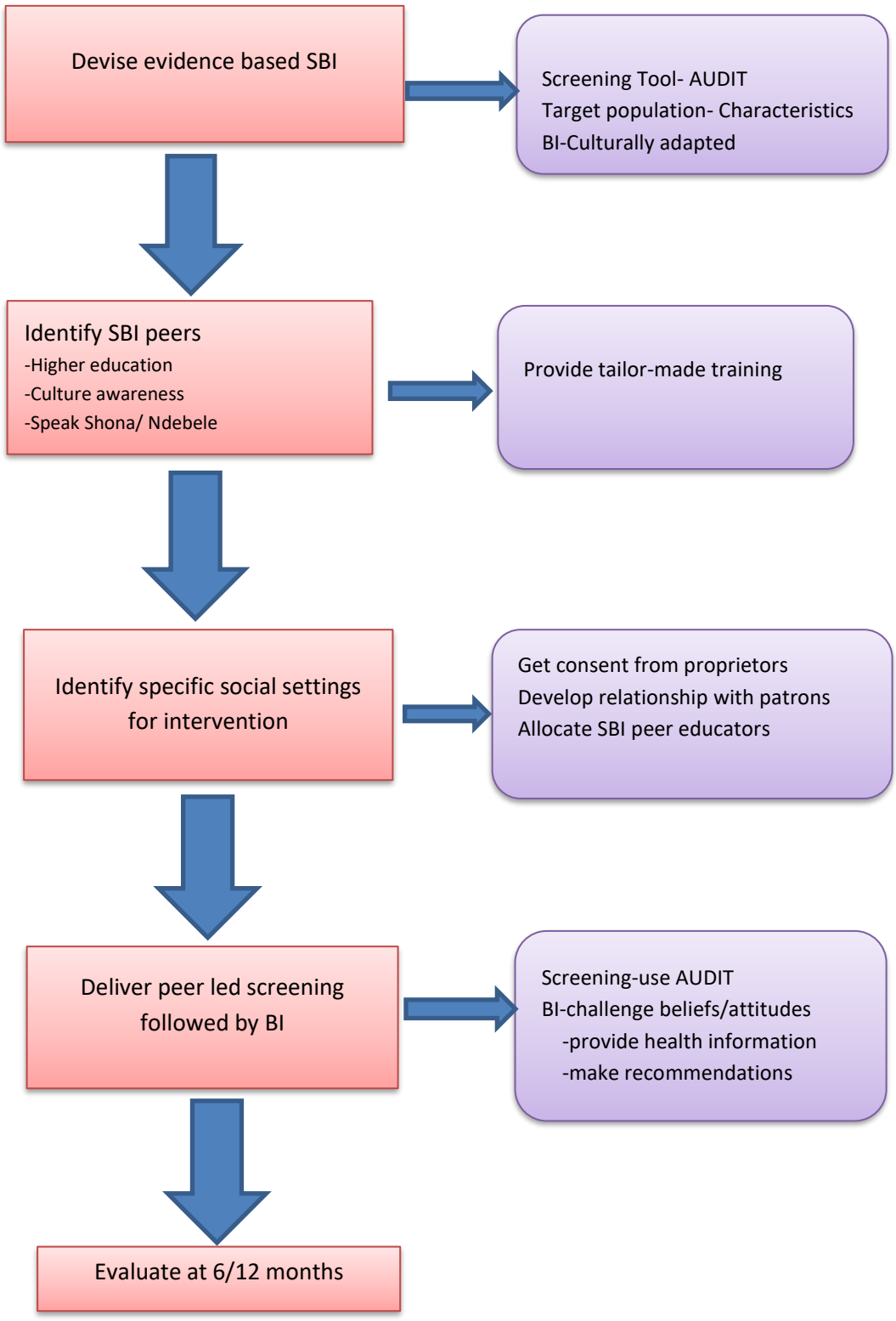
The ethnography showed that there is an element of discomfort by participants in labelling their fellow peers as having problems with drinking, particularly so if the person experiencing the drinking problem is a well-respected and older member of the community. Also, the way participants defined what constituted alcoholism is primarily culturally driven and at odds with definitions used in western literature on alcoholism, which heavily rely on the medical model. Hence, an intervention program that is respectful of, and responsive to the health beliefs, practices and cultural and linguistic needs of migrant populations is likely to bring about positive health outcomes. The content of a potentially effective SBI and peer education program for Zimbabwean migrants should therefore focus on the long term physical harm caused by alcohol, as most patrons would argue that their alcohol use is not interfering with their daily lives.

In view of the strong cultural influences on attitudes and beliefs about alcohol use, it is imperative that the intervention is tailored to everyone's readiness to change as well as being able to invoke relevant cultural values and providing feedback on alcohol use in the context of Zimbabwean patterns and beliefs. The ethnography revealed key stressors in the context of acculturation, as narrated by participants, which are believed to influence drinking patterns among Zimbabwean migrants. These stressors included changing family dynamics, loss of family members in Zimbabwe, social isolation, discrimination, employment difficulties, immigration status, and changes in social status. Hence, rather than inquiring about drinking using standard SBI methods, alcohol intervention on Zimbabweans in the UK should be adapted to include discussions of these potential stressors, and discussions on the perceived realities of living as a migrant. Bernal *et al.* (2009) defined cultural adaptations as ''the systematic modification of an evidence-based treatment (EBT) or intervention protocol to consider language, culture, and context in such a way that it is compatible with the client's cultural patterns, meanings, and values''.

Other than deliver peer education on the negative consequences of alcohol to health, the intervention should also focus on the potential negative effects of drinking on spouses and other family members. Those delivering the SBI and peer education should be sensitive to the socio-economic and psychological struggles being faced by Zimbabwean migrants, as understanding this will make participants more open about their needs (Nicolaidis, *et al*., 2010). This approach to delivering a tailor-made SBI model to at risk drinkers should therefore be grounded in the cultural and social aspects of Zimbabwean drinking patterns and beliefs, and focus on participants' cultural and social contexts, and other environmental factors.

Heavy alcohol use is sanctioned differently in different cultures, and with Zimbabweans it may be considered acceptable unless overt family problems result. Zimbabweans use alcohol as a normative way of either managing stress or for celebrating an event. Thus, incorporating cultural contexts in SBI for Zimbabwean migrants and addressing practical aspects of their daily lives such as raised in the focused ethnography is essential. Figure 14 below is a flowchart depicting the processes involved from implementation to evaluation of SBI program for Zimbabwean migrants in the UK.

Figure 14: Flowchart depicting the processes involved from implementation to evaluation of SBI program for Zimbabwean migrants in the UK



7.5 Research Limitations.

The data reported in this study had its limitations. First the survey data is cross-sectional and therefore does not allow causal inferences to be made. Although narratives from the ethnography suggest more intensive drinking by Zimbabwean migrants, particularly among males when compared to the pre-immigration era, the cross-sectional nature of this study means it is not possible to comment on trends on alcohol consumption.

Second, though all efforts were made to reach out to Zimbabweans in the UK from all walks of life, it was not practical in view of the time and available resources to design a sampling framework that could capture a sample representative of the study population. It should be noted that this study may be limited in its generalizability and therefore caution must be applied when generalizing the results to the entire Zimbabwean migrant community in the UK. Though unlikely, UK regional differences in drinking patterns may have had an influence on the findings. The fact that the ethnography was conducted only in South Yorkshire region and the questionnaire used snowballing techniques may have impacted on the representativeness of the sample. Also, poor response to the post code question means that it was not possible to check representativeness of the sample.

Third, the sample size was too small to get richer inferences. However due to the sensitive nature of the subject, and bearing in mind that a large proportion of Zimbabweans in the UK feel targeted for deportation, a low response rate was not unexpected. It is not uncommon to have studies on alcohol use among migrants which use small sample sizes, the likely reason among others being that migrants are hard to reach out due to the inherent fear of getting labelled as deviant. A study by Wong *et al.* (2011) on intimate partner violence, depression and alcohol use among female migrants of Southeast Asian origin in the USA used a sample size of only 220 respondents. Another example is a study by Loewenthal *et al.* (2003) of beliefs about alcohol among UK Jews which used a sample size of only 161 respondents. Narratives of fears of deportation for engaging in activities which participants felt were undesirable in the UK, irresponsible drinking included, were described in the ethnography. The small

sample size and the lack of an appropriate sampling framework for the population of interest therefore counted as a significant weakness to the study.

Fourth, a measure of deprivation, which can be established from respondent post code data, an important explanatory variable for health related lifestyles, was not used in the final analysis due to a very poor response to this particular survey item. Though all effort was used to reassure respondents that their data would be kept 100% confidential, some respondents were clear in their comments at the end of the survey by stating feeling uncomfortable in providing their post codes on confidentiality grounds. Again the poor response may be explained by findings from the ethnography which portrayed an inherent fear and mistrust of UK institutions by Zimbabwean migrants. In light of this, future studies on migrant communities in the UK may need to incorporate proxy measures of deprivation in their surveys in order to establish the link between deprivation levels and the risk of harmful drinking.

Fifth, it is likely that some form of under-reporting did occur because of the sensitive nature of some of the negative behaviours related to alcohol use. This assumption is supported by the apparent poor response rate on the post code variables and a large number of missing values on the drink and driving variable. It is clear from previous studies on alcohol research that under-reporting remains one of the most pressing weaknesses of using self-report measures of alcohol use, and to support this, sales figures are always way higher than alcohol consumption estimates from self-report data. Taking this into account, using alcohol sales data at Zimbabwean settings and estimating the number of patrons at these settings per unit period may provide future lines of investigation alongside self-report measures.

Sixth, it is not possible to determine whether the 44 participants who were interviewed in the focused ethnography also were among the 331 respondents to the online survey. There is the likelihood of response bias or ‘response shaping’ if the case is participants in the ethnography were also respondents to the online survey

Seventh, the logistics regression modelling process was significantly affected by collinearity. In statistics, collinearity is a phenomenon in which two or more explanatory variables in a multiple regression model are highly correlated,

meaning that one can be linearly predicted from the others with a substantial degree of accuracy. During the regression modelling, the coefficient estimates changed erratically in response to small changes in the multivariate regression model, which will have had an impact on the predictive power of the final model as a whole by reducing the explanatory variables to only five when more were expected. That is, a multiple regression model with correlated predictors can indicate how well the entire bundle of predictors predicts the outcome variable, but it may not give valid results about any individual predictor, or about which predictors are redundant with respect to others. Nonetheless, collinearity does not reduce the predictive power or reliability of the model as a whole and therefore estimates using the univariate regression model remain equally valid in predicting the relationship between the explanatory variables and the outcome variable.

7.6 Reflexive Narrative and Conclusions

7.6.1 Introduction

The reasoning behind undertaking the focused ethnography as one of my MM strands was threefold. First, I aimed to use the outcome of the ethnography to inform the development of questionnaire items for a survey which was implemented in the second phase of my data collection. Second, my aim was to capture the socio-cultural dynamics of Zimbabwean migrants' relationship with alcohol in order to further deepen my understanding of attitudes, beliefs and perceptions of Zimbabweans towards alcohol, as proposed in my research objectives. I had come to the conclusion that the survey on its own was not adequate enough to capture some of the subjective attributes related to alcohol use in relation to the population of interest. Third, I designed the ethnography to support, through triangulation, the empirical evidence which was expected to arise from the survey. In order to achieve this, I embarked on sixteen weeks of interviews and participant observations at three study settings which are geographically situated in the Yorkshire region of the UK.

7.6.2 Rationale

At the very start of the focused ethnography in March 2015, I had set to base my field accounts on my own personal understanding and construction of events based on what I observed and what was being said by participants. This was also congruent to Freshwater and Rolfe (2001) who suggested that the function of research is not to present an analysed theory about the world, but is rather an opportunity for research participants to tell their story. On the other hand, I felt a strong urge to use a framework focussing on alcohol use not just from the point of view of its pathological links or as a social problem, but more so as a culturally valued resource which plays multiple roles in Zimbabwean lives.

The urges to use a framework or terms of reference were based on my perception that it is unscientific to initiate data collection without an idea of what exactly I wanted to know. My dilemma is supported by de Laine (1997) who on one hand argued that ethnographers do not work with either a priori theory or variables but that these are expected to emerge from the enquiry, while on the other hand Kirk and Miller (1986) emphasized on the importance of having a general plan prior to commencing the data collection phase. As the weeks of fieldwork progressed I found myself taking the position shared by Strauss and Corbin (1998) who argued that the golden mean is to be open minded enough that new, surprising discoveries are not ignored, but on the other hand, remaining focused enough to avoid being ‘ in a virtual data flood’.

Having said this, I was also well aware of the impossibility of being entirely independent of the research process. It is for this reason that I employed reflexivity at every stage of the research process, based on its wide acceptance in the field of ethnography. There are several definitions of reflexivity, however I personally admired Coffey’s (1999) definition who states that reflexivity is having an ongoing conversation about experience whilst simultaneously living the moment. This required me to go through a long series of corrections and adjustments to my approach as I went through a field unknown to me. To increase the rigour and plausibility of ethnographic research, it is suggested that researchers include a reflexive account in their report. It is for this very reason that I chose to employ reflexivity to minimise the inevitable biases linked to

playing the dual role of both a peer and the researcher. The validity and reliability of qualitative research, especially in cases like mine where I took a pure constructivist/ constructionist standpoint, is often highly criticized, with some arguing that the empirical inquiry inevitably depends on the arbitrary predilections of the researcher (Paley and Lilford, 2011).

My goal when in the field was to observe, interact with participants and report my findings as an 'insider', meaning that I had to immerse myself (in the best way possible) in the lives of participants, and their daily routines. This also meant that to be accepted by participants as an 'insider' required a climate of complete trust between me and them, a position which is supported by the American Anthropological Association (2004) which states that cultivating an ethical climate for ethnographic research requires trust among all involved in the process of implementing a research project. Reflecting on the specifics of my study, the American Anthropological Association (2004) added that because the ethnographer often resides in the participants' community or geographical area and participates in community life, trust develops between the ethnographer and participants as a result of ongoing relationships. On the other hand, however, I was also aware that to increase the integrity and trustworthiness of my findings meant adopting a more objective stance. This called for a need to 'remove' myself from participants' lives and experiences, by playing a more passive role while in the field. The question remained as to how I would justify my findings as objective rather than just an expression of mere subjectivity. In this respect, I felt that a reflexive approach fitted this dilemma as it would enable me to continually monitor myself. I felt that a reflexive approach would also allow me to transform my personal experiences into public accountable knowledge by revealing how the outcome of my study may have been 'co-created or co-produced' by myself and my participants. A reflexive approach also had the potential to address the challenges I faced in addressing my position as a 'researcher' and my participants as the 'researched' and the dynamic stance I took in positioning myself within an array of reflexive positions.

7.6.3 My personal value systems and subjectivities

I present in this section how my personal core values and subjectivities may have shaped the outcome of the entire focused ethnography by paying attention to the interactions and events that transpired during the data collection phase and how reflexivity helped me to address this. I also demonstrate here some awareness of my personal values to provide insight into how my analysis and interpretation of my finding can be taken into context. At the start of my fieldwork, I tried every 'trick of the trade' to present myself in an informal tone and acted in a pleasant, friendly and humble manner. I was very conscious of the fact that doing a PhD is something many of my participants perceived as extraordinarily special and academically out of reach to them. For that reason, this made me very sensitive, fearing being taken as someone more special than the people I was researching. I also now realise in retrospect, that subconsciously my personal core values may have helped shape the way I presented myself to participants, particularly so when listening to the many sensitive stories of their experiences as immigrants. Human beings have their personal core values which influence the way they respond to certain situations. Though I was subconscious of this, in retrospect I realise that my own personal core values would have certainly influenced the outcomes of this research. I am generally a humble person. In being humble made patrons see me as an approachable person, an attribute which in retrospect played in my favour in getting patrons become participants. As a courteous person, I was also fully sensitive to the needs and feelings of my participants, which helped in getting information on participants' very personal experiences about their daily lives. As a naturally generous person, I sometimes found myself forcing myself to keep my finances within check, with regards to buying drinks to those around me. On the other hand, my character of being courteous and not wanting to disappoint meant that I sometimes felt it hard to decline offers of drinks from patrons who were ever willing to buy. However, my ethical considerations as set in my ethics application were of paramount importance and always played on my mind in positioning myself in such circumstances, at the expense my natural personality. To conclude on this, researchers possess different personal core values, impinge on how they behave, react and perceive situations. Likewise, my personal core values interfered with my interaction with clients and in the process helped shape the outcome of my research. If it had been another

researcher who has the same background as me but held a different set of personal core values, my assumption is the outcomes of this research could have been entirely different.

7.6.4 My social location

Using reflexivity in ethnographic studies has the potential to enhance the quality of research through its ability to extend our understanding of how our positions and interests as researchers affect all stages of the research process (Primeau, 2003). And within discussions of reflexivity, attention is often drawn to the importance of recognizing the social location of the researcher (Mauthner and Doucet, 2003). For this reason, the following account describes my social location within the context of this focused ethnography and the population of interest. The following account also acknowledges how my social location could have contributed in shaping my approach to participants as well as the interpretations of my findings.

Knowing well that my participants had little social capital, and poor access to those with the powers to get their views heard, I felt as if I had become a symbol of 'authority', to them, meaning that I had become a focal point to get their views heard through the publication of their 'voices' in future research articles. The downfall to this imbalance of power between the 'researched' and the 'researcher' meant that my participants were inclined to exaggerate their experiences in order to get their views taken seriously. However, recognizing that I had not personally experienced most of the very severe difficulties faced by many Zimbabwean (financial difficulties, dodging immigration officials, living away from the immediate family, and experiencing the death of close relatives included), I viewed my participants as experts in my topic area. In as much as they saw me as an authority, I also perceived them as 'the authority' in that my study was dependent on their contributions.

Stradley (1979) argued that in order to discover the hidden principles of another way of life, the researcher must become a student. I had the tendency to privilege the narrated accounts of my participants. This posture may have resulted from my experience of migrants' voices being underestimated due to the dominant

society's stereotyping of minority and excluded communities. It is my view that institutions such as the media are controlled predominantly by privileged sections of society who often carry particular worldviews. For that reason, such institutions tend to reflect their own subconscious values and beliefs about migrants' lives without genuinely reflecting the truth. I was very conscious of the fact that without a deep understanding of my participants through trusting their 'voices' it was easy to fall into the trap of stereotyping a community into which I also belonged. In my attempt to prioritize my participants as experts in my investigation, positioned myself at risk of failing to fully acknowledge or objectively take into account my own subjectivities of what was being said to me.

I have lived in the UK for more than seventeen years. Being a Zimbabwean, my reasoning and motivations for choosing to live in the UK is likely to be similar to my participants' own reasoning and motivations. This means that there was a potentially inherent bias in my thought processing even before the start of the field work. My exposure to Zimbabwe by virtue of being born and raised there up to the age of twenty-nine means that that I was already well versed with the norms, values and beliefs about the study population and other attributes relevant to its culture. I was aware from the point of commencing my fieldwork of the fact that I shared the same background as my participants. However, I was not particularly concerned about how this could impact on the outcome of my interaction with participants. It might be that participants responded to the questions posed to them in a particular way, with their knowledge that I am Zimbabwean. It is very likely that participants' behaviours in the study settings may also have been influenced by their knowledge of the fact that I was Zimbabwean like them. If this was the case, it makes sense that the interpersonal dynamics which ensued between me and the researched may have influenced the way some aspects of the data set were interpreted after completion of the fieldwork. Nevertheless, the advantage of being an 'insider' is supported by Pellatt (2003) who argues that unlike early anthropological studies, ethnography is today more often carried out by members of a culture and related cultures than by complete strangers.

On my very first visit to Matute, I felt out of place and psychologically removed from my participants. Though I could speak the same language as my participants

and understood most of the lingo etc., I felt that the interaction between me and participants was at a superficial level. I realised there was the need to reflect on my experiences with participants and the general environment at the end of each visit. I used a diary to record my experiences about some of the encounters I faced when in the study settings. However, as the weeks progressed, the dynamics between myself and the participants in my opinion became increasingly natural. I felt that as the weeks progressed participants became increasingly more open about the various issues we discussed, some of which I felt were very personal to them. I felt very privileged that they 'accepted me into their world' and shared with me their aspirations in life, their challenges and their frustrations. I was surprised by how open some participants were in narrating their personal experiences. It may be that the way I actively listened to participants' stories, even on issues that were irrelevant to the purpose of my study, enabled me to develop closer relationships with them.

Though I have always consumed alcohol since my early adulthood, I initially felt uncomfortable drinking in the research environment and in the circumstances I found myself. I initially felt that to remain objective meant I had to remain sober by abstaining from alcohol. However, as I continued with my field work, I began to consume alcohol with participants, albeit in a controlled manner. Buying in rounds, contributing towards the purchasing of meat for barbeques, and sharing food from the same plate contributed immensely in developing close ties with my participants and in the evolution of my social location.

On many occasions, I often felt as if I was failing to capture every detail of the participants' 'voices'. Of particular worry was the possibility of failing to capture relevant detail. I would frantically jot down notes, and at times inevitably lose some detail. At times I would find myself 'damaging' the natural rhythm of my conversations with participants as I found myself having to listen, and at the same time having to record what was being said to me. My intention was to capture as much information as I could in blueprint without losing detail, and though I am satisfied that the conversations cited in my thematic coding were as accurate an account as was feasibly possible, I fully recognize that I did lose some detail in the process. I also utilized every window of opportunity such as on my way home on the train or bus to jot down issues arising from my fieldwork when they were

still fresh in my mind. This included reflecting on observed events and devising items for further questioning or clarification in future visits.

Creating a balance between capturing as much information as I could, and avoiding damaging the rhythm of engagement with participants was one of my biggest challenges. At times I would utilize toilet facilities as a private space for recording data which I would then expand at the first instance on returning home. In some instances, I used this private space away from patrons if I need to record immediate interpretations of the participants' stories. Such an iterative mode of collecting data was necessitated by the need to avoid recording data when in the middle of conversations to avoid damaging rhythm.

7.6.5 My Ontological and Epistemological Position

Focused ethnography as a method was new to me. Also while my methodological objective was one of an 'immersed', pragmatic and subjective researcher, I felt a somehow positivist pressure to render myself neutral and objective when in the field because of initial biases of perceiving alcohol use as more a pathological issue rather than a socially and culturally valued activity. Despite this pressure, as planned, I adopted constructivist/constructionist principles as the underlying philosophical assumptions for the ethnography.

Constructivist research is relativist, transactional and subjectivist (Guba and Lincoln, 1998). Relativism is the philosophical position that all points of view are equally valid and that all truth is relative to the individual (IEP, 2016). This definition suggests the absence of an objective truth, and an emphasis on the diversity of interpretations that can be applied to the world. Constructivist principles, often thought to have arisen from the work of Max Weber (1864-1924), allowed me to look for culturally derived and historically situated interpretations of the social world into which Zimbabwean migrants in the UK find themselves. This fitted in well with my ethnography as it allowed me to use the concept of culture as a lens through which to interpret my participants' 'voices'. Hence the ethnography was well aligned to a constructivist approach as supported by the work of Max Weber (1864-1924). Guba and Lincoln (1994: p110-111) argue that with this approach the investigator and the object of investigation are assumed to be interactively linked so that the `findings' are literally created as the

investigation proceeds. Pellatt (2003) cites Barnes (1992) as arguing that ethnographers recognize they are unable to put their own knowledge of the social world to one side in the hope of achieving objectivity, because both researcher and researched use the same resources to understand meaning.

My guiding principles to conducting the ethnography were to analyse, interpret individual actions and attitudes, and how Zimbabwean migrants' beliefs, cultural meanings, symbols and social circumstances about alcohol use affected their behaviour. This called for a constructivist approach as this, according to Creswell and Clarke (201) generally works for qualitative studies that value multiple perspectives and deeper understanding of meanings. On the other hand, I was also influenced by the social constructionist theory of knowledge which allowed me utilized ethnographic methods of both participant observation and interviews to generate my data. Adopting this philosophical paradigm, as Gergen (1985) argued, influenced me to interpret my participants' lives as existing due to social and interpersonal influences.

With the knowledge that constructionism takes the view that all knowledge, and therefore all meaningful reality as such, is contingent upon human practices, being constructed in and out of interaction between human beings and their world, and developed and transmitted within an essentially social context allowed me to view the 'voices' of my participants as being constructed rather than discovered. The fact that I was well aware of the differences in cultural backgrounds between my participants and the world they lived in, meaning the UK, meant that I viewed drinking practice by Zimbabwean migrants as being socially influenced at both an individual and communal basis. Apart from the inherited and developmental aspects of humanity, Owen (1995) argued that social constructionism hypothesizes that all other aspects of humanity are created, maintained and destroyed in our interactions with others through time. The most important elements to the theory are the assumption that human beings rationalize their experience by creating a model of the social world and how it functions and that language is the most essential system through which humans construct reality (Leeds-Hurwitz, 2009).

7.6.6 My emotional responses to participants' voices

Mixed emotions constantly arose as a result of participants' stories. I experienced feelings of excitement and nostalgia as funny accounts that reminded me of Zimbabwe unfolded. At times I would experience feelings of sadness, for example when stories of deportations and deaths in Zimbabwe of participants' relatives were shared with me. In many ways I feel privileged when I reflect on the experiences many of my participants faced in the process of settling in the UK. Stories of lawyers, teachers and engineers working as carers in nursing homes for hours exceeding 60 a week hurt me. A story of a Zimbabwean woman who was nearly hit by a train after recognising that she had got onto the wrong platform and then deciding to cross over the rails to the correct platform for fear of being late to work captivated my imagination and reminded me of the desperation which existed in many Zimbabwean homes.

I found Patrick's story captivatingly sad. He informed me he had arrived in the UK in 2002, and had worked in several nursing homes before eventually managing to get a nursing post in a local psychiatric unit. He told me he had never consumed alcohol in his lifetime but did not mind being in the company of other men for banter and recreational purposes. Seeing someone having a soft drink was very unusual. He noted:

My elder brother died of alcoholism in 2012. Initially he would drink normally just like we do here. He always drank lager, but as time went on he began to become more reclusive, not wanting to be seen in places where Zimbabweans meet. He started to drink vodka, ending up drinking several bottles a day……. His marriage broke down, the kids and the wife left him, he lost his job as a nurse even though they had tried to support him with his problem. …. I am still blamed at home for having him die of alcohol. They think I ought to have done more to stop him from getting to that stage. They don't understand that there is nothing I could have done… It was a disgrace to my family.

Patrick appeared genuinely relaxed as his story unfolded whereas I felt uncomfortable listening to such a personal experience. It was a story I wouldn't have been able to share with anyone other than my close friends and colleagues. Hearing such stories made me realise how close my relationship with participants

had developed. I felt that providing participants with the opportunity to vent their feelings and thoughts about their more personal experiences, though at times uncomfortable to listen to, was an important aspect of forging this relationship.

I noted with interest and mixed feelings a story by Cashton, who owned Matute. He spoke to me about a lack of support by the local council when he had proposed to open a bigger and more modern facility for Zimbabweans. His story made me recognise the dreams and aspirations of newly settled migrants, contrary to the general belief that Zimbabwean migrants were there just to work for others and make ends meet. His story made me realise the struggles and aspirations of some Zimbabweans, and reinforced my perceptions of Zimbabweans as a highly success driven community, contrary to some common perceptions about migrants by the host population such as that migrants are only there to usurp the UK's benefit system.

I also noted with a feeling of satisfaction the spirit of cohesion and community responsibility when an obviously very drunk man in his early 30s walked into the Rhinos. Despite trying to coerce others to buy a drink on his behalf, none of the patrons therein present fell to his request. I later learnt that he did petty jobs for Zimbabweans on a cash basis because of his immigration status not allowing him to work in mainstream industry. He spoke with an accent from the east of the country where I am from, an accent which is often taken with ridicule in Zimbabwe. This made me feel emotionally close to him by virtue of our common upbringing. Patrons portrayed him as their comedian, and as drunk as he was, made patrons laugh and the drinking experience more enjoyable.

I found Chipunza's story educational and intriguing when he spoke about his father never believing the existence of the spirit world until during one traditional ceremony held in his village. A black and white bull was chosen by the village elders to symbolize their spirit medium to protect their family from adversities. The ceremony, in his words, involved pouring traditional beer onto the bull, followed by giving the bull the name of his great grandfather. From that point the bull became an embodiment of the deceased, enabling it to look after their family, acting on behalf of the deceased great grandfather, providing protection from evil

and witchcraft. Unbeknown to him, his story also gave me an insight into the role of alcohol in Zimbabwean culture. He continued:

That evening after the ceremony, the bull just disappeared from our pastures. We never saw it for about 3 days and we thought it had been stolen. Then one morning as we got to the kettle pen to milk the cows, amazingly we found it there, right in the kettle pen. How it got inside, up to now no one knows. It could not have jumped in as the fencing was just too high. From that day onwards, my father started to believe in traditional spirits and the role of ancestry…

In light of the numerous stories being told, I realized I had a lot to learn about my population of interest. This was contrary to my earlier preconceptions that by virtue of being Zimbabwean, I was in a privileged position to know about every aspect of Zimbabwean myths, history and traditions. In now agree with Coffey (1999) who describes ethnography as a personal journey of self-discovery. My journey of discovery made me aware of the similarities which exist between my experiences in the field and my professional work as a mental health nurse. At work, I allow patients to vent their feelings and thoughts about their daily lives, and how these feelings and thoughts shape their modes of recovery in a world which is heavily stigmatized towards mental illness. Similarly, my interviews and participant observations allowed the venting of thoughts and feelings too, which made me realise that in fact every person has a story to tell if they are given the opportunity to do so, and that this was an important aspect of forging trusting relationships. Over time, I personally felt trust developing between me and my participants and found myself having to put in less effort to do so.

As a mental health nurse, the challenge I always face is creating a balance between emotional detachment and therapeutic attachment. This is similar to the challenges I faced while in the field. However, there are also existing differences, for example while I conducted my fieldwork I took myself as a learner and in so doing placed the balance of power in the hands of my participants by listening to their stories more rather than them having to listen to me. As a healthcare practitioner, working in institutionalized environments, the opposite is true. The reality of the matter is that the nurse is always in a position of power at the

unfortunate expense of the patient, though there is a progression of efforts to develop patient empowerment and user involvement policies

Appendices

Appendix 1- Spreadsheet of review articles by author, year, title, country, methodology, data analysis and study themes.

	AUTHOR	YEAR	TITLE	COUNTRY	METHODOLOGY	DATA ANALYSIS	THEMES
2	AGIC, B.	2011	Alcohol use in seven ethnic communities in Ontario: A qualitative investigation	Canada	Focus groups	Thematic	Attitudes and perceptions
3	ALMEIDA-FILHO	2005	Social inequality and alcohol consumption-abuse in Bahia, Brazil-- interactions of gender, ethnicity and social class.	Brazil	Primary survey	Odds ratio and logistic regression	SES, gender and ethnicity vs alcohol
4	AMUNDSEN, E.J.	2012	Low level of alcohol drinking among two generations of non-Western immigrants in Oslo: a multi-ethnic comparison	Norway	Secondary Data- Survey	Frequency measurements	SES, gender and ethnicity vs alcohol
5	ANDERSON, P.	2006	Global use of alcohol, drugs and tobacco.	Denmark	Literature Review	Synthesis	Global demographies of alcohol usef
6	ARFKEN, C.L.	2011	Alcohol use among Arab Americans: what is the prevalence?	USA	Secondary Data-survey	Descriptive	Accuturation ans patterns
7	ASBRIDGE, M.	2010	Driving under the influence of alcohol: examining ethno-specific rates and the mediating effects of psychological distress	Canada	Secondary Data-Survey	Logistic regression models	Patterning of use
8	BACIO, G.A.	2013	Drinking initiation and problematic drinking among Latino adolescents: explanations of the immigrant paradox.	USA	Secondary Data- Survey	Logistic regression models	Alcohol use paradoxes
9	BÉCARES, L	2011	The ethnic density effect on alcohol use among ethnic minority people in the UK	UK	Secondary Data-Survey	Multilevel logistic regression	Ethnicity and alcohol use
10	BERGER, L.K	2011	Sociodemographic correlates of energy drink consumption with and without alcohol: results of a community survey	USA	Telophone survey	Logistic Regression and Chi- Square	Patterning of alcohol use
11	BERNARDS, S	2009	I have no interest in drinking': a cross-national comparison of reasons why men and women abstain from alcohol use	UK	Questionnairre survey	Hierarchical linear modelling regression	SES and abstinence
12	BHALA, N	2011	Mortality for alcohol-related harm by country of birth in Scotland, 2000-2004	UK	Secondary Data	SMR Estimates	Mortality by ethnicity
13	BLUTHENTHAL, R.N	2005	Characteristics of malt liquor beer drinkers in a low-income, racial minority community sample	USA	Mixed Methods	Multinomial logistics regression	SES, Brand and ethnicity
14	BODENMANN, P.	2010	A health behaviour cross-sectional study of immigrants and non-immigrants in a Swiss urban general-practice setting.	Sweden	Questionnairre survey	Odds ratio and logistic regression	Immigrant risk behaviours and alcohol
15	BRYANT, A., N	2013	The relation between acculturation and alcohol consumption patterns among older Asian and Hispanic immigrants	USA	Secondary Data-survey	Multi-methods	Acculturation
16	BURSZTYN, P.G.	1986	Alcohol and blood pressure: a social comparison in Zimbabwe.	Zimbabwe	Mixed Methods	Descriptive Statistics	Zimbabwean drinking and culture
17	CAETANO, R.	1998	Alcohol consumption among racial/ethnic minorities: theory and research.	USA	Literature Review	Thematic	Ethnicity and alcohol use
18	CAETANO, R.	1998	Trends in alcohol consumption patterns among whites, blacks and Hispanics: 1984 and 1995.	USA	Survey -Interviews	Logistic regression	Ethnicity and alcohol consumption
19	CAETANO, R.	2000	Intimate partner violence and drinking patterns among white, black, and Hispanic couples in the U.S.	USA	Primary Survey	Logistic regression/Chi Square	Violence, ethnicity and alchol use
20	CAETANO, R.	2010	Sociodemographic predictors of pattern and volume of alcohol consumption across Hispanics, Blacks, and Whites: 10-Yr	USA	Secondary Data- Survey	Chi- Square/t-tests/Multiple linear regres	
21	CERVANTES,R	1990	Psychosocial and cognitive correlates of alcohol use in younger adult immigrant and US born Hispanics	USA			
22	CHERSICH,M.F	2010	Causal links between binge drinking patterns, unsafe sex and HIV in South Africa: Its time to intwervene	South Africa	Literature Review	Thematic	Alcohol, Unsafe sex/HIV/Interventions
23	CHIN, K.L	1990	Social Adjustment and alcoholism among Chinese immigrants in New York	USA			
24	CLAUSEN,T	2009	Diverse alcohol drinking patterns in 20 african countries	Africa	Secondary data-interviews	Crude correlation coefficints/descriptive	Diversity in african drinking habits
25	COLDIRON, M.E.	2008	Relationship btwn alcohol consumption and unprotected sex among known HIV-discordant couples in Rwanda & Zambia.	Rwanda & Zambia	Questionnaire interview	Chi Square Multivariate Analysis	Alcohol and HIV transmission
26	COOK, W.K.	2013	Who's at risk? Ethnic drinking cultures, foreign nativity, and problem drinking among Asian American young adults.	USA	Secondary data-survey	Multiple logistics regression	Alcohol, Acculturation & Socioeconomics
27	COOK, W.K.	2009	Rethinking Acculturation: A Study of Alcohol Use of Korean American Adolescents in Southern California.	USA	Survey	Multivariate Regression	Alcohol, Acculturation & Socioeconomics
28	COOK, W.K.	2012	Ethnic drinking cultures and alcohol use among Asian American adults: findings from a national survey.	USA	Survey	Multiple logistics and linear regression	Ethnicity, intergration and alcohol use
29	CUBBINS, L.A.	2012	Alcohol use and abuse among rural Zimbabwean adults: a test of a community-level intervention.	Zimbabwe	Interviews	t tests and logistic regression	Alcohol use & interventions in Zimbabwe
30	DI COSMO, C	2011	Immigrant status and acculturation influence substance use among New Zealand youth.	New Zealand	Survey	Logistic regressin model	Acculturation, status and substance use
31	DILLON, F.R	2012	Preimmigration Family Cohesion and Drug/Alcohol Abuse Among Recent Latino Immigrants.	USA	Survey	Multivariate poisssson regression	Pre-immigration influence on alcohol use
32	Doku, D	2012	Socioeconomic differences in alcohol and drug use among Ghanaian adolescets	Ghana	Cross sectional survey	Logistic regression models	SES and alcohol use
33	DONATH, C	2011	Alcohol consumption and binge drinking in adolescents: comparison of diffrent migration backgrounds and rural vs urban	Germany	Representative survey	Descriptive, ANOVA, Chi Square	Drinking behaviour and background
34	DONOVAN, J.E	2008	Children's introduction to alcohol use: sips and tastes.	USA	Computer assisted interviews	Logistic regression	Parents influence children to drink
35	EIDE,, A, H	1996	Cultural orientation and adolescents' alcohol use in Zimbabwe.	Zimbabwe	Survey	Principal component anslysis, Regression	Western vs Zim culture and alcohol use
36	EIDE, A.H.	1996	Diferent alc types- different modes of drinking: the association btwn alc type preferences & indicators for regular drinking	Zimbabwe	Survey	Principal component anslysis, Regression	Mixed Alcohol types = less drinking
37	EITLE, T.M.,	2009	Immigrant generation, selective acculturation, and alcohol use among Latina/o adolescents.	USA	Secondary data-survey	Logistic Regression	Generational diffrences in alcohol use
38	FANG, L.	2011	Alcohol use among Asian American adolescent girls: the impact of immigrant generation status and family relationships.	USA	Primary Survey	Structural Equation Modelling	Acculturation, families and alcohol use
39	FATCH, R.	2012	Alcohol consumption as a barrier to prior HIV testing in a population-based study in rural Uganda.	Uganda	Secondary Data-Survey	Poison models, bi/multivariate analysis	Alcohol as a barrier to HIV testing
40	FERRON, C.,	1997	Health behaviours and psychosocial adjustment of migrant adolescents in Switzerland	Switzerland	REQUESTED		
41	FESAHAZION, R.G.	2012	Disparities in alcohol use: does race matter as much as place?	USA	Secondary Data-Survey	Multiple Regression	Race dont matter if background similar
42	FIELD, C.A.	2004	Ethnic differences in intimate partner violence in the U.S. general ppn: the role of alcohol use and socioeconomic status.	USA	Literature Review	Thematic	IPV related to alcohol use by race.
43	FIERRO, I.	2010	Differences in alcohol-related mortality between foreign-born and native-born Spaniards.	Spain	Secondary Data	Mortality Rates, Prevalence	Differences exist with less in foreign born
44	FINCH, B.K.	2003	Employment frustration and alcohol abuse/dependence among labor migrants in California.	USA	REQUESTED		
45	FINCH, B.K.	2013	Subjective social status and substance use severity in a young adult sample.	USA	Survey -Online	Structural equation models	SSS can predict alcohol use vs SES
46	FOSTER, J.	2007	A review of tobacco and alcohol use literature in the native and migrant Greek community	Greece	Literature Review	Review	Difference with western alcohol use
47	FREEMAN, R	2008	Binge drinking and HIV/AIDS risk in Africa.		Letter	Review	
48	FRITZ, K.E.	2002	The association between alcohol use, sexual risk behavior, and HIV infection among men attending beerhalls in Harare	Zimbabwe	Survey	Logistic Regression modelling	HIV, Alcohol use and risky sex behaviours
49	FRITZ, K	2011	Evaluation of a peer network-based sexual risk reduction intervention for men in beer halls in Zimbabwe	Zimbabwe	RCT		Alcohol, sex and peer education effect
50	FRITZ, K.	2010	Alcohol: the forgotten drug in HIV/AIDS	N/A	Literature Review	Review	Alcohol use associated with sexual risk
51	GALVAN, F.H.	2003	Alcohol use and related problems among ethnic minorities in the United States.	USA	Literature Review	Review	Ethnicity in relation to alcohol use/problem
52	GARCIA, V	2008	Problem Drinking among transnational mexican migrants: Exploring migrant Status and Situational Factors.	USA	Ethnography./Focus groups	Thematic Analysis	REQUESTED
53	GEREVICH, J.	2006	[Spectrum of hazardous alcohol use].	Hungary	Abstract only		
54	GILLAM, S.	2004	Health needs of Zimbabweans are poorly recognised in UK	UK	Letter	Review	Zimbabwean health needs in UK
55	GILMAN, S.E	2008	Education and race-ethnicity differences in the lifetime risk of alcohol dependence	USA	Survey	Odds Ratios/ Modelling	
56	GONZÁLEZ-LÓPEZ, J	2012	Prevalence of alcohol, tobacco and street drugs consumption in adult Latin American immigrants.	Spain	Survey	Descriptive Statistics	Drug use in adult migrants
57	GREENFIELD, T.K	2009	Modeling cognitive influences on drinking and alcohol problems.	USA	Survey	Path Analysis	Cognition
58	GREENFIELD, T.K	2006	Maximum quantity consumed and alcohol-related problems: assessing the most alcohol drunk with two measures	USA	Secondary Data-Survey	Logistics Regression	Measurements for alcohol use
59	GREENSLADE, L	1995	A good man's fault: alcohol and Irish people at home and abroad.	UK	Literature Review	Thematic/Standardised Rates	Stereotyping irish migrant drinking
60	GUPTA	2010	Spatial mobility, alcohol use, sexual behavior and sexual health among males in India. *AIDS And Behavior*	India	Survey	Logistic Regression	Migration, mobility, alcohol and STI/HIV
61	GUTMANN, M.C	1999	Ethnicity, alcohol, and acculturation	USA	Literature Review	Discussion	Stereotyping ethnicity with alcohol use
62	HAASEN, C.	2008	Alcohol use disorders among Afghan migrants in Germany	Germany	Survey	Descriptive Statistic/Correlation	Acculturation stress/audit & alcohol use
63	HAHN, J.A	2011	Adding fuel to the fire: alcohol's effect on the HIV epidemic in Sub-Saharan Africa.	Sub Sahara	Literature Review	Discussion	Alcohol influence on HIV transmission
64	HAMILTON, H.A.	2013	Subjective Social Status, Immigrant Generation, and Cannabis and Alcohol Use Among Adolescents	Canada	Survey	Logistic Regression	SSS versus substance use in the young
65	HANSEN, A.R	2008	Health behaviour among non-Western immigrants with Danish citizenship	Denmark	Survey	Logistic Regression	Migrants and health behaviours/ alcohol
66	HARRISON, L.	1993	Consumption and harm: drinking patterns of the Irish, the English and the Irish in England	UK	Literature Review	Review	Realities of irish drinking
67	HARRISON, L.	1997	Ethnic differences in substance use & alcohol-use-related mortality among 1st generation migrants to England and Wales	UK	Review	Trend Analysis	Ethnicity and alcohol mortality
68	HATCH	2011	Identifying socio-demographic and socioeconomic determinants of health inequalities in a diverse London community	UK	Survey	Logistics Regression	SES, demographics and health outcomes
69	HATZENBUEHLER, M	2011	Discrimination and alcohol-related problems among college students: A prospective examination of mediating effects	USA	Survey	Structural Equation Modelling	Discrimination results in alcohol use
70	HAWKINS, S.S	2008	Influence of moving to the UK on maternal health behaviours: prospective cohort study	UK	Survey	Descriptive Statistics	Changing patterns in health behaviours
71	HENNESSY-BURT	2011	A Pilot Binational Study of Health Behaviors and Immigration	USA	Survey	Logistic Regression	Acculturation assocation with health
72	HERD, D.	1993	Drinking contexts and drinking problems among black and white women	USA	Survey	Factor Analysis/Path Analysis	Drinking choices and contexts evaluation
73	HIGUCHI, S.	1994	Relationship betwn age & drinking patterns & drinking problems among Japanese, Japanese-Americans, and Caucasians	USA	Survey	Logistic Regression	Demographics and alcohol
74	HINES, A.M.	1998	Alcohol and AIDS-related sexual behavior among Hispanics: acculturation and gender differences	USA	Survey	Logistic Regression	Acculturation, gender and risky sex
75	HINES, A.M.	1998	Acculturation, alcohol consumption and AIDS-related risky sexual behavior among African American women	USA	Survey	Logistic Regression/ Chi Square	Acculturation, black women and risky sex
76	HJERN, A	2004	Alcohol-related disorders in first- and second-generation immigrants in Sweden: a national cohort study.	Sweden	Survey	Relative Risk	Influence of migrant generation status
77	HUERTA, M.C	2010	Education, alcohol use and abuse among young adults in Britain	UK	Survey	Descriptive Statistics/Odd Ratios	Association between education and alcohol
78	IDEMUDIA, E.S.	2013	Migration challenges among Zimbabwean refugees before, during and post arrival in South Africa	South Africa	Focus groups/Interviews	Thematic analysis/ grounded theory	Personal Experiences of the diaspora
79	ISMAYILOVA, L	2013	Mental Health and Migration: Depression, Alcohol Abuse, and Access to Health Care Among Migrants in Central Asia	REQUESTED			
80	ISRALOWITZ, R.	2009	Late life alcohol use and gender differences among Former Soviet Union immigrants	Israel	Survey	t-tests, chi-square	Gender , elder adults and alcohol use
81	JAMSHIDI, Y.	2010	Tribal ethnicity and CYP2B6 genetics in Ugandan and Zimbabwean populations in the UK	UK	Survey	Transformations	Genetics and HIV in Zimbabwean migrants
82	JOHNSON, T.P	1996	Alcohol and drug use among displaced persons: an overview.	USA	Literature Review	Trend Analysis	Theoretical processes of alcohol use
83	JOHNSON, T.P	2002	Migration and substance use: evidence from the U.S. National Health Interview Survey	USA	Survey	Descriptive/ Logistics Regression	Immigrant alcohol use theories in the USA
84	JONES-WEBB	1995	Relationships between socioeconomic status and drinking problems among black and white men.	REQUESTED			
85	JONES-WEBB,	1997	Predictors of increases in alcohol-related problems among black and white adults:84 and 92 National Alcohol Surveys	USA			
86	KAHN, M.W.	1995	Children of South Sea Island immigrants to Australia: factors associated with adjustment problems	Australia	Survey- Interviews	Descriptive Statistics	Deliquency and alcohol use (not printed
87	KALICHMAN, S.C	2013	Bringing it home: community survey of HIV risks to primary sex partners of men and women in alcohol-serving estabs	South Africa.	Survey	Logistics Regression	HIV and Alcohol (5)
88	KANTOR, G.K	1997	Alcohol and spouse abuse ethnic differences	USA	Literature Review	Trend Analysis	Ethnicity culture and wife assults 4,5
89	KAPTSAN, A.,	2006	Ethnic origin of alcoholics admitted to an Israeli treatment center	Israel	Survey-Interviews	Chi Square	Ethnicity, Religiosity and Alcohol3, 4,5
90	KARAM, E	2007	Alcohol use among college students: an international perspective	Global	Systematic Review	Trend Analysis	students and global alcohol use 2,5
91	KARRIKER-JAFFE, K.	2013	Income inequality, alcohol use, and alcohol-related problems.	USA	Survey	Logistics Regression	Income Inequality and alcohol 2,7
92	KEYES, K.M.	2012	Stress and alcohol: epidemiologic evidence	USA	Literature Review	Evidence Review	Stress and alcohol use 4,5,6,8
93	KEYES, K.M.	2011	Stressful life experiences, alcohol consumption, and alcohol use disorders	USA	Literature Review	Evidence Review	Stress and alcohol use 4,5,8
94	KIENE, S.M.	2013	Event-level association between alcohol use and unprotected sex during last sex....Sub Saharan Africa	Africa	Survey	Event Level Aanalysis- Linear Regression/OR.	Unprotected sex.. 2,5
95	KIM, D.K.	2013	Innate health threat among a visibly hidden immigrant group: Zimbabwean workers in Botswana.	Botswana	Ethnography	Thematic Analysis	Zim Immigrant experience 2,5
96	KIM-GODWIN, Y	2004	Stress among migrant and seasonal farmworkers in rural southeast North Carolina	USA	Survey	Regression, ANOVA, t-tests, Descriptive Stats	Perceived Stess and Alcohol 1,2,5,8
97	KIM-GODWIN	2009	Gender differences in IPV & alcohol use among Latino-migrant and seasonal farmworkers in rural SEast North Carolina	USA	Survey	Descriptive Statistics, Bivariate Statistics	IPV and Gender 5,6
98	KOOPMAN, F.A.	2008	Addressing alcohol problems in primary care settings: a study of general medical practitioners in Cape Town, South Africa	South Africa	Survey	Descriptive Satistics	GP Screening challenges 7
99	KRUEGER, P.M.	2011	Race/ethnic differences in adult mortality: the role of perceived stress and health behaviors	USA	Survey	Modelling techniques	Perceived Stress, Mortality and ethnicity 2
100	KUMAR, N.	2009	Comparing dietary and other lifestyle factors among immigrant Nigerian men living in the US... Potential Implications	USA	Survey	Descriptive Statistics, Bivariate Analysis	Risk Reduction- Prostate cancer, 4,5
101	LA ROSA, , MARIO	2012	Alcohol Use Among Latinos: A Comparison of Pre-Immigration, Post-Immigration, and US Born Latinos	USA	Survey	Chi Square/Descriptive	Pre/Post Immigration use 2
102	LANDRINE, H	2004	Culture change and ethnic-minority health behavior: an operant theory of acculturation	Global	Literature Review	Review	Accuturation theories 3,4
103	LARSEN, S	1993	The origin of alcohol-related social norms in the Saami minority.	Norway	Literature Review	Review	Ethnic native populations 4
104	LEÃO, T.S.	2006	Hospitalization due to alcohol and drug abuse in first- and second-generation immigrants	Sweden	Survey	Cox Regression Models	SES and consequences 2,5
105	LEE, J.P.	2008	Alcohol use among two generations of Southeast Asians in the United States	USA	Survey/Interviews(MM)	Descriptive Stats/Thematic Analysis	Socioeconomic status 2,3
106	LEGGE, C.	1990	Perception of alcohol use and misuse in three ethnic communities: implications for prevention programming	Requested/RECEIVED			
107	LEWIS, J.J.C	2005	Beer halls as a focus for HIV prevention activities in rural Zimbabwe	Zimbabwe	Survey	Chi-Square, Regresssion	HIV prevention 5,6,7
108	LI, H.Z.	1994	Exploring factors influencing alcohol consumption patterns among Chinese and Caucasians	Canada	Survey	Model testing via Path Analysis	psychosocial vs biomedical 3,4
109	LI, Q.	2010	Cohabitation, gender, and alcohol consumption in 19 countries: a multilevel analysis	Global	Survey	Descriptive Stats	Intimate partner set up influence 6
110	LIM, W.,	2007	Trends in alcohol consumption in Singapore 1992 2004	Singapore	Surveys	Descriptive Stats, Odds Ratios	Trends 0,2
111	LINDERT, J.	2008	Mental health, health care utilisation of migrants in Europe	Europe	Literature Review	Review	Mental Health 2
112	LO, C.C.	2012	Problem drinking by race and nativity: what is learned from social structural & MH related data of US-born and immigrants	USA	Survey	Linear Regression	Stress and Mental Health 2,4,8
113	LOURY, S.	2011	Binge Drinking Among Male Mexican Immigrants in Rural North Carolina.	USA	Survey	Linear Regression	SES and acculturation 2,3
114	LOURY, S.	2007	Correlates of alcohol and tobacco use among Mexican immigrants in rural North Carolina	USA	Survey	Linear Regression	SES, Gender and acculturation 2,3,6
115	LUO, X.F	2012	Prevalence & correlates of alcohol use and subsequent sexual activity: adult males in a rural China...	China-Abstract	Survey	Odds Ratios	Ethnicity and demographics, HIV 4.5
116	MABUNDA, M.M	2008	Magnitude and categories of pedestrian fatalities in South Africa	South Africa	Survey	Descriptive Statistics	Magnitude and temporal factors 2
117	MAGER, A	2004	White liquor hits black livers': meanings of excessive liquor consumption in SA in the second half of the twentieth century	Soth Africa	Literature Review	Evidence Review	Social and political connotations. 2
118	MAKIMOTO, K	1998	Drinking patterns and drinking problems among Asian-Americans and Pacific Islanders.	USA	Literature Review	Evidence Review	Ethnicity and demographics 4
119	MALDONADO	2011	Drinking and driving among immigrant and US-born Hispanic young adults	USA	Survey	Logistics Regression	Drink Driving initiation 2, 4
120	MALUNGUZA, N.J	2012	Investigating alcohol consumption as a risk factor for HIV transmission in heterosexual settings in SS African communities	Africa	Survey	Mathemal	HIV prevention 5,6,7

121	MARIO, DILLON,	2013	Alcohol Use among Recent Latino Immigrants Before and After Immigration to the United States	USA	Survey	Chi-Square, RMANOVA	Etnicity and Acculturation 3,4
122	MARSIGLIA, F.F.	2008	Immigrant advantage? Substance use among Latin American immigrant and native-born youth in Spain.	Spain	Survey	Descriptive, t tests, correlation	Ethnic Identity and risk taking 4
123	MARSIGLIA, F.F	2009	Cohesion and conflict: family influences on adolescent alcohol use in immigrant Latino families.	USA	Survey	Logistics Regression	Family influence 4,2
124	MARTINEZ, P.	2011	Alcohol abstinence and drinking among African women: data from the World Health Surveys.	AFRICA	Survey	Logistics Regression	Gender 6
125	MASEL, M.C.	2006	Examining the role of acculturation in health behaviors of older Mexican Americans	USA	Survey	Logistics Regression/Descriptive	Acculturation measures and SES 2,3
126	MATAURE, P.	2002	Alcohol use and high-risk sexual behavior among adolescents and young adults in Harare, Zimbabwe	Zimbabwe	Survey	Descriptive/ Thematic	HIV prevention MM use 5,7
127	MATZOPOULOS, R.	2012	Global Fund collusion with liquor giant is a clear conflict of interest	South Africa	Literature Review	Evidence Review	Alcohol Policy 7
128	MEHTA, N.K.	2012	Migrant selection and the health of U.S. immigrants from the former Soviet Union.	USA	Survey	Descriptive/Logistics Regression	Immigrant paradox and Health Status 2
129	MEZUK, B.	2010	Reconsidering the role of social disadvantage in physical and mental health: stressful life events, health behaviors, race, and depression.	Survey	Logistics Regression	Disadvantage indicators 2,5
130	MOHINDRA, K.S	2011	Alcohol use and its consequences in South India: views from a marginalised tribal population	India	Particiapatory/Interviews	Thematic Analysis	Subjective viewpoints, 4
131	MONSHOUWER, K.	2007	Ethnic composition of schools affects episodic heavy drinking only in ethnic-minority students.	Netherlands	Survey	Logistic Regression	Ethnic Protectiveness 4
132	MUKAMAL, K.J	2007	Impact of race and ethnicity on counseling for alcohol consumption: a population-based, cross-sectional survey.	USA	Survey	Logistics Regression	Counselling disparities 4
133	MULIA, N.	2012	Social adversity, stress, and alcohol problems: are racial/ethnic minorities and the poor more vulnerable?	USA	Survey	Logistic Regression/ ANOVA	Stress 8
134	MULIA, N.	2009	Disparities in alcohol-related problems among white, black, and Hispanic Americans.	USA	Survey	Logistic Regression	Consequence 4,5
135	MULIA, N	2008	Social disadvantage, stress, and alcohol use among black, Hispanic, and white Americans	USA	Survey	Logistic Regression	Stress and social disadvantage 4,8
136	MYERS,	2013	Barriers to alcohol and other drug treatment use among Black African and Coloured South Africans	South Africa	Survey	Logistics Regression	Interventions 7
137	NEFF, J	1995	Alcohol use, liberal/conservative orientations, and ethnicity as predictors of sexual behaviors.	USA	Survey- abtract only	Logistic Regression	Sex, ethnicity and gender 4,6
138	NEFF, J.A.	1992	Acculturation and drinking patterns among U.S. Anglos, blacks, and Mexican Americans.	USA	Survey- abstract only	Logistics Regression	Acculturation generations, ethnicity 3,4
139	NGUYEN, L.T.	2012	Cigarette smoking and drinking behavior of migrant adolescents and young adults in Hanoi, Vietnam	Vietnam	Survey	Logistics Regression	Smoking and adolescents
140	NICHOLS, B.E.	2012	Density of drinking establishments and HIV prevalence in a migrant town in Namibia	South Africa	Ecological Study	Poisson Regression	HIV and alcohol 5
141	OBOT, I.S.	2012	Developing countries ignore drinking and driving problems at their own peril	UK	Commentary	Comments	Drink and Driving 5
142	PAGE, R.M.	2009	Psychosocial distress and alcohol use as factors in adolescent sexual behavior among sub-Saharan African adolescents	Africa	Survey	Logistic Regression	HIV, Stress and in Adolescents 5,8
143	PÄRNA, K	2010	Alcohol consumption in Estonia and Finland: Finbalt survey 1 Finland/Estonia	Finland	Survey	Logistic Regression	SES and Ethnicity, 2,4,6
144	PARRY, C.D.	2011	Alcohol consumption and non-communicable diseases: epidemiology and policy implications.	Global	Review	Secondary Data Analysis	Consequences, 5
145	PARRY, C.D.H.	2010	Alcohol policy in South Africa: a review of policy development processes between 1994 and 2009.	South Africa	Review	Data Synthesis	Policy Development, 7
146	PARRY, C.D.H.	2005	Alcohol use in South Africa: findings from the first Demographic and Health Survey (1998).	South Africa	Survey	Logistic Regression	SES, 2
147	PEER, N.,	2013	Urban-rural and gender differences in tobacco, alcohol use, diet and physical activity among young black SAn btn 98-03	South Africa	Survey- REQUESTED	Logistic Regression	Gender, SES and NCD. 2,6,5.
148	PELTZER, K.	2011	Alcohol use and problem drinking in South Africa: findings from a national population-based survey.	South Africa	Survey- REQUESTED	Logistic Regression	SES, 2
149	PELTZER, K.	2013	Problem drinking and associated factors in older adults in South Africa	South Africa	Survey	Logistic Regression	Older adults, Comorbidity, SES 2,5
150	PELTZER, K.	2012	Alcohol use and health-related quality of life among hospital outpatients in South Africa.	South Africa	Survey	Descriptive/ Linear Regression	Consequences on QoL, 5
151	PENGPID, S.,	2011	Prevalence of alcohol use and associated factors in urban hospital outpatients in South Africa.	South Africa	Survey	Logistic Regression	Demographic factors 2,6,7
152	PENGPID, S.	2013	Screening and brief interventions for hazardous and harmful alcohol use among uni students in SA: results from a RCT	South Africa	RCT	T Test/Chi Square, Descriptive	Screening and intervention efficacy, 2
153	PEREZ-CARCELES, M	2014	Screening for Hazardous Drinking in Migrant Workers in Southeastern Spain.	Spain	Survey	T Test/Chi Square, ANOVA, Descriptive	Screening and SES, 2,7
154	PITHEY, A	2009	Descriptive systematic review of Sub-Saharan African studies on the association between alcohol use and HIV infection	South Africa	Systematic Review	Data Synthesis	HIV 2, 5
155	PITPITAN, E.V	2012	GBV and HIV sexual risk behavior: alcohol use and MH problems as mediators among women in drinking venues	South Africa	Survey	Modelling	Gender and HIV, 5,6,8
156	PLUDDEMANN, A	2004	Alcohol use and trauma in Cape Town, Durban and Port Elizabeth, South Africa: 1999--2001	South Africa	Survey	Z Trend Test/ Chi Square	Trauma correlates, 2,5

192	THOMAS, G	2010	A two-sex model for the influence of heavy alcohol consumption on the spread of HIV/AIDS	Botswana	Survey- Abtsract only	Simulation/ Modelling	Modelling on gender and consq5,6,7
193	TOBLER, A.L.,	2013	Perceived racial/ethnic discrimination, problem behaviors, and mental health among minority urban youth.	USA	Survey	Regression	Discrimination and consequences 4,5,8
194	TOMPKINS, C.N.E.,	2003	Associations between migrancy, health and homelessness: a cross-sectional study	UK	Survey	Correlation	Migration effects 2,5
195	TONIGAN, J.S.	1998	Special populations in Alcoholics Anonymous.	USA	Literature Review	Review	Interventions and ethnicity 4,7
196	TORTAJADA, S.,	2010	Perception and consumption of alcohol among the immigrant population from Latin America in Valencia region (Spain)	Spain	Survey	Descriptive	Latino to Europe 2
197	TRIPATHI, B.M.	2010	Ethnographic mapping of alcohol use and risk behaviors in Delhi	India	Ethnographic Mapping	Thematic Analysis	Multifactor risk links to alcohol 7
198	TSAI, S.,	2012	A study of the health-related quality of life and work-related stress of white-collar migrant workers.	China	Survey	Chi Square, Mann Whitney	Stress 8
199	TSCHANN, J.M.	2005	Emotional distress, alcohol use, and peer violence among Mexican-American and European-American adolescents.	USA	Survey	ANOVA, Multiple Linear Regression	Stress and Violence 5,8
200	URQUIA, M.L	2012	Revisiting the immigrant paradox in reproductive health: the roles of duration of residence and ethnicity.	Canada	Survey	Prevalence Ratios	Immigrant paradox, acculturation 3
201	VAN GEERTRUYDEN,	2015	Alcohol and antiretroviral adherence? What about Africa?	Africa	Review	Commentary	HIV, 5
202	VAN HEERDEN, M.,S.	2009	Patterns of substance use in South Africa: results from the South African Stress and Health study.	South Africa	Survey	Logistics Regression	Patterns, SES
203	VAN ROMPAY	2012	Acculturation and sociocultural influences on dietary intake and health status among Puerto Rican adults in Massachusett	USA	Survey	ANCOVA, Linear Trend, Chi Square	Acculturation and lifestyles 3,5,8
204	VAN TIEU, H	2009	HIV, alcohol, and noninjection drug use.	Global	Review-Abstract only	Review	HIV, 5
205	VEGA, W.A	2003	Co-occurring alcohol, drug, and other psychiatric disorders among Mexican-origin people in the United States	USA	Survey	Descriptive Stats	CD-morbidity and ethnicity 4,5
206	VERMA, R.K	2010	Alcohol & sexual risk behavior among migrant female sex workers and male workers in India	India	Survey	Chi Square, Logistics Regression	HIV and risky behaviours 5,6
207	VINTHER-LARSEN,	2013	Area level deprivation and drinking patterns among adolescents.	New Zealand	Survey	Multi-level Linear Regression	Deprivation 2
208	WAHL, A.G.	2010	Gender, acculturation and alcohol use among Latina/o adolescents: a multi-ethnic comparison	USA	Survey	Multi-variate logistic Regression	Acculturation and gender 3,6
209	WALLACE, J.M.	1999	The epidemiology of alcohol, tobacco and other drug use among black youth	USA	Survey- Abstract only	Trend Analysis	Black versus others 4
210	WARNER, T.D.	2010	The risk of assimilating? Alcohol use among immigrant and U.S.-born Mexican youth.	USA	Survey	Multivariate Analysis	Assimilation vs acculturation, 3
211	WATERSON, E.J.	1989	Alcohol, smoking and pregnancy: some observations on ethnic minorities in the United Kingdom.	UK	Survey-Abstract only	Descriptive Statistics	UK women, 4,6
212	WATT, M.H	2012	Because he has bought for her, he wants to sleep with her"	South Africa	Participant Observations	Thematic Aanalysis	Ethnographic methods 6
213	WEISER, S.D.	2012	A population-based study on alcohol and high-risk sexual behaviors in Botswana.	Botswana	Survey	Multi-variate logistic regression	HIV and gender 5,6
214	WEISS, S.	2008	Alcohol Use and Problems Among Immigrants from the Former Soviet Union in Israel.	Israel	Literature Review	Review	Implications for research 4,7
215	WELLS, S.	2007	Gender differences in the relationship btwn alcohol & violent injury: an analysis of cross-national A&E data	Multi- State	Survey- Requested	Bi/ multivariate Analysis	Gender and consequences 5,6
216	WHEELER, K.	2010	Immigrants as crime victims: Experiences of personal nonfatal victimization	USA	Survey	Logistic Regression	Demographics. 2,5
217	WONG, F	2011	IPV, Depression, and Alcohol Use Among a Sample of Foreign-Born Southeast Asian Women in an Urban Setting..	USA	Survey	Chi Square/Logistic Regression	Immigrant behaviours 4,6
218	WOOLF-KING, S.	2011	Alcohol use and high-risk sexual behavior in Sub-Saharan Africa: a narrative review	SSA	Narrative Review	Data Synthesis	African contexts and modelling, 5
219	WORBY, P.A	2007	Alcohol use and problem drinking among male Mexican and central American/immigrant laborers	USA	Literature Review	Data Synthesis	Cultural driving factors. 5, 4
220	WRIGHT, C.B.,	2006	Reported alcohol consumption and cognitive decline: The northern Manhattan study	USA	Survey	Multivariate Regression	Neurogical and cognitive functioning ,5
221	ZÚÑIGA	2013	A Transnational Approach to Understanding Indicators of MH, AU and R/Health Among Indigenous Mexican Migrants	USA	Mixed Methods	Data Synthesis- Validation	Overall look on migrants

Appendix 2- Request for permission letter- Proprietors

Dear Proprietor

I am a PhD student based at Sheffield Hallam University's Centre for Health and Social Care Research (CHSCR).

I am undertaking a research on alcohol use among Zimbabwean migrants living in the UK. The participant Information sheet will fully explain the nature of my research and what I hope to achieve from undertaking it.

You can assist me in completing this research by providing permission to collect the required data at your premises. Any data collected from your premises will be used solely for the purpose of this research and will not be shared with anyone else not directly involved in this research. Please also note that all the information collected will be kept strictly confidential. No names or locations will be used for protecting your identity and the identity of others willing to participate in this research.

You are fully entitled to withdraw your permission at any time in the event you have concerns regarding any aspects of this research.

Again I would like to remind you that the full details of this research are provided in the attached participant information sheet.

You can also raise any queries you may have by contacting me or my Director of Studies using the details provided below.

If you agree to provide permission for me to undertake this research in your premises, please complete the form accompanying this letter and return it in the stamped pre-addressed envelope provided.

Yours Faithfully

Walter Tasosa

Contact details:
Walter Tasosa- PhD Research Student
Faculty of Health and Wellbeing
Centre for Health and Social Care Research
Sheffield Hallam University
Collegiate Campus
Telephone: 01142255555
Mobile: 07719150153
E-mail: walter.d.tasosa@student.shu.ac.uk

Shona Kelly- Director of Studies
Faculty of Health and Wellbeing
Centre for Health and Social Care Research
Sheffield Hallam University
Collegiate Campus
Telephone: 01142254377
E-mail: s.kelly@.shu.ac.uk

Appendix 3 - Request for Permission Return Form- Proprietors

Full title of Study: Alcohol use among Zimbabwean migrants living in the UK

Name of Researcher: Walter Tasosa (PhD Research Student, Sheffield Hallam University)

Contact Details:

Mobile Number: 07719150153

E-mail address: walter.d.tasosa@student.shu.ac.uk

Please tick alongside each statement to confirm your permission:

I confirm that I have read and understand your request for permission letter and the accompanying participant information sheet provided. ……..…

I understand that my agreement to provide permission is voluntary ….....

I am free to withdraw my permission at any time, without giving reason. .....

I have had the opportunity to consider the information given, ask questions and am pleased that all my queries have been answered satisfactorily .....

I agree to the researcher undertaking his research at my premises. .....

I agree that data gathered in this study may be stored (after it has been anonymised) during the process of this research. .....

Name of Proprietor..... Date..... Signature.....

Name of Researcher.....Date..... Signature.....

Appendix 4 - Participant Information Sheet- Ethnography

Project Title

Alcohol use among Zimbabwean migrants living in the UK

Participant Invitation

You are being invited to take part in a research project that aims at exploring alcohol use among Zimbabwean migrants living in the UK. Before you decide to take part, it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information carefully and discuss it with others if you wish. You can ask me if there is anything that is not clear or if you would like more information about the project. Please take your time to decide whether or not you wish to take part.

Purpose of the Research

The aim of this study is to examine attitudes, perceptions and levels of alcohol use among Zimbabwean migrants living in the UK. Specifically it aims at exploring attitudes and perceptions regarding the use of alcohol and whether these vary due to differences in participants' socio-demographic attributes. I also aim to explore if Zimbabwean migrants are at any greater health risks due to alcohol harm compared to the general population. In order for me to get the answers to my research questions, I need to observe you and other patrons who visit your recreational/ social centre, as you get on with your normal routines like any other day. I may also need to talk to you and other patrons present.

Why have you been chosen to take part?

You have been chosen to participate in this project because you are part of the Zimbabwean community living in the UK. Choice of participants is entirely random as long as you are a migrant to this country. You have also been chosen because you have a good understanding of English and hence can participate in the interviews. There is no limit in the number of participants willing to take part in this research.

Do I have to take part?

It is up to you to decide whether you want to take part or not. Taking part in this research is entirely voluntary. Refusal to participate will not affect you in any way. You may discontinue participation at any time during the process. You do not even have to give a reason why you have decided not to take part. If you have concerns regarding this research taking place in your local recreational/ social club, please let me or the proprietor know at your earliest convenience.

What is involved and what will happen to me if I take part?

I will be visiting your local recreational/social centre several times during the course of my research. If you are a regular patron it means that you will probably see me on several occasions. You will also be observed by me as you get on with your normal routines while in the premises. I may also ask you some questions related attitudes and perceptions about the use of alcohol by yourself and/or other Zimbabweans. Questions asked to you will also include your views about other Zimbabwean issues related to alcohol use. You are free to add your own comments about alcohol use, not necessarily asked by me. Field notes will be taken using a portable computer to record information arising from both my observations of you and others as well as the interviews I will be conducting.

What are the possible disadvantages and risks of taking part?

I do not anticipate any disadvantages or risks in taking part in this research except that my presence may disrupt your normal routine in that I will be asking to talk to you and others. You may also find that some of the questions posed to you in the interviews may sound personal, or may revoke unwarranted thoughts. However you do not have to answer any question that you feel uncomfortable with. And you also have the right to have the interviews or observations terminated if this is making you uncomfortable. I will put in all my effort to make you feel as free and as comfortable as possible. Also remember that anything you say to me or anything I observe of you and others will be strictly confidential and only used for the purpose of this research.

What are the possible benefits of taking part?

There are no direct benefits to participants for taking part in this research. However there is a possibility that some of my discussions with you or others may lead to you or someone getting help regarding their drinking, only if they are willing to. Alcohol has always played a central role in Zimbabwean and African culture for many years, and in this respect our conversations about this topic could be educational in that it provides a platform for us to learn and reflect on our cultural association with alcohol.

What if something goes wrong?

Should you have any problems with my presence, you are free to let me or the proprietor know as soon as possible and all steps will immediately be taken to resolve your concerns. In my absence, you can still raise your concerns with the proprietor, or the Director of this study, Dr Shona Kelly who is based at Sheffield Hallam University. Contact details of either Shona or me are provided at the end of this information sheet.

Will my taking part in this project be kept anonymous?

All the information collected will be strictly anonymous and only used for the purpose of this research. There will be very restricted access to the information you provide. No names or addresses will be used in this project as all this will be coded. You will not be able to be identified in any reports or publications. Once the field notes have been used for data analysis, they will be destroyed confidentially and will not be archived or stored in any way for future use.

Who is organising and funding the research?

Funding and organisation of this project is by me, Walter Tasosa of Sheffield Hallam University's Centre for Health and Social Care Research. Some technical material for this research will be provided by the University.

Who has ethically approved this project?

This project has been ethically approved by the Centre for Health and Social Care Research. The University's Research Ethics Committee monitors the application and delivery of the University's Ethics Review Procedure across the University.

Contacts for further Information

Should you require further information please feel free to contact the following persons by means most convenient to you

Walter Tasosa- PhD Research Student
Faculty of Health and Wellbeing
Sheffield Hallam University
Collegiate Campus
Telephone: 01142255555
Mobile: 07719150153
E-mail: walter.d.tasosa@student.shu.ac.uk

Or

Dr Shona Kelly- Director of Studies
Faculty of Health and Wellbeing
Sheffield Hallam University
Collegiate Campus

Appendix 5 - Poster

My name is Walter Tasosa

I am a research student from Sheffield Hallam University

I will be attending these premises on the following dates and times in order to carry out my research

November 25 - 1600hrs to 2030hrs

November 29 - 1600hrs to 2030hrs

December 1- 1500hrs to 2000hrs

December 15- 2030hrs to 2230hrs

Please read the Information leaflet provided in these premises to gain more information about my research. This includes my contact details in case you have any enquiries.

Hope to see you then

Thank You

Appendix 6 - Ethnographic Interview Schedule guidelines

Interview Schedule

1. Did you start drinking alcohol when you were still in Zimbabwe or only since you moved to the UK?

2. What do you think are the reasons for the majority of Zimbabwean migrants drinking alcohol?

3. What do you think motivates Zimbabwean migrants to drink?

4. Are the reasons and patterns of drinking among Zimbabwean migrants similar to those of other migrant communities?

5. Do you think Zimbabwean migrants drink more or less than the general population?

6 Would you know where to seek help or advice if someone you know started having problems with alcohol?

7. What do you think is the choice of alcoholic beverages for most Zimbabweans and is there a reason for it?

8. How do you think being a Zimbabwean migrant affects drinking habits?

9. Where do most Zimbabwean migrants prefer to have a drink, in what circumstances and for what reason?

10. From your own experience and observation can you tell me what sort of problems Zimbabweans have due to alcohol consumption? I am thinking about the law, relationships, work etc.

11. Have you got anything else you may want to say about anything relating to this topic?

Appendix 7 - Ethics Approval letter

Sheffield Hallam University | Centre for Health and Social Care Research

Date: 07012015

Ref: 2014-5/HWB/HSC/STAFF/6

Dear Walter TASOSA

This letter relates to your research proposal:

Alcohol use among Zimbabwean migrants living in the UK.

This proposal was submitted to the Faculty Research Ethics Committee for ethics and scientific review. It has been reviewed by three independent reviewers and has been passed as satisfactory. The comments of the reviewers are enclosed. You will need to ensure you have all other necessary permission in place before proceeding, for example, from the Research Governance office of any sites outside the University where your research will take place. This letter can be used as evidence that the proposal has been reviewed ethically and scientifically within Sheffield Hallam University.

The documents reviewed were:

Name of documents reviewed here

Walter Tasosa - RF2 Report.pdf

Tasosa Nov 2014.pdf

Good luck with your project.

Yours sincerely

Peter Allmark

Peter Allmark

Chair Faculty Research Ethics Committee

Faculty of Health and Wellbeing

Sheffield Hallam University

32 Collegiate Crescent

Sheffield

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Telephone +44 (0) 114 225 5854 Fax +44 (0) 114 225 4377

Email: chscr@shu.ac.uk www.shu.ac.uk/chscr

Appendix 8: Quantitative Questionnaire.

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Alcohol use among Zimbabwean migrants living in the UK

Introduction

Alcohol use among Zimbabwean migrants living in the UK

My name is Walter Tasosa. I am a PhD Research Student at Sheffield Hallam University. I am inviting you to complete an online questionnaire which aims at exploring alcohol use among Zimbabwean migrants living in the UK.

The study is being completed as part of my PhD at the Centre for Health and Social Care Research which is based at Sheffield Hallam University. Your response to this survey is important and equally appreciated to enable me to complete this study. However, you are under no obligation to complete the survey as participation is entirely voluntary. You are also free to withdraw from the study, without giving a reason for your withdrawal.

On average the questionnaire will only take about 10 to 15 minutes of your time. I will be grateful if you could complete and return it by the 15th of December 2015. After completion of this study I will NOT be able to discuss the results with you, however I will be happy to share the results with you once it has been completed and written up

The study has been ethically approved by the University's Research Ethics Committee.

All the information that you choose to give will be kept anonymous, strictly confidential and only used for the purpose of this research. There will be very restricted access to the information you provide. No names or addresses will be used and so you will not be identifiable in any reports or future publications.

By moving on to the next page, you are agreeing that:

You have read and understood the information above regarding this study.

You are free to withdraw from the study, without giving a reason for your withdrawal.

You do not have to answer questions that you are not comfortable with

Should you require further information please feel free to contact the Director of Studies for this PhD, Professor Shona Kelly at s.kelly@shu.ac.uk
or myself at walter.d.tasosa@student.shu.ac.uk

Thank You

Are you Zimbabwean, of African Heritage and immigrated to the UK from 1990 onwards?

◯ Yes

◯ No

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Alcohol use among Zimbabwean migrants living in the UK

About your alcohol consumption

Did you previously consume alcohol in Zimbabwe before moving to the UK?

- ◯ Yes
- ◯ No

Have you consumed alcohol in the last 12 months

- ◯ Yes
- ◯ No

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Alcohol use among Zimbabwean migrants living in the UK

Alcohol consumption

How often do you have a drink containing alcohol?

- ◯ Monthly or less
- ◯ 2-4 times a month
- ◯ 2-3 times a week
- ◯ 4 or more times a week

How many standard drinks containing alcohol do you have on a typical day when drinking?

- ◯ 1 or 2
- ◯ 3 or 4
- ◯ 5 or 6
- ◯ 7 to 9
- ◯ 10 or more

How often do you have six or more drinks on one occasion?

- ◯ Never
- ◯ Less than monthly
- ◯ Monthly
- ◯ Weekly
- ◯ Daily or almost daily

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Alcohol use among Zimbabwean migrants living in the UK

About your alcohol consumption

During the past year how often have you:

	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
found you were not able to stop drinking once started	◯	◯	◯	◯	◯
failed to do what was expected due to drinking	◯	◯	◯	◯	◯
needed a drink in the morning to get yourself going	◯	◯	◯	◯	◯
felt guilt or remorse after drinking	◯	◯	◯	◯	◯
unable to remember what happened the night before because you had been drinking	◯	◯	◯	◯	◯

Have you or someone else been injured as a result of your drinking?

- ◯ No
- ◯ Yes, but not in past year
- ◯ Yes, during the past year

Has a relative or friend, doctor or health worker been concerned about your drinking or suggested you cut down?

- ◯ No
- ◯ Yes, but not in past year
- ◯ Yes, during the past year

In the last year have you ever driven while intoxicated or rode in a car with a driver who was intoxicated?

- ○ Never
- ○ Once in a while
- ○ Often
- ○ Very often

Please rank the following alcoholic drinks in order of preference? Where 1 is the most preferred and 5 the least preferred.

- Lager/beer
- Wine
- Cider
- Alcopops
- Spirits

Choose an option that best describes where you would prefer to have a drink

- ○ Local pub
- ○ Night Club
- ○ Zimbabwean run settings
- ○ At home
- ○ Other (please specify)

Please rank your main reasons for choosing where you would prefer to drink. Where 1 is the most preferred and 4 the least preferred.

- Price
- Atmosphere
- To meet other people
- To meet other Zimbabweans

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Alcohol use among Zimbabwean migrants living in the UK

About your social life

How often do you talk to any of your neighbours? Is it

- ◯ On most days
- ◯ Once or twice a week
- ◯ Once or twice a month
- ◯ Less often than once a month
- ◯ Never

Suppose that you were in bed ill and needed someone to go to the chemist to collect your prescription while they were doing their shopping. How comfortable would you be asking a neighbour to do this?

- ◯ Very comfortable
- ◯ Fairly comfortable
- ◯ Fairly uncomfortable
- ◯ Very uncomfortable

Do you have any close friends who are not Zimbabweans whom you speak to or see regularly?

- ◯ Yes
- ◯ No

If you had any of the following problems, is there anyone other than a Zimbabwean you could rely on to help you from outside your own household?

	Yes	No	Not sure
If you were feeling depressed	◯	◯	◯
If you needed help finding a job for yourself or a member of your family	◯	◯	◯
If you needed to borrow money to pay an urgent bill like electricity, gas, rent or mortgage	◯	◯	◯

How often do you go out socially with friends/neighbours/colleagues and co-workers , for example to a pub, restaurant, cinema or somewhere else?

	Zimbabwean Friends/colleagues/neighbours	Non Zimbabwean Friends/colleagues/neighbours
Every day	☐	☐
Several times a week	☐	☐
At least once a week	☐	☐
At least once a fortnight	☐	☐
At least once a month	☐	☐
Less than once a month	☐	☐
Never	☐	☐

Do you think there is a lot of prejudice in Britain against people of your race?

	A lot	A little	Hardly any	None
Generally speaking	○	○	○	○
When it comes to getting a job	○	○	○	○

Sheffield Hallam University | Centre for Health and Social Care Research

Alcohol use among Zimbabwean migrants living in the UK

Your feelings about life in the UK

Please indicate your answer to the following:

	Yes	No	Don't know
I find it difficult to develop long lasting friendships with white people	○	○	○
I definitely plan to return and settle back in Zimbabwe	○	○	○
If I were to die here I would prefer to be buried in Zimbabwe	○	○	○
The UK is now my adopted home country	○	○	○
I feel more Zimbabwean than British	○	○	○

Please indicate your answer to the following:

	Yes	No	Don't mind/either
I would prefer my son/daughter to marry a Zimbabwean rather than a white person	○	○	○
It would be unacceptable for my son / daughter to marry a white person	○	○	○
I prefer Zimbabwean food to British food	○	○	○

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Alcohol use among Zimbabwean migrants living in the UK

About your general health

The next questions are on your general health. Please choose the statement you most agree with based on your general health.

In general would you say your health is?

- ◯ Excellent
- ◯ Good
- ◯ Fair
- ◯ Poor
- ◯ Very Poor

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Alcohol use among Zimbabwean migrants living in the UK

About your general health

Instructions: The questions in this scale ask you about your feelings and thoughts during the last month.

In each case, please indicate with a check how often you felt or thought a certain way.

	Never	Almost never	Sometimes	Fairly often	Very often
In the last month how often have you felt that you were unable to control the important things in your life?	◯	◯	◯	◯	◯
In the last month how often have you felt confident about your ability to handle your personal problems?	◯	◯	◯	◯	◯
In the last month how often have you felt that things were going your way?	◯	◯	◯	◯	◯
In the last month how often have you felt difficulties were piling up so high that you could not overcome them?	◯	◯	◯	◯	◯

Sheffield Hallam University | Centre for Health and Social Care Research

Alcohol use among Zimbabwean migrants living in the UK

Religiosity

Choose a category that best describes your religious affiliation

- ◯ Mainstream Christianity (Catholic, Methodist, Anglican)
- ◯ Pentecostal Christianity
- ◯ African Traditional beliefs
- ◯ Not religious at all
- ◯ Other (please specify)

How important is religion in your life?

- ◯ Very important
- ◯ Somewhat important
- ◯ Not really important
- ◯ Not at all important

How often do you attend a church or religious institution?

- ◯ Never
- ◯ Less than once a year
- ◯ Less than once a month
- ◯ Once a month
- ◯ Every 2 weeks
- ◯ Once a week
- ◯ More than once a week
- ◯ Only on special occasions

Sheffield Hallam University | Centre for Health and Social Care Research

Alcohol use among Zimbabwean migrants living in the UK

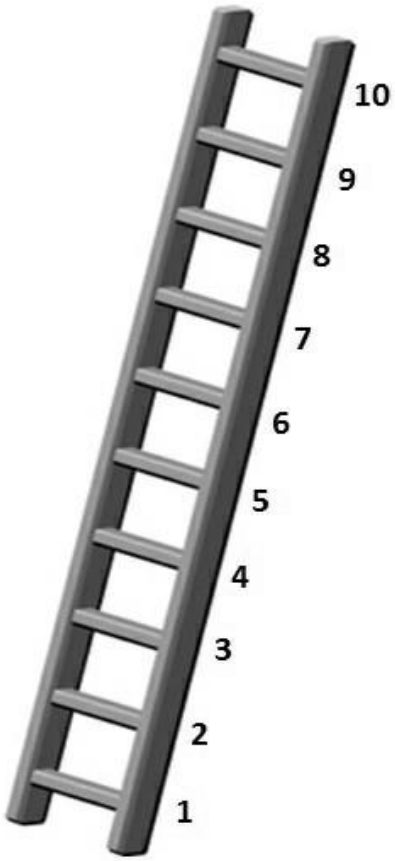
About your social position in Zimbabwe

Think of this ladder as representing your social status in Zimbabwe before you came to the UK.

In Zimbabwe there were people in high social positions and people in low social positions. At the top of the ladder are the people who had the highest status and the highest social positions. At the bottom are the people who had the least status and the least social positions. The higher you were on this ladder, the closer you were to the people at the very top, the lower you were, and the closer you were to the people at the very bottom.

Where would you place yourself on this ladder which is numbered 1-10?

Choose a number on the ladder which represents your social status relative to other people in Zimbabwe before you came to the UK.



Sheffield Hallam University | Centre for Health and Social Care Research

Alcohol use among Zimbabwean migrants living in the UK

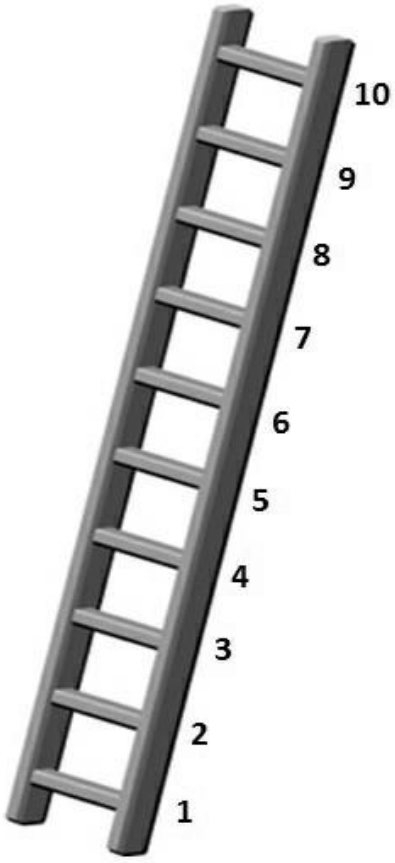
About your social position in the UK.

Think of this ladder as representing your social status in the UK.

In the UK there are people in high social positions and people in low social positions. At the top of the ladder are the people who have the highest status and highest social positions. At the bottom are the people who have the least status and the least social positions. The higher you are on this ladder, the closer you are to the people at the very top, the lower you are, and the closer you are to the people at the very bottom.

Where would you place yourself on this ladder which is numbered 1-10?

Choose a number on the ladder which represents your social status as it stands now relative to other people in the UK.



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Alcohol use among Zimbabwean migrants living in the UK

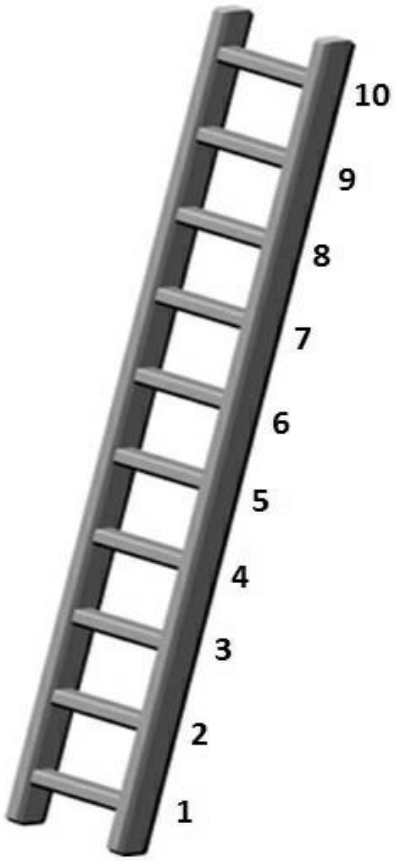
About your social position in the UK Zimbabwean Community

Think of this ladder as representing your social status relative to other Zimbabweans who live in the UK.

At the top of the ladder are Zimbabweans who have the highest status and the highest social positions in the UK. At the bottom are Zimbabweans who have the least status and the least social positions in the UK. The higher you are on this ladder, the closer you are to Zimbabweans at the very top, the lower you are, and the closer you are to Zimbabweans at the very bottom.

Where would you place yourself on this ladder which is numbered 1-10?

Choose a number on the ladder which represents your social status as it stands now relative to other Zimbabweans who live in the UK.



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About you

Are you?

- ○ Male
- ○ Female
- ○ Other (please specify)
- ○ Prefer not to say

What is your age?

- ○ 18 to 24
- ○ 25 to 34
- ○ 35 to 44
- ○ 45 to 54
- ○ 55 to 64
- ○ 65 to 74
- ○ 75 or older

How long have you been living in the UK?

- ○ Less than 5 years
- ○ between 6 - 10 years
- ○ between 11 - 15 years
- ○ 16 years and over

What is your immigration status

- ○ Naturalised British
- ○ Indefinite Leave to Remain/Residence Permit
- ○ Work Permit
- ○ Student Visa
- ○ 5 year Asylum/Refugee Visa
- ○ Other (please specify)

What is your current marital status?

- ○ Single
- ○ Married/living as married/civil partner
- ○ Other (please specify)
- ○ Widowed
- ○ Divorced or separated

What is the highest level of education you have achieved?

- ○ No formal education
- ○ Went to school but did not finish
- ○ Completed school no qualifications
- ○ Completed school with qualifications
- ○ Further education qualification
- ○ Higher education qualification
- ○ Other (please specify)

What is your employment status at the moment? (Select as many as apply.)

- ☐ In paid employment - full time
- ☐ In paid employment - part time
- ☐ Self-employed with employees
- ☐ Self employed (working alone without employees)
- ☐ Homemaker
- ☐ Caring for children or relatives
- ☐ Other (please specify)
- ☐ Unemployed (looking for work)
- ☐ Retired/pensioner
- ☐ In education or training
- ☐ Not working due to illness or incapacity
- ☐ Volunteer

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About your accommodation

Where do you live?

- [ ] England
- [ ] Northern Ireland
- [ ] Scotland
- [ ] Wales
- [ ]

In order to ensure we get responses across the whole of the UK and are able to compare our data across the country we are asking for your postcode. Please give your postcode in the box below.

Which of the following housing arrangements applies to you?

- ○ Owner occupied - with and without mortgage
- ○ Shared ownership
- ○ Housing Association tenant
- ○ Local Authority tenant
- ○ Rent privately
- ○ Living with parents/partner/friends

Do you have any children under 18?

- ○ Yes
- ○ No

How many people currently live in your household?

Adult aged 18+	
Children under 18	
Total	

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About your financial situation

Please mark which best corresponds to your gross income; and the total gross income of your household. (Pensions, unemployment benefits and study loans count as income). (Gross income is total income before any deductions made for tax, national insurance, rent etc),

Total	My gross income	household gross income
Under £5,000	☐	☐
£5,000 - £9,999	☐	☐
£10,000 - £19,999	☐	☐
£20,000 - £29,999	☐	☐
£30,000 - £39,999	☐	☐
£40,000 – £49,999	☐	☐
£50,000 - £59,999	☐	☐
£60,000 or more	☐	☐
Don't know	☐	☐

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Future research

Any other comments

Thank you very much for your time, please be reassured all your answers are strictly confidential.

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Thank you for your help.

If you are concerned that you or someone you care about has a problem with alcohol there is lots of help available. Useful links are listed here.

www.alcoholconcern.org.uk/help-and-advice

www.addaction.org.uk

www.alcoholics-anonymous.org.uk

Alternatively, you can contact your GP who would be able to advise you on where to seek help.

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