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ACTIONS TO REDUCE THE HARMFUL USE OF ALCOHOL

Report of the Regional Director

CONTENTS

BACKGROUND

1. The disease burden attributable to harmful use of alcohol is significant at global level and in the African Region. Trends in globalization and international trade agreements make alcohol widely available and affordable for consumption.

2. Studies reveal a large proportion of drinkers in some countries in the Region, even among women. According to a WHO STEPS survey,[1] large percentages of respondents in Cameroon (84%), Mozambique (77.2%) and Cote d'Ivoire (71%) had drunk alcohol in the previous 12 months. The same survey in the Democratic Republic of Congo in 2005 showed that in the previous 12 months only 53.7% of women reported not having drunk alcohol.

3. In 2000, harmful use of alcohol globally was responsible for 4.0% of the burden of disease and 3.2% of all deaths, almost as much overall damage to health as tobacco (4.1%) and high blood pressure (4.4%). In 2000 and 2002, the estimates of total deaths attributable to harmful use of alcohol in the African Region show a significant burden of 2.1% and 2.2%, respectively.[2]

4. In the last few years, increases in consumption and changes in drinking patterns among adolescents have been reported by countries in the Region. In 2004, the Global School-based Student Health Survey[3] showed that 42.3% of Zambian adolescent students between 13 and 15 years old were current consumers of alcohol, and from those, 42.8%, had already been drunk at least once in their lives. In Namibia, 32.8% were current alcohol consumers and 31.8% had already been drunk.

5. Heavy alcohol consumption is defined as a pattern of drinking that exceeds a specified daily amount (e.g. three drinks a day) or quantity per occasion (e.g. five drinks on an occasion, at least once a week) and is considered high-risk drinking. In contrast, low-risk drinking is defined as having no more than two drinks a day five days a week.[4] The gap between men and women regarding heavy alcohol consumption seems to be narrowing and there is an increase and change of patterns of consumption in these two groups.[5] In Zambia, female adolescents surpass males in current consumption of alcohol (45.1% against 38.7%) and in heavy alcohol consumption (50.2% against 44.1%).[6]

6. At the fifty-seventh session of the WHO Regional Committee for Africa, Member States expressed concern over the impact of harmful use of alcohol on public health.[7] They emphasized the need to strengthen responses in the Region and requested WHO to support the development, implementation and evaluation of policies and plans to combat the harmful use of alcohol in Member

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1 WHO, surveillance data from the STEPS survey, Brazzaville, World Health Organization, Regional Office for Africa, Division of Noncommunicable Diseases Prevention and Control, 2006.

2 WHO, *WHO Expert Committee on problems related to alcohol consumption*, second report, Geneva,World Health Organization, 2007 (Technical Report Series no. 944).

3 WHO, surveillance data from the Global School-based Student Health Survey, Brazzaville, World Health Organization, Regional Office for Africa, Division of Noncommunicable Diseases Prevention and Control, 2004.

4 Available at http://www.who.int/substance_abuse/terminology/who_lexicon/en/index.html

5 Mustonen H et al, Alcohol drinking in Namibia. In: WHO, *Surveys of drinking patterns and problems in seven developing countries*, Geneva, World Health Organization, 2001, pp. 45–62. See also, Ibanga AJ et al, The contexts of alcohol consumption by men and women in Nigeria. In: Obot IS and Room R, *Alcohol, gender and drinking problems: perspectives from low and middle income countries*, Geneva, World Health Organization, 2005, pp.143–167.

6 WHO, surveillance data from the Global School-based Student Health Survey, Brazzaville, World Health Organization, Regional Office for Africa, Division of Noncommunicable Diseases Prevention and Control, 2004.

7 WHO, Harmful use of alcohol in the WHO African Region: situation analysis and perspectives, Brazzaville, World Health Organization, Regional Office for Africa, 2007 (AFR/RC57/14).

countries. They similarly requested the Regional Office to prepare and submit a regional strategy for consideration by the Regional Committee for Africa in 2009.

7. At its one-hundred-and-twenty-second session, the WHO Executive Board recommended a resolution on alcohol for adoption at the Sixty-first World Health Assembly in 2008. Proposed by African Region Member States through Rwanda, the resolution called for the development of a global strategy to be submitted in 2010 with inputs from Member States and requested countries to monitor and strengthen national responses to alcohol use.

8. In the African Region, there is a need to build consensus on effective alcohol policies and plans of action, taking into consideration national contexts, and to strengthen country commitment to address public health problems caused by harmful use of alcohol. This process will provide a solid basis for the regional strategy as well as global initiatives.

9. This document updates Member States on current knowledge on the harmful use of alcohol in the African Region and proposes actions to address the problem.

ISSUES AND CHALLENGES

10. Although several studies and surveillance data provide some insight into the impact of harmful use of alcohol in the Region, regular systematic surveillance and recording systems for alcohol production, consumption and harm do not exist in many countries. Establishing and strengthening these systems will encourage and facilitate appropriate policy responses.

11. Country participation in the WHO Global Survey on Alcohol in 2008, 2010 and 2012 will constitute a major opportunity to monitor alcohol consumption, its health and social consequences, and existing policy responses in the Region. However, to achieve this monitoring task, countries need more resources to strengthen their surveillance systems.

12. Alcohol use in African countries includes both home-brewed and industrial beverages. Industrial beverages tend to be consumed along with home brews, rather than replacing them, thus increasing the total amount of alcohol intake. This consumption poses important challenges regarding quantities consumed and safety issues related to the unregulated production of alcohol.

13. Alcohol consumption in the Region can be characterized by high levels of intake among those who drink,[8] popularity of home produced beverages and high prevalence of alcohol related problems.[9,10] According to a WHO STEPS survey[11] in Cote d'Ivoire and Mozambique, among those who drank in the previous year, 23.7% had engaged in harmful patterns of drinking; in Algeria, 60% of alcohol consumers had a harmful drinking pattern. Despite different levels of per capita consumption, countries face similar and important types of alcohol-related harm; therefore, reduction of consumption and of alcohol-induced harm needs to be recognized as a public health priority.

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[8] WHO, global alcohol database, Geneva, World Health Organization, Department of Mental Health and Substance Abuse, 2007.

[9] Mustonen H et al, Alcohol drinking in Namibia. In: WHO, *Surveys of drinking patterns and problems in seven developing countries*, Geneva, World Health Organization, 2001, pp. 45–62.

[10] WHO, *Global status report on alcohol 2004*, Geneva, World Health Organization, 2004.

[11] WHO, surveillance data from the STEPS survey, Brazzaville, World Health Organization, Regional Office for Africa, Division of Noncommunicable Diseases Prevention and Control, 2006.

14. Intoxication and chronic effects of alcohol consumption can lead to permanent health damage (e.g. fetal alcohol syndrome, delirium tremens), neuropsychiatric and other disorders with short- and long-term consequences, traumatic injury or even death (e.g. road traffic accidents[12]). There is also increasing evidence linking alcohol consumption with high-risk sexual behaviour and infection with HIV.[13] The impact of alcohol on the individual and on society needs to be acknowledged and accepted if countries are to develop effective interventions to reduce harmful use of alcohol.

15. Health and social costs for the drinker and for society have a negative economic impact on Member States and cannot be ignored. In the Region, harmful use of alcohol leads to unemployment, increased admissions to health-care facilities, crime and violence, especially against women.[14] In South Africa, 25% to 30% of general hospital admissions are directly or indirectly related to alcohol use, and in Lesotho, Mauritius and Swaziland, more than 50% of admissions into mental health institutions are related to alcohol as the primary substance abused.[15]

16. Lack of information in an environment of unrestrained marketing strategies, especially those targeting youth, can have a major impact on cultural values and norms leading to increased alcohol consumption.[16] Low budgetary allocations for information and advocacy campaigns and the absence of comprehensive policies are impediments to the reduction in the demand for alcohol which results in negative health and social impact.

17. Early identification and effective treatment of alcohol disorders and co-morbid conditions in health-care settings can reduce associated morbidity and mortality as well as improve the well-being of those affected. In the Region, routine screening and brief interventions are not part of health practitioners' routine care. Specialized treatment settings for alcohol dependence are nonexistent or misplaced in psychiatric wards where the only treatment offered is short-term detoxification. Hence, adequate intervention and treatment policies should be developed to serve the needs of the population. These should range from brief interventions in primary care to more intensive treatment in specialized settings.

18. In the African Region, there is opportunity for market expansion by alcohol producers and this benefits countries economically by creating employment and generating government tax revenue. However, these benefits need to be weighed against the costs of managing the effects of harmful use of alcohol. Documentation in the Region[17] reveals increases in drinking-driving arrests, alcohol dependence admissions, chronic liver disease and cirrhosis deaths after government taxes were reduced.

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[12] Gureje O, Country profile on alcohol in Nigeria. In: Riley L et al, *Alcohol and public health in eight developing countries*, Geneva, World Health Organization, 1999.

[13] See two articles in the special issue of *African Journal of Drug & Alcohol Studies*: Ashley JW, Levine B, Needle R, Summary of the proceedings of the meeting on "Alcohol, HIV risk behaviours and transmission in Africa" 5(2): 192–200; Morris CN, Three-country assessment of alcohol-HIV related policy and programmatic responses in Africa 5(2):170–184, 2006.

[14] Parry C, Dewing S, A public health approach to addressing alcohol-related crime in South Africa, *African Journal of Drug & Alcohol Studies* 5(1): 41–56, 2006. Tumwesigye N et al, Gender and the major consequences of alcohol consumption in Uganda. In: Obot IS, Room R., *Alcohol, gender and drinking problems: perspectives from low and middle income countries*, Geneva, World Health Organization, 2005. WHO, *Alcohol use and sexual risk behaviour: a cross-cultural study in eight countries*, Geneva, World Health Organization, 2005.

[15] SADC Epidemiology Network on Drug Use, *SENDU report January-June 2005*, Medical Research Council, Republic of South Africa, 2005. Obot IS, Alcohol use and related problems in sub-Saharan Africa, *African Journal of Drug & Alcohol Studies* 5(1): 17–26, 2006. LNB, *Report on the Lesotho Epidemiology Network on Drug Use: Period July to December 2001*, Maseru, Lesotho Narcotics Bureau, 2001.

[16] Graeme W, My goodness: Nigeria overtakes Ireland in Guinness sales, Guardian Unlimited, August 30, 2007.

[17] WHO, *Alcohol in developing countries: a public approach*, Geneva, World Health Organization, 2002.

19. In the majority of African countries, regulatory and legislative mechanisms regarding trade, industrial or agricultural decisions on alcohol that take into account the public health interest do not exist or are not effectively enforced. Broader political interaction and international collaboration through relevant bodies, such as the World Trade Organization, World Bank, and Food and Agriculture Organization, and based on a global strategy are needed to ensure that the public health interest is reflected in trade agreements and in global strategies for the eradication of poverty.

20. Public health problems caused by harmful use of alcohol are considerable and multidimensional. They require a combination of measures that target the general population, vulnerable groups and affected individuals, and take into account local needs and contexts. In order to support national policy decisions, evidence on effective interventions needs to be established and documented in different contexts in the Region.

ACTIONS PROPOSED

21. The following actions, in appropriate combination according to country contexts, and the level of involvement of different stakeholders, may be the basis for national alcohol policies. They will be articulated in the proposed regional strategy and presented for consideration at the fifty-ninth session of the Regional Committee for Africa, following detailed consultation with Member States.

Short-term and medium-term actions

22. **Raise political commitment and build partnerships:** The development of comprehensive national policies and action plans will facilitate contributions and clarify responsibilities of the various sectors, partners and stakeholders. Coherent, consistent and strong action with relevant actors, such as producers, retailers, health-care workers and community stakeholders, is fundamental for effective implementation and reinforcement of national policies and action plans. International trade agreements require the development of additional mechanisms at global level for establishing a solid and sustainable basis for alcohol control. At national level, public awareness and support are essential for the sustainability of such policies.

23. **Increase community action and support:** Public education on the negative consequences of drinking alcohol can be effective in increasing recognition of alcohol-related harm in the community and providing active participation in policy measures. Health education can include both active measures (e.g. parental education, school prevention programmes, including the integration of harmful use of alcohol in the curricula of primary and secondary schools, mass media and social marketing campaigns) and passive measures (e.g. warning labels). Mutual help groups such as Alcoholics Anonymous can be an inexpensive alternative and adjunct to treatment.

24. **Establish and strengthen alcohol information and surveillance systems:** Obtaining high quality surveillance data will allow countries to increase their knowledge and understanding of the current situation and trends as well as contribute to gathering public support for national policies. Resources for regular collection and dissemination of data to inform the community are essential to increase awareness and to make evidence-based decisions.

25. **Strengthen health sector response:** In primary health care, the involvement and training of health-care professionals increases early detection of problems related to alcohol consumption and

prevents the development of more serious conditions. Treatment interventions and community services for people with alcohol use disorders are shown to be effective when supported by adequate policies and systems and integrated in a broader preventive strategy. Efforts are needed to improve training and provide an adequate framework for interventions at different levels of care.

26. **Enact, strengthen or enforce drinking and driving laws:** There is strong evidence for a specific set of drink-driving countermeasures. These notably include setting a low blood alcohol level as an acceptable limit for driving. Enforcement of legislation, severity of penalties imposed and on-going awareness campaigns are the basis for the success of this measure.

Long-term actions

27. **Regulating availability of alcohol:** Specific alcohol control legislation and licensing systems, such as control of illegal production and trading, as well as restricting the number, types and opening hours of outlets have been shown to be effective strategies in a variety of sociocultural circumstances. In countries where there is substantial home production, licence-enforced restrictions may increase competitiveness from the alternative market. Therefore, community information, mobilization and support mechanisms for alternative means to generate income need to be put in place before adopting such measures.

28. **Restrict the sale of alcohol:** Bans or restrictions on the sale of alcohol in specific places or under specific circumstances (e.g. at work, under intoxication) are already present in some countries. A minimum age for purchasing or drinking alcohol is the most widely used control measure in the Region, but the effectiveness of under-age sales bans depends considerably on the degree to which restrictions are enforced. There is a need to invest more in better control and enforcement systems.

29. **Regulate alcohol marketing:** Young people have become important targets for alcohol marketing, especially through direct advertising whenever possible. Promotional activities, such as sponsorships, contests, and sport events are also used to make alcohol increasingly more popular among the young. The effectiveness of partial or complete ban on such practices depends on efforts to systematically regulate this market; hence, countries need to agree on necessary mechanisms to reinforce marketing control strategies.

30. **Increase taxes and prices:** Imposition of taxes is one way to influence prices and reduce alcohol affordability. Tax changes should be accompanied by efforts to bring the illegal and informal production of alcohol under effective government control and introduce mechanisms to control illegal trading, smuggling and cross-border purchases. Revenues resulting from these tax changes could be used to create a special fund to fight alcohol consumption.

31. The Regional Committee is requested to examine and endorse the actions proposed.