

REPORT OF FIRST PAN AFRICAN CONSULTATION ON A LCOHOL POLICY AND ITS SIGNIFICANCE FOR THE REGION

INTRODUCTION

The World Health Organization (WHO) Technical Consultation on the “Public health problems caused by harmful use of alcohol in the African Region” was held at WHO/AFRO, in Brazzaville, Congo, from 10-12 May 2006. The meeting was convened as a follow-up to the adoption of Resolution WHA58.26 on Public Health Problems Caused by Harmful Alcohol Use at the fifty-eighth World Health Assembly in May 2005 (WHO, 2005) which gave the WHO the mandate to make a number of specific requests of Member States and the WHO Director-General to intensify efforts to reduce the burden of alcohol-related problems nationally, regionally and globally.

The primary goals of the consultation were to assess the situation related to alcohol production and consumption and its harmful consequences, and to develop a programme to guide the work on alcohol in the African region over the next five years.

The meeting was attended by representatives from 13 sub-Saharan countries, representatives of non-governmental organizations, the United Nations Office on Drugs and Crime, and the WHO Secretariat. Participants were representatives of health ministries, academia, medical and allied professions, non-governmental organizations and civil society.

THE BURDEN OF ALCOHOL CONSUMPTION IN AFRICA

In Sub-Saharan Africa an estimated 1.8% of the disease burden is attributable to

alcohol, and 1.3% is attributable to high-risk drinking (Rehm et al. 2006). It has been estimated that alcohol contributes 7% to the burden from death and disability in South Africa, and is the third in burden of disease after unsafe sex and interpersonal violence (Schneider, personal communication). In most parts of Africa, problems associated with alcohol consumption can be expected to rise as a result of increased economic development (Rehm et al., 2004). Africa Region Eⁱ has among the highest total litres of alcohol consumed *per drinker* in the world at 16.6 litres per adult per year (WHO, 2004). This is similar to adult per capita consumption for Europe Region C (a low child mortality and high adult mortality region, including countries such as the Russian Federation and the Ukraine), where the figure is 16.5 litres. The most characteristic patterns of alcohol consumption in the region involve binge and episodic drinking.

Levels of alcohol consumption, and alcohol-related problems and harm are related to the availability of alcohol. When calculating the availability of alcohol in countries and in the region, it is essential to focus on both unrecorded and recorded alcohol consumption. Unrecorded alcohol consumption is reported to be approximately 50% for the

ⁱ Africa Region E is one of two sub-regions of WHO's Sub-Saharan Africa Region, and comprises countries with very high child mortality and very high adult mortality rates (e.g. Ethiopia and South Africa). WHO member states are grouped into six regions: Europe and Central Asia, the Americas and the Caribbean, Sub-Saharan Africa, East Asia and the Pacific and South East Asia.

African region as a whole, and high (above 80%) in many East African countries such as Tanzania, Uganda, and Kenya (WHO, 2004).

Alcohol and young people

Among young people, binge drinking – typically operationalised as the consumption of five or more drinks per occasion - is also the most common pattern of alcohol consumption. Several delegates pointed to the decreasing age of onset of alcohol use and the increasing prevalence rates of alcohol use among young people as being of particular concern.

Alcohol and women

Numerous delegates also reported that rates of alcohol consumption among women are on the increase, but that their overall rates of alcohol consumption are still generally lower than those of men. However, the rates of *problem drinking* among men and women who consume alcohol are not always substantially different.

Risk factors for harmful alcohol use

The post-colonial era has evidenced a marked change in patterns and quantities of alcohol consumed (Odejide, 2006; Parry, 2005). Many delegates identified the causes of such changes to include urbanization, the commercialization of the production and consumption of alcohol, the weakening of cultural controls that used to limit the quantities and frequency of alcohol consumed, and reductions in social cohesion. Participants from various parts of the region identified stress, conditions of work, and financial and family problems as psycho-social risk factors for harmful alcohol use.

Quantities of alcohol consumed

The actual quantities of alcoholic beverages consumed in Africa are

difficult to establish because as much as 50% of consumption is estimated to be unrecorded, often comprising non-commercially produced beverages.

Health and social problems associated with harmful use of alcohol

The delegates of the consultation identified the most serious social and health problems associated with the harmful use of alcohol as being intentional and non-intentional injuries; road traffic (and other) accidents; family and interpersonal conflict; sexual violence, high risk sexual behaviours and decreased condom use that lead to HIV infection; and unemployment and economic problems. The highest recorded rates of foetal alcohol syndrome have also been found in Africa (e.g. May et al., 2000).

Alcohol use disorders and treatment

Harmful alcohol consumption can lead to the development of alcohol use disorders and a need for specialist intervention. Many delegates echoed a concern that treatment services, which are generally provided as part of general psychiatric services and infrequently at specialist treatment centres, are generally inadequate, particularly for women, young people, and people of lower socio-economic groups.

SITUATION ASSESSMENTS

Data collection and information systems

The meeting identified a lack of reliable and consistent information on alcohol consumption and alcohol-related harm in many parts of the African region. Delegates described various data collection and information systems on alcohol and other drugs that have been used in certain African countries that

could be rolled out more widely. Two such systems that were highlighted are the WHO's Stepwise approach to non-communicable disease risk factor surveillance (WHO, 2003) and the Southern African Epidemiology Network on Drug Use (SENDU; Parry et al., 2005).

Situation assessments at the country-level

The consultation identified uneven degrees of implementation of situation assessments across the region. The lack of reliable, valid and standardised tools for measurement of home-brewed beverages has made it difficult to accurately measure such alcohol consumption. In addition, a lack of reliable sources of routine facilities-based alcohol data (e.g. from hospitals, and other health care facilities) in many countries prevents the use of such records in surveillance.

Identified activities for improving situation assessments in the region

Various activities were identified by the participants as potentially useful for improving situation assessments in countries and the region. These include the completion of mapping and auditing exercises to determine the nature of existing information, data collection systems, and prevention and treatment responses; the execution of research to determine the specific harms caused by home-distilled beverages; the execution of research to determine patterns, trends and harms related to alcohol consumption among particular sub-populations (e.g. women and youth); the execution of more research on the role of alcohol in HIV transmission; and the training of health care and allied workers on situation assessment and data collection methods to increase the sustainability of surveillance efforts.

Recommended Strategies for the Regional Office

The consultation recommended various coordinating and oversight activities for the WHO regional office to facilitate situation assessments on the country and regional levels. These include among other things, the development or adaptation of guidelines, norms and standards, and research tools for countries; training and capacity building for research; the promotion, support and expansion of regional surveillance networks and the organizing of periodic meetings/conferences for information sharing.

INTERVENTIONS

Current national responses to alcohol-related problems

The consultation identified great variation and unevenness in the extent of implementation of responses to address public health and social problems caused by harmful alcohol use across countries. The following were identified as among the current responses that are implemented, but poorly enforced in most countries:

- (1) Regulations on drink-driving, the sale of alcohol, under-age drinking, and liquor outlet density and locations;
- (2) Education and life-skills programmes;
- (3) Treatment and rehabilitation;
- (4) Training of health care workers;
- (5) Taxation of alcohol products;
- (6) Advertising restrictions;
- (7) Work place initiatives.

A number of factors were identified as hindering the implementation of clear policies in various countries in the African region, including human resource constraints (competence and capacity), alcohol-related problems among health care workers, denial, and a reluctance to

tackle problems. Other challenges to effective implementation of policies include a lack of awareness of the extent of the burden of alcohol consumption at the societal, community and individual levels. Inaction was also attributed to a lack of political will and a perception that there are more urgent public health problems, such as HIV/AIDS and malaria, which need attention.

Recommended policy strategies for the African region

Given the relatively low level of implementation and enforcement of policies and regulations in the African region, the meeting identified the following strategies as most urgent for policy and intervention development at the national level:

- (1) Raising awareness about the seriousness of alcohol-related social and health problems (such as HIV/AIDS, TB and violence) among policy makers, community and other key stakeholders, and encouraging greater financial commitment to prevention activities;
- (2) Developing and strengthening national alcohol policies and legislation, with existing and new evidence, and with a particular emphasis on those activities that are most likely to have success in the shorter term;
- (3) Education and training of health care and allied professionals;
- (4) Community empowerment and mobilization;
- (5) Policy research and programme evaluation activities;
- (6) Treatment, rehabilitation and brief interventions in health care settings, to improve access and address resource and capacity challenges.

Recommended regional mechanisms

for supporting alcohol policy and intervention

To support countries' development and implementation of alcohol policies and interventions the proposed mechanisms for the WHO regional office to adopt include among other things:

- (1) The establishment of guidelines, norms and standards for policy development;
- (2) The identification of potentially effective policies, with particular attention being paid to non-commercially produced beverages, and unrecorded alcohol;
- (3) The provision of technical support (and capacity building) for the development of national policies;
- (4) The organising of high level meetings on alcohol in the region for advocacy and increasing commitment of member states, including the involvement of the African Union;
- (5) The mobilisation of resources with support from WHO Headquarters and other sources.

PARTNERSHIPS/COLLABORATION

Collaboration with partners at country, regional and international levels was viewed as being vital to the success of the programme. A potentially useful mechanism for coordination of activities at the country level could involve a national coordinating body headed by the Ministry of Health in each country or by the WHO country office. Such a body would work in consultation with representatives of different local or global NGOs and professional associations, the media network, and international agencies and intergovernmental organizations.

Potentially useful mechanisms could

involve holding regular meetings of national focal points under the auspices of WHO and collaborating with sub-regional centres to work with WHO on data collection, analysis and dissemination. “Collaboration” or “partnership” with the alcohol industry (as opposed to “dialogue”) was discouraged so as not to compromise the public health agenda of the proposed programmes.

CONCLUSION

There was general agreement at the end of the consultation that the adoption of the WHO resolution WHA58.26 was an important and not-to-be-missed opportunity for the African community to implement programmes to address alcohol problems in the region. The availability of reliable data to inform responses in the Afro region was seen as essential to the success of the programmes. In addition, it was acknowledged that greater attention needs to be placed on identifying and implementing interventions that are likely to succeed in addressing the burden of harmful use of alcohol in the African region in the short and medium terms. The most important time-frame for the programme is five years (2005-2010), while the initial activities, including the outcomes of the consultation are planned to be presented at the World Health Assembly in 2007. Continued involvement of the participants will entail group work focusing on information at the country and regional levels. The meeting participants identified a strong need for immediate action and encouraged the commitment of the partners to implement programmes of action to raise awareness and urgently address the public health problems that are associated with harmful alcohol use in the African region.

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