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HARMFUL USE OF ALCOHOL IN THE WHO AFRICAN REGION: SITUATION ANALYSIS AND PERSPECTIVES

Report of the Regional Director

EXECUTIVE SUMMARY

1. The harmful use of alcohol in the African Region is increasing. The situation will worsen if appropriate action is not taken to address the problem. Episodic or binge drinking is a significant characteristic pattern of consumption, and estimated total deaths attributed to alcohol consumption show an important burden of mortality.

2. In 2006, a WHO technical consultation on the public health problems caused by the harmful use of alcohol recognized that alcohol-related problems are a serious public health concern in the African Region.

3. The approach to this problem in the African Region may benefit from the experiences and proven initiatives from other regions and worldwide.

4. This document provides an overview of the harmful use of alcohol in the WHO African Region; it also proposes perspectives for a way forward.

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BACKGROUND

1. Harmful use of alcohol is defined as a pattern of drinking that causes or contributes to "physical or psychological harm, including impaired judgment or dysfunctional behaviour, which may lead to disability or have adverse consequences for interpersonal relationships."[1] In this document, *harmful use of alcohol* refers to the public health effects of alcohol consumption, without prejudice to religious beliefs and cultural norms.

2. In the African Region, more countries are reporting an increase in consumption and changes in drinking patterns. Home-made beverages provide a very important channel for alcohol availability and household income. A significant characteristic pattern of alcohol consumption in the Region involves episodic heavy drinking, defined as a drinking occasion that includes consumption of at least 60 grams of alcohol, that is, five or more standard drinks. Episodic heavy drinking is also called *binge drinking*.[2]

3. Trends in globalization, international trade agreements, and the social and cultural roles of alcohol cause it to be widely available for consumption. However, there is an increase in the negative health and social consequences of alcohol consumption worldwide. Some WHO regions have addressed this problem through resolutions,[3] policies and strategies.[4] The African Region has not yet collectively addressed the problem, though a few countries have undertaken some actions.

4. The present document was inspired by discussions at the Sixtieth World Health Assembly, and its purpose is to stimulate discussions by the Regional Committee in order to take a common African position on the subject which is scheduled for the agendas of the Executive Board in January 2008 and the World Health Assembly in May 2008.

THE SITUATION

5. The volume of drinking is linked to most disease outcomes through specific dose-response relationships.[5] African countries differ dramatically in terms of adult per capita consumption, ranging from less than 1 litre to more than 10 litres, with an average recorded consumption of about 4 litres of pure alcohol or ethanol.[6] Data from international estimates, surveys and studies show that, even if a considerable number of people in Africa do not drink, those who do drink consume high quantities of alcohol. Several African countries have some of the highest levels of per capita absolute consumption in the world, especially when traditional beverages are included in the estimates.[7] The estimated proportion of deaths attributable to alcohol consumption in the Region show an important burden of 2.1% in 2000 and 2.2% in 2002.[8]

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1 WHO, ICD-10, *Classification of Mental and Behavioural Disorders*, Geneva, World Health Organization, 1992.
2 Anderson P, Baumberg B, *Alcohol in Europe: A public health perspective*, UK, Institute of Alcohol Studies, 2006.
3 Resolution WHA58.26: Public health problems caused by harmful use of alcohol, Geneva, 25 May 2005; Resolution SEA/RC59/R8: Alcohol consumption control-policy options, Bangladesh, 25 August 2006.
4 EUR/RC55/R1: Framework for alcohol policy in the WHO European Region, Bucharest, 15 September 2005; WPR/RC57/7: Regional strategy to reduce alcohol-related harm, New Zealand, 22 September 2006.
5 Rehm J et al, The relationship of average volume of alcohol consumption and patterns of drinking to burden of disease: An overview, *Addiction* 98: 1209–1228, 2003.
6 Obot IS, Alcohol use and related problems in sub-Saharan Africa, *African Journal of Drug & Alcohol Studies* 5(1): 17–26, 2006.
7 WHO Global Alcohol Database, available on line at http://www.who.int/globalatlas/default.asp (last accessed 4 June 2007).
8 WHO, Expert Committee on Problems Related to Alcohol Consumption, Geneva, World Health Organization, 2007.

6. About 50% of all alcohol consumption in the Region goes unrecorded. This includes locally-produced commodities as well as beverages brought into countries by travellers and those smuggled in for commercial proposes. Therefore, it is difficult to estimate actual quantities of alcoholic beverages consumed in Africa.

7. Traditional alcoholic drinks constitute hidden dimensions of drinking problems in several countries. Much of what is consumed in the Region, especially in rural areas and among the urban poor, includes beverages home-brewed using traditional methods of either fermenting or distilling malted grains, fruits, sugar-cane, honey or palm sap. Because these beverages are poorly monitored for quality and strength, consumption leads to serious health consequences and death, as reported in some countries.[9] Adulterants and impurities can lead to cases of methanol poisoning and toxic effects of high nickel, manganese and aflatoxin concentrations. Health and safety hazards as well as economic costs resulting from counterfeit and substandard alcoholic beverages are unknown or under-reported in the Region.

8. Besides the direct effects of intoxication and dependence, harmful use of alcohol is causally linked to more than 60 different disease conditions with short- and long-term consequences, including mental and behavioural disorders, gastrointestinal conditions, cancers and cardiovascular diseases.[10] In the African Region, estimates show significant alcohol-attributed disease burden from neuropsychiatric disorders and unintentional injuries in both men and women.[11]

9. Studies in Africa have shown increasing evidence linking alcohol consumption with high-risk sexual behaviour, infection with HIV and other sexually-transmitted infections, and reduced adherence to antiretroviral and tuberculosis treatment.[12] Alcohol-use disorders carry a high degree of co-morbidity with other substance-use disorders such as nicotine dependence and drug use.[13]

10. Multiple levels (physiological, psychological and social) of connection between behaviours as well as common shared neurobiological, psychological and social determinants require an integrated approach to substance abuse. Medical approaches to substance abuse problems need to be complemented by population-based public health interventions.

11. Large-scale commercial production, globalization, aggressive marketing and promoting strategies that target young people increase availability and accessibility of alcoholic beverages, and also contribute to the development of new drinking cultures.[14] The tendency, especially among young people, is to consume large quantities, frequently, in a short time span and outside of meals.[15]

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[9] WHO, Expert Committee on Problems Related to Alcohol Consumption, Geneva, World Health Organization, 2007.

[10] Room R, Babor T, Rehm J, Alcohol and public health, *The Lancet* 365: 519–530, 2005.

[11] WHO, *Global burden of diseases 2002*, Geneva, World Health Organization, 2002.

[12] Ashley JW, Levine B, Needle R, Summary of the proceedings of the meeting on alcohol, HIV risk behaviours and transmission in Africa: Developing programmes for the United States President's Emergency Plan for AIDS relief (PEPFAR), *African Journal of Drug & Alcohol Studies* 5(2): 192–200, 2006. See also, Kebede D et al, Khat and alcohol abuse and risky sex behaviour among in-school and out-of-school youth in Ethiopia, *BMC Public Health* 5:109, 2005, available from http://www.biomedcentral.com/1471-2458-5-109.

[13] WHO, Expert Committee on Problems Related to Alcohol Consumption, Geneva, World Health Organization, 2007.

[14] Wills J, Drinking crisis? Change and continuity in cultures of drinking in sub-Saharan Africa, *African Journal of Drug & Alcohol Studies* 5(1): 1–15, 2006; Obot IS, Alcohol use and related problems in sub-Saharan Africa, *African Journal of Drug & Alcohol Studies* 5(1): 17–26, 2006.

[15] Ibanga A et al, The contexts of alcohol consumption by men and women in Nigeria, in: Obot I, Room R, *Alcohol, gender and drinking problems: Perspectives from low and middle income countries*, Geneva, World Health Organization, 2005; Tuimwesigye N, Rogers K, Gender and the major consequences of alcohol problems in Uganda, in: Obot I, Room R, *Alcohol,*

12. Drinking to intoxication is a significant cause of alcohol-related harm, and its impact is greater in younger age groups of both sexes, especially due to fatal injuries such as road accidents or suicide.[16] In Africa, there is a generalized lack of data regarding youth drinking. Existing studies tend to focus on behaviours of urban youth and students which confirm early onset of drinking (ages 10–16); changes in patterns of consumption, with alcohol deliberately used to get drunk; and alcohol as an essential component for having fun.[17] Several surveys in South Africa indicate high levels of alcohol misuse among high school students.[18]

13. Although overall rates of alcohol consumption among women in the African Region are generally still low, some studies indicate an increase and change in patterns of consumption in this group. Even at low average volumes of consumption, and particularly during the first trimester of pregnancy, alcohol can increase the risk of spontaneous abortion, low birth weight, prematurity and intrauterine growth retardation. A recent study from South Africa reports the highest recorded rates of fetal alcohol syndrome of 19–103 per 1000 births.[19]

14. Harmful alcohol use cannot be dissociated from its social impact: family disruption, child abuse and neglect, malnutrition, work problems, violence, crime, social stigmatization and poverty. In the African Region, studies have reported associations between alcohol use and domestic violence; in addition, studies reveal the estimated costs of the economic impact on society in South Africa to be approximately US$ 1.7 billion per annum or 2% of gross domestic product.[20] Such economic impact includes costs to health services, social welfare and criminal justice systems as well as loss of productivity.

15. On the other hand, traditional beverages constitute an important source of employment and economic revenue in Africa, especially for women, enabling them to contribute economically to their families.[21] In a broader sense, alcoholic beverages contribute to national economies and tax revenues; the industries are recognized by government as providers of formal and informal employment. While further research is needed on these issues, current evidence suggests that declining consumption, as a result of effective control measures, may not necessarily affect employment levels in industries linked to alcohol.[22]

16. The enormous cost of harmful use of alcohol in terms of health and social harms cannot be ignored and calls for regulation of alcohol. In the majority of African countries, regulatory and legislative mechanisms regarding trade, industrial and agricultural decisions on alcohol that consider public health, advertising and marketing, availability, pricing and illicit marketing do not exist or are not enforced. Any existing policies have been gradually weakened or dismantled, often from pressure of increasing trade globalization.

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gender and drinking problems: Perspectives from low and middle income countries, Geneva, World Health Organization, 2005.

[16] Kebede D, Ketsela T, Suicide attempts in Ethiopian adolescents in Addis Ababa high schools, *Ethiopian Medical Journal* 31: 83–90, 1993.

[17] Odejide O, Alcohol policies in Africa, *African Journal of Drug & Alcohol Studies* 5(1): 27–39, 2006.

[18] Parry C et al, Trends in adolescent alcohol and other drug use: Findings from three sentinel sites in South Africa (1997–2001), *Journal of Adolescence* 27(4): 429–440, 2004.

[19] WHO, Report on the WHO technical consultation on the public health problems caused by harmful use of alcohol in the African Region, Geneva, World Health Organization, 2006.

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

[21] Pietila T, Drinking mothers feeding children: Market women and gender politics in Kilimanjaro, Tanzania, in Bryceson D, *Alcohol in Africa: Mixing business, pleasure, and politics*, Portsmouth, NH, Heinemann, 2002.

[22] Anderson P, Baumberg B, *Alcohol in Europe: A public health perspective*, UK, Institute of Alcohol Studies, 2006.

17. Alcohol problems in the Region are not recognized or addressed within the health system due to lack of appropriate skills and knowledge as well as lack of adequate resources and conditions for effective screening and intervention. Most existing data are estimates which may not always reflect the true situation in countries, especially regarding alcohol consumption, patterns and harm in various forms.

18. There is also a lack of reliable, valid and standardized tools to collect information on alcohol consumption and alcohol-related harm in many parts of the African Region. However, some tools, namely the WHO STEPwise approach to surveillance, the Southern African Epidemiology Network on Drug Use, and the East African Drug Information System, are gradually being used.[23]

ROLES AND RESPONSIBILITIES

For countries

19. Countries should acknowledge the harmful use of alcohol as an important public health issue and consider its impact on other co-existing situations in the Region such as injuries, HIV, violence and conflict or post-conflict situations, health and social inequities, and poverty.

20. Countries are encouraged to consider the issues raised in this document and identify a common position on the harmful use of alcohol to take to the Executive Board meeting in January 2008 and at the World Health Assembly in May 2008.

21. Countries should conduct national surveys using standardized tools; support the expansion of existing networks; and ensure appropriate financial and human resources to set up mechanisms at country level to collect, analyse and disseminate data for evidence-based policy decisions.

For WHO and other partners

22. Considering the need to collect and improve evidence-based information at country and regional levels, WHO will provide technical support and guidance to countries for conducting the Global Survey on Alcohol and Public Health.

23. Addressing the rising pattern of consumption and problems related to the harmful use of alcohol in the African Region at macro- and multi-sectoral levels constitutes a matter of priority. WHO and other partners, with the involvement of the African Union, need to work on the adoption of evidence-based alcohol policies and agreements on specific policy issues relevant to regional public health needs. A pan-African regional conference should be convened with representation from all sectors.

24. WHO and other partners should establish a regional observatory for monitoring progress in addressing the harmful use of alcohol in the Region.

25. WHO should prepare a regional strategy to address the harmful use of alcohol in the African Region to be presented at the fifty-ninth session of the WHO Regional Committee for Africa in 2009.

[23] Morojele N et al, Report of the first Pan African consultation on alcohol policy and its significance to the Region, *African Journal of Drug & Alcohol Studies* 5(2): 186–190, 2006.