African Journal of Drug and Alcohol Studies

The *African Journal of Drug & Alcohol Studies* is an international scientific journal published by the African Centre for Research and Information on Substance Abuse (CRISA). The Journal publishes original research, evaluation studies, case reports, review articles and book reviews of high scholarly standards. Papers submitted for publication may address any aspect of alcohol and drug use and dependence in Africa and among people of African descent living anywhere in the world.

The term "drug" in the title of the journal refers to all psychoactive substances other than alcohol. These include tobacco, cannabis, inhalants, cocaine, heroin, prescription medicines, and traditional substances used in different parts of Africa (e.g., kola nuts and khat).

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CONTENTS

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EDITORIAL

Alcohol has been associated with numerous health and social problems for centuries but it is only in recent years that the extent of such problems has been quantified. According to World Health Organization (WHO) estimates, alcohol is the fourth leading risk factor for death and disability globally, almost at par with tobacco (WHO, 2002). In some parts of the world, especially in emerging societies, alcohol is the leading risk to population health, contributing wholly or partially to more than 60 disease categories and injury. Added to the acute and chronic health consequences of harmful use of alcohol are social problems caused by drinking to intoxication and dependence.

Little is known about the patterns of alcohol consumption and the contribution of alcohol to health and social problems in African countries. There are, nevertheless, estimates from the WHO Global Alcohol Database (WHO, 2004) and specific surveys which show that though high proportions of Africans do not drink drinkers among them tend to consume high volumes of alcohol. Indeed several African countries have some of the highest levels of per capita consumption in the world, especially when traditional beverages are included in the estimates.

The papers in this special issue of the *African Journal of Drug & Alcohol Studies* are devoted to shedding more light on the extent and patterns of use, and factors associated with alcohol consumption and related problems in the continent. A second objective is to highlight and discuss the prospects for evidence-based and cost-effective interventions to limit the health and social damage caused by alcohol in the face of what is expected to be increasing consumption and problems.

The five original contributions to this volume were invited from experts who have spent many years doing research on alcohol and contributed to the development of alcohol policy in various ways. Comments on the 2005 World Health Assembly resolution on the "public health problems caused by harmful use of alcohol" (reprinted here in full) were also sought from experts. Three of the comments are published in this volume.

This special issue of the African journal is the result of a twinning arrangement with Nordic Studies on Alcohol and Drugs (Nordisk alkohol- & narkotikatidskrift, NAT). The arrangement between the two international journals originated with discussions at a meeting of the International Society of Addiction Journal Editors (ISAJE) in Hydra, Greece in 2004, a global organization that has made it one of its objectives to help in developing and sustaining addiction journals in underserved parts of the world. As the only journal devoted to publishing African substance use research and making such knowledge available to the international community, the AJDAS has become a beneficiary of this vision of a world where the knowledge gap between rich and poor countries, north and south is bridged.

Beginning with this volume the journal aims to maintain a regular publication schedule of two issues per year (in June and November). A new and expanded editorial board is in place with the appointment of senior scholars to act as deputy editors responsible for papers from different regions. Though some of them have been strong supporters of the journal since inception it is still gratifying to have them on board at this level of involvement. These are indeed exciting days for the journal and we look forward to receiving and processing your papers for publication.

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Isidore S. Obot
Editor-in-Chief

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Full responsibility for editing and production of the journal lies with its editorial board, but the journal will benefit from the technical and marketing resources of NAT, while NAT subscribers will receive copies of the special issues of AJDAS. Subsequent special issues on alcohol will be devoted to poverty and development, and sexual risk behaviours.

The journal acknowledges with thanks the central role played by former ISAJE president and editor-in-chief of NAT, Dr Kerstin Stenius, in finding financial support for the publication of this journal.

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DRINKING CRISIS? CHANGE AND CONTINUITY IN CULTURES OF DRINKING IN SUB-SAHARAN AFRICA

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ABSTRACT

This paper offers a brief historical survey of drinking cultures in Africa, from the nineteenth century to the present. It questions the notion of a pre-colonial past of harmonious 'integrated' drinking, and suggests that while there has been substantial change in drinking cultures there are also substantial continuities, notably in ideas of temperance. Striking features of change have been the introduction of large-scale commercial production – which has brought increasingly globalized marketing strategies to Africa; the commoditization of 'traditional' beverages; and the growth in consumption of spirits, often produced on an artisanal basis by illicit small-scale distillers. The last decade has also seen the increasing diversion of non-beverage industrial spirits into beverage use. The paper argues that there is no clear evidence of an overall 'drinking crisis' affecting the whole of Africa, and that it is not safe to assume that modern drinking is necessarily worse than pre-colonial drinking. But the paper also notes that there are substantial gaps in our knowledge of current drinking cultures in Africa, and that there is clear evidence of 'risky' drinking in several parts of Africa. This may not be a completely new phenomenon, but it does present public health challenges.

KEY WORDS: Alcohol, Africa, history, culture

INTRODUCTION

> *In the past [alcohol] was drunk peacefully … In the past they drank at home or in a group . . . but today it is brought in cars from Buyaga, it is brought to town, people drink there, even if it is not a bar. You can even go to the store and put a straw and start to drink and, in the time you have taken to come here, one is already drunk. Now another thing is that they buy from bars even if you want a bottle or a whole jerrican. And they bring it to the village and we sit from morning and start drinking till next day; and women and children have started drinking.*†
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> *Many children do not like farming and instead go to drink beer. This has made people not care about dying, or working like we did, because of beer. If you tell him to work, he is rude.*‡

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† Interview with Jospeh Kiiza, Katasiiha, Uganda, 19 Feb. 1998

‡ Interview with Paul Samuel Mwandembwa, Mpuguso, Tanzania, 10 Feb. 1997

> *Why I am saying the devil has spread is because nowadays they are drinking beer and when they drink, they are unbalanced, those of the devil. This one we are drinking nowadays is for the devil, that is why I am saying it has changed. Long ago we were drinking clean beer.*[§]

Such dramatic accounts of a modern crisis of drinking are easy enough to elicit in Africa: people readily assert that current consumption of alcohol is greater, and more disorderly, than it once was. Media reports too make much of the problem of drinking: drinking by the wrong kind of people, of the wrong kinds of thing, at the wrong time. 'Alcoholism has a firm grip on the country's productive generation', reported a Kenyan newspaper recently; 'One in every eight people who drinks alcohol in the country drifts into alcoholism and becomes addicted . . . Alcohol consumption is no longer restricted to senior age-groups or to restricted occasions'.[**] In less sensational terms, some academic studies have also argued that drinking in sub-Saharan Africa has become increasingly socially problematic, in some societies at least; a phenomenon that is directly connected to the increasing commoditization of beverages, as a result of which 'traditional sanctions restricting consumption to moderate levels apparently cease to operate effectively' (Carlson, 1992: 56; *idem.*, 1989; Colson and Scudder, 1988). Even Deborah Bryceson's recent synthesis, while avoiding any simple picture of crisis, has argued for a change in drinking patterns towards a modern culture in which drinking is defined 'overwhelmingly by income'(Bryceson, 2002a: 45).

Whether alcohol consumption *per capita* has increased in sub-Saharan Africa in recent years is a moot point. The bulk of production and consumption in most of the continent is unrecorded, and this is a field for small surveys and large extrapolations: most of the commentary is entirely impressionistic (Willis, 2002). While scholars writing on Cameroon confidently assert that 'The consumption and the production of alcohol are likely to have increased by about 400% during the last 20 years' they offer no evidence to substantiate this; neither does the historian who reports that 'a characteristic feature of alcohol policy in Namibia during the last two decades has been the rapid increase in the consumption of alcohol beverages' [sic] (Yguel, 1990, p. 114; Siiskonen, 1994). Such arguments seem to rest simply on the assumption that 'drinking patterns are going to change with development and sophistication with tendency towards increased consumption of alcohol'(Acuda, 1985, p. 125).

Nor is there consistent evidence on the larger question of whether drinking really has 'got worse' in a public health sense. Some of the most alarming-sounding survey evidence seems methodologically unreliable (NACADA, 2004); and while there is a substantial body of much better-grounded work which identifies significant health issues, there is really no compelling statistical evidence of the increasing 'riskiness' of drinking across the continent, though there may be good reason to suspect this in particular instances (Riley and Marshall, 1999; Room et al., 2002). Journalistic assertions about alcoholism aside, the notion of increasing drinking problems draws on two rather different approaches. On the one hand, medical and other professional commentators comment on the apparent prevalence of

[§] Interview with Eva Kyando, Itunge, Tanzania, 30 Oct. 1997.

[**] Is drinking now the curse of Kenyans? *Daily Nation*, 12 October 2005.

'risky drinking': patterns of alcohol consumption which in themselves are a physiological threat to health, or are associated with kinds of behaviour which endanger the well-being of the individual and 'the continuing erosion of family and community life'(Parry and Bennetts, 1998, p. 7). On the other hand, there are critiques rooted in local cultural values which identify some kinds of consumption as problematic because they challenge established local ideas of propriety and order. In practice these disparate strands of discourse on the nature of intemperance often overlap – as in Albert Moukolo's suggestion that modern drinking is problematic because of the 'quasi-absence of norms' (Moukolo, 1990, p. 130). But the very existence of these local notions of temperance hints at the extent to which there has actually been substantial cultural continuity in some aspects of alcohol consumption in Africa.

This article will suggest that any generalized picture of a continental drinking crisis is probably over-simplified, and that modern drinking patterns are not simply defined by wealth. But it suggests also that there is some clear evidence of 'risky drinking' in a public health sense, and that Africa's recent past has seen the fragmentation of drinking cultures, and the development of new drinking cultures, so that these increasingly overlap geographically and socially. It is this fragmentation which has ensured increasing debate, and uncertainty over temperance, within African societies. That is, Africa does face some new alcohol-related challenges; but the intensity of the debate over alcohol is more generally a reflection of wider moral debates.

The term 'drinking culture' is used here in the way that Juha Partanen suggested the term, to describe a set of ideas about proper drinking which is directly associated with wider ideas about propriety, status and authority (Partanen, 1991). This is somewhat in the sense that Bryceson has suggested the term 'drinking modality', but with the implication that such cultures are rather more multiple than are her 'modalities' (Bryceson, 2002a). Members of a particular community may be aware of more than one drinking culture, and the practice of drinking may anyway challenge the norm. But it is consistently the case that people express ideas about proper drinking which reflect and reinforce particular ideas about proper behaviour more widely: 'the ceremonials of drinking construct an ideal world', as Mary Douglas put it (Douglas, 1987, p. 8). The fragmentation of these cultures is not, however, simply a symptom of a grand social disjuncture. Some of these drinking cultures exhibit substantial continuity from earlier notions of proper drinking; others are innovative, in some cases self-consciously so, overtly challenging older ideas of temperance and the patterns of age and gender authority which were associated with these.

DRINKING IN MERRIE AFRICA?

Popular arguments on modern drinking have offered a contrast (often explicit) with the halcyon days of pre-colonial Africa, when drinking was unproblematic. Some academic work has accepted this romantic image of a harmonious drinking past (Parry and Bennetts, 1998); though such work risks falling into the genre of romantic and profoundly ahistorical idealizations of a precolonial African past which have been derided as the 'Merrie Africa' school. But some recent scholarship – inspired in part by Robin Room's seminal attack on the idea of drinking in preindustrial societies as unproblematic – has increasingly

questioned this vision of 'integrated drinking', and has argued that even before colonial rule, African societies saw debates on drinking and the idea of temperance (Ambler, 1987; Akyeampong, 1996; Room, 1984). Drinking was not simply 'functional'; people argued over ideas of temperance, some broke the rules which others tried to set on drinking, and cautionary tales about the dangers of the wrong kind of drinking were woven into oral culture (see for example Stanley, 1988). In view of the frequency with which a past of ideal drinking is evoked, it is worth briefly discussing the evidence for a rather more complex pre-colonial history of drinking.

It is customary to preface generalizations about Africa with a cautionary comment on how difficult it is to generalize for such a large and diverse continent. This is, of course, true; but there are some useful general points which may be made about alcohol in pre-colonial Africa. Almost all of the alcohol consumed was locally made, through artisanal production, and it was almost all in a state of continuing fermentation. The material for fermentation came from a range of sources: malted grains (usually varieties of millet), the sap of some palm trees, sugar cane, honey, and fruit were all used. The labour processes and technology were relatively simple, which allowed almost anyone to make alcoholic beverages and set clear limits on the size of any one batch of liquor. When combined with the substantial difficulties of communication across most of the continent, this small-scale production of live liquor meant that most alcohol was consumed very close to its point of production, and that where commerce in alcohol did exist, this was local, and on a limited scale(Willis, 2002). The only partial exception to this was in West and West-central Africa and Cape Colony, where imported spirits had become available with the growth of commerce – especially the slave trade – with Europe. Elsewhere, distillates were almost completely unknown in sub-Saharan Africa before the later nineteenth century.

Several distinct contexts for drinking can be identified in pre-colonial societies right across the continent. Crucially, these were very largely not commercial: alcoholic beverages were generally not made to sell, nor purchased for consumption. Alcohol was widely drunk – and poured – in ritual performances: Eileen Krige's description of Lobedu society in the early 1930s – 'in almost all religious rites beer is essential' – might be applied to many African societies in the nineteenth century (Krige, 1932). This applied to both rites of passage, which marked stages in the life of individuals in society, and what one might call rituals of intercession, which involved some form of communication with ultra-human agencies which were believed to affect well-being (Akyeampong, 1997; Willis, 2002). These might be the spirits of dead ancestors, or the tutelary spirits of particular cults. Such use of alcohol could turn into a sort of extended theatre, as with the rite to appease a possessory spirit observed by the traveller Joseph Thompson in the 1870s: 'they required to use the most powerful charms they could think of, namely beer, dancing and music. They had now kept this process going on for about twenty-four hours'(Thomson, 1968). Alcohol was also consumed in the dramatic performance of political power. The king and other prominent men of the Asante drank extravagantly, letting the palm wine flow down their beards in a casual flaunting of excess; they plied their guests with drink; and on grand occasions they quite literally poured out drink for the populace, who were expected to become more drunk than their rulers

(Bowdich, 1966). Zulu warriors were given beer to make them 'hard'(McAllister, 1993). And alcohol was consumed in daily life, in the seasonal round of agricultural and domestic work: beer was supplied to work parties of neighbours and kin who came together to cultivate, harvest or build; beer was drunk by neighbours whenever someone had made it.

There was, then, a good deal of drinking. Accounts differ as to the consequence of this. Richard Burton, a rather jaundiced mid-nineteenth century observer, painted a picture of general and constant intoxication in what is now central Tanzania

> The men are idle and debauched, spending their days in unbroken crapulence and drunkenness, whilst the girls and women hoe the fields, and the boys tend the flocks and herds. They mix honey with their pombe, or beer, and each man provides entertainment for his neighbours in turn. After midday it would be difficult to throughout the country to find a chief without the thick voice, fiery eyes and moidered manners, which prove that he is either drinking or drunk (Burton, 1961, p. 309)

Frederick Lugard, observing Ugandan society a few decades later, was less disparaging in his comments on the ubiquity of drink:

> The people are very much addicted to the banana wine (pombe). Even on the march a man carries a kitoma with a tube in it, and sucks; when talking, he sucks at intervals. He sucks, apparently, 'from early morn till dewy eve' . . . The liquor, however, appears to be very harmless, and I have not seen anyone visibly the worse for drink, or boisterous and quarrelsome (Lugard, 1968, p. 367)

Another European commented of Uganda that 'I have never seen drunken men here as I have in Europe'(Schweinfurth, 1888, pp. 76-77). Such differences no doubt result partly from the differing prejudices and preconceptions of the observers – how else can one reconcile Lugard's account with the roughly contemporaneous one from a missionary who wrote of the 'constant drivelling inebriation' of people in Uganda, and the 'cantankerous, quarrelsome' behaviour that resulted (Purvis, 1909, p. 340)? But it is also no doubt true that there was great variation in drinking practice between different African societies, and that within one society different contexts might be associated with different cultures of drinking. In Asante, the pouring of a few libatory drops to the ancestors, a routine practice in quotidian drinking, reflected an ideal of drinking which implicitly asserted the social power of elder men – dead, as well as living – whose good will was necessary to well-being. But the tumultuous drinking encouraged by the king and the behaviour of his inebriate retinue, asserted rather the primacy of his authority, over elder men and all (Bowdich, 1966).

Similar conflicts may be discerned in inter-lacustrine East Africa in the nineteenth century, where kings rewarded with drink the young warriors who ensured their power over older men (Willis, 2002). More widely, the ritual use of drink by older men – pouring libations to ancestors, or blessing young initiands – were features of many societies, and ideals of quotidian drinking often revolved around the notion that drink, and the maintenance of societal well-being, were a matter for the older men who headed households, not for women or young men; it was the drinking of such men which lay

at the heart of what Robert Carlson has called the 'symbolic mediating' performed by liquor (Carlson, 1992). It was said of Maasai society in the late nineteenth century that 'A very fiery spirit, made from fermented honey, is drunk only by the elders, who periodically get intoxicated. The warriors are never allowed even to smell this'(Hinde and Hinde, 1901, pp. 45-6). Temperance was not a matter of quantity, or time, of drinking: it was defined by gender and generation(Willis, 2002). Even the beer-party for workers was about authority, as well as neighbourly reciprocity: women and younger men did the work, but the elder and wealthier men might claim the lions' share of the drinking (Speke, 1967). As Charles Ambler puts it, in nineteenth-century Africa: 'the rituals of [alcohol] consumption taught the lessons of hierarchy'(Ambler, 1987; Landau, 1995).

But actual practice in daily life may have sometimes have questioned these lessons. Even if we take with a large pinch of salt the accounts of widespread bacchanalia offered by travellers such as Burton (and his companion, Speke, who wrote that 'Pombe [beer]-brewing, the chief occupation of the women, is as regular here as the revolution of day and night, and the drinking of it just as constant'), there is evidence that women and younger men did drink (Speke, 1967). And in societies where there was some centralized authority, drinking at the palace followed quite different patterns: there it was young men and women – some of them captives, others voluntary additions to the royal following – who drank. And it was they whom the king could use to dispossess, and kill, recalcitrant heads of household. There may have been a widespread culture of drinking which asserted that alcohol was the prerogative of older men; but drinking practice could and did challenge this, as alternative cultures of drinking emerged (Ambler, 1987: 13; Akyeampong, 1996).

MONEY AND TOWNS

Money and towns were among the dramatic consequences of colonialism in Africa. Not that either was entirely novel: there had been systems of currency in operation in parts of the continent for a long time, and substantial urban settlements had existed in many places too. But both money and towns became much more common during and after colonial rule; and the role of alien political and economic forces in both ensured that cash transactions and town life offered ready opportunity for cultural challenge and innovation. The vision of the town as a place of immorality where young men and women stepped outside the bounds of proper behaviour in their pursuit of money may be stereotypical; but it reflects an important dynamic of twentieth century Africa.

In West Africa, the ability of the young to earn money – through wage labour, or by selling cash-crops – had already by around 1900 created societal tensions between young and old which found expression in arguments over the drinking habits of the young; while in East Africa, Monica Wilson's classic study of south-western Tanzania showed how wage employment there allowed younger men to earn money and challenge the authority – and the near-monopoly on beer-drinking – of their elders (Akyeampong, 1996; Wilson, 1977). And there is ample evidence from across the continent of the disquiet caused to men by women who began to sell for money the grain beer which they brewed. Instead of being supplied to the household head in acknowledgement of his dominance, beer became a source of independent income for women – though

it was not always very lucrative, and men too could and did deal in various types of locally-made alcohol (Beidelman, 1971; Willis, 2002). Drinking in Africa's rapidly growing towns was largely commercial from the start; drink was given and consumed not as part of patterns of reciprocity and obligation which ran through society, but in return for money. The location for quotidian drinking became not the household of neighbours but some specialized drinking place – a licensed beershop, or an illegal drinking den. The novelty of such arrangements allowed cultural challenge. In some places it was the presence of both men and women in the same drinking place that was the challenge; elsewhere there was innovatory mixing of old and young in drinking events.

Even as commercialization created new cultures of drinking, colonial authorities anxious to control Africans living in the town legislated to enforce novel – indeed, alien – ideas of temperance. There could be a gender element to the colonial state's ideas of temperance, with women being forbidden to make or possess liquor in towns; and there was some age element to it, too, as alcohol was forbidden to those under sixteen, or eighteen years of age. But in other aspects, these ideas of temperance were absolutely innovatory. Race was central to this; particularly in British colonial territories, the law distinguished categorically between kinds of beverage which Africans could drink and those which Europeans could drink. The imposition of controls on where liquor might be sold and drunk, and the hours at which this might take place, were also quite new; as was the creation of licensing system (or rather, usually, two systems, one for 'native liquor' and the other for the 'intoxicating liquor' drunk by Europeans (and Asians). The licensing systems worked quite separately, following different procedures and with different requirements regarding the times and places at which sale was legal, but each required sellers of liquor to obtain some sort of permit or licence. Such attempts at control were inspired partly by colonial anxiety about the disorderly tendencies of drunken subjects, but there was also an economic concern: drink disrupted the labour supply, making people unfit for work, and drink-selling offered a ready income to urban 'undesirables' who employers thought should really be working for a wage. Over time, licensing systems spread from the towns and out into rural areas, so that the legal framework of the colonial state came to apply to drinking everywhere (Willis, 2002).

There was a good deal of popular resistance to such laws, and indeed in some places they proved extremely difficult to enforce; unlicensed brewing and selling, often by women, was common, and so too was consumption off premises, and outside hours. In South Africa, in particular, this issue came to play a central role in the long struggle between the majority African population and the white-dominated state; and state control here reached its most striking physical form, in the creation of the municipal beer halls, in which urban local authorities sold industrially produced 'traditional liquor' to African drinkers penned into wire cages (Ambler and Crush, 1992).

But the struggle could be complex. Attempts at controls on urban drinking sometimes commanded a degree of popular support; and the steady growth in the sale – rather than the giving or exchange – of liquor was as disquieting to many of the colonial states' subjects as it was to their white rulers. Some might resent youthful drinking, or the alleged

profits reaped by women brewers; others drew on the spreading influence of Islam or of evangelical Protestantism to condemn all kinds of alcohol (Akyeampong, 1996). Advocates of this latter idea of temperance were perhaps more socially radical than the youthful drinkers of the towns; as Paul Landau has observed of Botswana, temperance crusades could be 'acts of feminine resistance' against the dominance of male household heads (Landau, 1995). And the teetotaller could use abstinence as a justification for stepping out of the multiple obligations to kin and neighbours which were entailed in the constant round of giving and receiving drinks (Parkin, 1972). In South Africa, the distinction between the 'red' people and the 'school' people – between those who self-consciously adhered to tradition and those who embraced literacy and education – was clearly marked through attitudes to drink (Mayer, 1961). Political radicalism and temperance developed a link which was to endure into the 1970s, when militant youth in Soweto bewailed their fathers' drunken subservience to the apartheid state.

In South Africa, and in most other parts of Anglophone Africa, African subjects of the colonial state who rejected locally made grain beer, palm wine or other such beverages could find no legal alternative: all kinds of 'European' liquor – even bottled beer – were forbidden by law to Africans in these territories through most of the colonial period(Pan, 1975; Willis, 2002). In French and Belgian territories, bottled beer and wine could be bought by the tiny minority of Africans who could afford them. Such prohibition was the consequence of the colonial anxiety to enforce distance between ruler and subject, and of the notion of paternal trusteeship which legitimized colonial rule to its practitioners: Africans were children, unable as yet to cope with the white man's liquor. Unsurprisingly, such discrimination turned European liquor into a high-status consumption item; the high price of these heavily-taxed beverages gave them rather the same status even where they were legally available to Africans. While some of Africa's emerging new educated elite were teetotal, using abstinence as a badge of status, others touted bottled beer as a mark of their wealth and respectability; here it was the substance consumed, as much as the place and time of drinking, or the age and gender of the drinker, which informed the culture of drinking.

INDEPENDENT SPIRITS

By 1950, changes in the law had made bottled beer legally available to most Africans; but in large parts of the continent spirits were still permitted only to a favoured few Africans until the later 1950s. The colonial fear that Africans were simply unready to drink such potent liquor was an enduring one, enshrined in the system of treaties which underlay the European colonial presence and so powerful that in much of sub-Saharan African distillation for European consumption was also forbidden, lest spirits escape the distillery – with the exception of some Portuguese and Italian territories, all spirits consumed by Europeans in colonial Africa were imported, and taxed heavily to discourage illegal supply to Africans. The corollary of these restrictions was a willingness to allow spirits as a mark of favour to those who were considered most 'civilised' – the *kabaka*, or king, of Buganda, for example.

More widely, however, people helped themselves to spirits. Local distillation was illegal, but it became widespread, and the

circumstances of its emergence played a defining role in the drinking culture which emerged around it. The practice had been almost unknown in nineteenth-century sub-Saharan Africa, but under colonial rule knowledge of distilling techniques spread quickly: the techniques of small-scale, 'artisanal' production, using simple stills to distil twenty of so litres at a time, were relatively easy to master. Imported spirits had already possessed a certain cachet before the colonial – because they were marks of involvement in a commerce with the wider world, it was the wealthy and powerful who had best access to them. Colonial restrictions and taxes emphasised this association – spirits were the drink of colonial rulers, and their favoured allies. Illicit distillation spread most quickly among those who were associated with the new politics and economics brought by colonialism, but not wealthy or important enough to be given access to imported spirits: soldiers, policemen, the chiefs who formed the lowest layers of the administrative system. By the 1930s, illicit distillation was sufficiently common in British West Africa to force reconsideration of attempts to tighten restrictions on imported spirits there, which had always been a little looser than those in eastern and southern Africa: colonial officials feared locally-distilled spirits even more than imported liquor. Locally-produced spirits were alleged to be particularly impure, indeed poisonous; and widespread involvement in illicit production and consumption was believed to be undermining respect for the law more generally (Akyeampong, 1996; Willis, 2001).

POST-COLONIAL DRINKING

By the end of the 1950s, in the last years of colonial rule, such concerns had led states across the continent to entirely abandon racial legislation on drinking, and as a new African political and economic elite took control of the states created by colonial rule, official attitudes to drink changed markedly: the subjects of the post-colonial state were positively encouraged to drink bottled beer, or branded spirits, rather than the fermented drinks or illicit spirits produced in back-yards and bush distilleries (Willis, 2002). Where 'European' liquor had been seen as too potent for African consumption, now it was officially encouraged. Until around 1960, the liquor industry's interest in African had been modest, because of the racial restrictions; but a rough alliance was formed – more successful in some places than others – between international liquor capital and Africa's new states. In the 1970s, a wave of nationalisations threatened the workings of this alliance, and the effectiveness of the industry, but the economic liberalization of the 1990s reversed this, and over the last fifteen years the major international liquor companies have consolidated their African interests, and their relationships with African states (Bryceson, 2002).

Breweries and distilleries have provided investment, a rather small number of jobs and a good source of tax revenue, and they have provided the kinds of drink which colonial experience and postcolonial practice had taught all to regard as modern, superior and safe. Most independent states have maintained the legal distinction between 'native liquor' (now more decorously, if not always accurately, called 'traditional liquor) and the kinds of drink produced by big breweries and distilleries, and distinct systems of licensing helped maintain a clear cultural separation between these beverages – they were (and are) drunk in different places, at different times, and often by different sorts of people. Not all postcolonial governments went so far as

Kenya, which sought to largely ban 'traditional' liquor (Haugerud, 1995). But most have maintained a legal ban on artisanal distillation, and the public practice of the political and economic elite has consistently favoured bottled beer and branded spirits; helping to create new kinds of drinking culture. The most successful drink in members' clubs, or hotels, or in their homes, and prefer imported wines or spirits; this is a culture which celebrates achievement in politics and/or business, and fits into a wider consumption pattern which emphasises clothing, cars and other goods which are mostly imported (Partanen, 1991). More widely there is a drinking culture in which bottled beer is central, and which is to some extent 'national' in each African state (with the idea of bottled beer as a national drink playing an important part in advertising) but which also shows some similarity across the continent (Bryceson, 2002). This is a drinking culture which is associated with men in salaried jobs or in business, the advertising of which often stresses both maleness and nationality, and it is located in the urban bar or in clubs which are much less exclusive than those of the elite; the irony of the rhetorical celebration of the 'national' through drinking a product which is increasingly transnational is only occasionally noted (for advertising see Mager, 2005; Willis, 2002; for drinking as a male activity see Rocha-Silva, 1991). Like the elite culture, the bottled beer culture is one which celebrates consumption as a demonstration of wealth, and which values the ability to 'hold one's drink'.

There have been experiments with the industrial production of a kind of 'traditional' grain beer, which grew out of the colonial schemes for municipal beerhalls, and in southern Africa in particular these have had some success; there were also one or two unsuccessful attempts at collecting and marketing artisanal spirits (Haggblade, 1992; Willis, 2002). But more generally, state and capital have looked askance at the alcoholic beverages produced in what is now called the 'informal sector'. Such hostility has not, however, succeeded in suppressing such production, or the alternative drinking cultures which exist alongside it, partly because of the widespread venality of petty officials in the post-colonial state but also because popular feeling would make enforcement impossible anyway. In much of sub-Saharan Africa (South Africa being a partial exception), the unwaged – that is, most people – cannot afford to participate regularly in the 'national' culture of bottled beer, much less the elite world of whisky and clubs (Yguel, 1990; Rocha-Silva, 1991; Rocha-Silva, 1998). Instead they drink locally-made informal sector fermented or distilled beverages, many of them produced in innovative ways with novel ingredients (tea leaves, dried bakers' yeast, processed sugar) (Maula, 1997). Whether urban or rural, such drinking is now very largely commercial: drink is made to sell (Green, 1999; Maula, 1997; Nelson, 1982; Nelson, 1997; Pietila, 2002; Saul, 1981).

Such commercial, unrecorded, drinking does not all take place within a single drinking culture. Local notions of propriety vary – in some places, the mingling of men and women at in drinking places is seen as unproblematic; in others, public drinking is largely a male preserve, and 'relative tipsiness is tolerated in men but not in women'(Partanen, 1991; Ngokwey, 1987). Where the state lays a relatively light regulatory hand on such beverages, the places where they are consumed are more likely to be a very public part of any community; where regulation is close or

prohibitory drinking may not be diminished, but it is definitely more covert. Such commercial drinking continues to be an important part of life, and to be associated with sociability. Some choose to reject this sociability, and the social obligations which it implies. There is no absolute correlation between abstinence and Islam or evangelical Protestantism, but there is a very strong association, and religious belief provides a ready means to explain a refusal to share drinking sociability (Partanen, 1990; Luning, 2002; van Dijk, 2002). There is a strong emphasis on sociability in the cultures of drinking around fermented beverages: drinking in groups, with systems of sharing or rotating the cost, is common. This kind of drinking group can also be found, especially among men, in the drinking of bottled beer, though it exists in a sort of tension with the element of individual status display and conspicuous consumption associated with bottled beer. Sociability is a prized aspect of drinking; that drink encourages talk and openness is widely considered to be desirable.

This emphasis on the beneficial consequences of alcohol on sociability is also apparent in the continued role of alcohol in a number of ritual performances; as Suzette Heald's research in the 1960s suggested, the selling of locally-made liquor did not mean that liquor immediately lost its ritual role (Heald, 1989). Ritual is an area where Christianity and Islam have had particular impact: the combination of 'pagan' practices and locally-made alcohol has attracted particular censure from local authorities, and in some societies rituals of intercession, and the use of alcohol in these, have substantially declined or disappeared (Sangree, 1966; Omori, 1978). But drink is still often a feature of weddings, funerals and other events which mark change in personal status; the social prestige attached to bottled beer has meant that this has generally become the preferred beverage for such events, but for those who cannot afford bottled beer, 'informal sector' drinks may still be used(Omori, 1978).

And alcoholic beverages of various kinds may still also feature in rituals of intercession in some societies: men on the Kenya coast still spill drops of palm wine to please their ancestors before they drink; libations are still poured in Asante society, too (McCaskie, 2000). Even though it is true of Maasai society, in East Africa, that 'access [to liquor]which used to be qualified by age seniority is increasingly mediated by monetary ability'(Kituyi, 1990, p. 67), this does not mean that, among the Maasai or elsewhere in Africa, liquor has entirely lost its ritual role or its association with the power of elder men. New cultures of drinking have developed; and older ones have been adapted to changing circumstances. This has not always been an easy or consensual process, and there are problematic aspects to the newer cultures of drinking. But this is not just the rise of 'drinking for drinking's sake' to replace an older 'integrated' drinking, as Colson and Scudder have argued (Colson and Scudder, 1988). There has not been a complete moral collapse around drinking, and it is interesting that while survey data on South Africa (one of the few remotely reliable datasets on this topic) suggest that 'risky' drinking may be common in townships and informal settlements, it also indicated that more generally men around the age of 40-50 were the principal drinkers, a pattern which would have fitted comfortably with older notions of temperance (Parry and Bennetts, 1998; Rocha-Silva, 1998). The causal link between the sale of 'traditional' liquor and the decline of an

older social order has been repeatedly argued, perhaps most memorably by one of Monica Wilson's informants in Tanzania: 'What brings disrespect is beer; formerly the young did not drink beer, but now they come with their own money and buy and drink. Beer brings pride'(Wilson, 1977, p. 93). But the very use of that argument is a reminder of the durability of the model of temperance – and of elder men's authority – which it implies

More individualized cultures of drinking have tended to develop around spirits. Consumption of spirits has continued to be seen as an assertion of status and sophistication(Rocha-Silva, 1991), though not all can afford to do this in the same way; while a political and business elite drink imported Johnny Walker in their clubs, the less wealthy consume locally-distilled spirits, which are in most parts of Africa still illegal. Perhaps partly because of its generally covert nature, this drinking seems usually to be less concerned with sociability, and less likely to involve sharing and group arrangements. It is perhaps around these cultures of drinking that forms of 'risky drinking' are most likely to develop. Emmanuel Akyeampong has suggested of Ghana that, faced with the overwhelming multiple challenges of life in modern Africa, many individuals have taken solitary refuge in drinking spirits as a way of surrendering responsibility – they would rather be seen as victims of drink than as social and economic failures (Akyeampong, 1995). Margrethe Silberschmidt has made a somewhat similar argument of western Kenya, identifying, arguing that socially destructive patterns of drinking among men are the result of socio-economic pressures on men (though she does not consider the actual culture of drinking in any detail) (Silberschmidt, 1990).

More widely, the individualized culture of spirit-drinking has allowed the development of practices which pose a direct risk to public health (Room et al., 2002). In the late 1970s, a study of the 'high prevalence of alcoholism' in western Kenya identified spirits drinking as the most problematic kind of consumption and – while there are methodological questions regarding that that particular research – this does seem to be an area for wider concern (Otieno, 1979). Problematic drinking styles are compounded by issues around the quality of the beverages involved. There have long been questions about the safety of artisanal distillation, though on the whole, the evidence has not shown that there are any consistent dangers associated with this. But there is an increasingly common practice of adulteration, rather than distillation – with various kinds of industrial alcohol being diverted to beverage purposes. This is particularly likely in situations where consumers who have grown accustomed to bottled beer or branded spirits find themselves faced with economic problems which leave them unable to afford these drinks. It would seem to be this which has led to several serious poisoning incidents in Kenya in recent years (Willis, 2003); and to similar events in Madagascar and Sudan.

CONCLUSION

There is much continuity and in cultures of drinking in Africa, and some of the debates over drink overstate the degree of change and social disruption in drinking – the more dramatic statements about drinking decline today seem very similar to those offered fifty years ago(Nsimbi, 1956). One might anyway question whether drinking in Africa was ever really 'integrated' in the way that some classic anthropological works have described it (Netting, 1964). But while

there is no need to assume an ideal drinking past, there is no doubt that certain kinds of drink, and of 'risky' drinking, have become more prevalent in some parts of Africa in recent years. The challenge for policy makers and public health professionals is to address these real problems, rather than to assume that the modern world inevitably brings a wholesale 'drinking crisis'.

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ALCOHOL USE AND RELATED PROBLEMS IN SUB-SAHARAN AFRICA

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ABSTRACT

Data from the World Health Organization Global Alcohol Database (GAD) show a wide variation in per capita consumption of recorded alcohol in African countries, ranging from less than 1 litre of pure alcohol in some (mostly Muslim) countries to more than 10 litres in a couple of others. For all countries, a pattern of increasing per capita consumption emerged in the 1960s, continued throughout the 70s, and peaked around 1979 at about 4.5 litres. The steady rise in consumption paralleled post-independence economic boom in many countries, just as the slight decline in per capita consumption in the past two decades might be associated with worsening economic conditions. Today, the average per capita consumption is a little under 4 litres, less than half of the European average. These figures do not account for much (in many cases the larger part) of the alcohol consumed in the form of traditional beverages since these are not reflected in official records. Though a lot remains to be known about drinking and alcohol-related problems in Africa, there are a few consistent finding from survey research. Abstention rates are high, especially among women; but high levels of (often episodic) consumption are common among male and female drinkers. Studies in several countries have shown an association between harmful consumption of alcohol and health and social consequences, including death from road traffic accidents, domestic violence, HIV infection, and disorders requiring demand for treatment. Consumption of commercial beverages is expected to rise in the coming years as the economic conditions continue to improve in some countries and as a result of increasing marketing and promotion activities by the industry. National responses to these problems will require better research evidence on the health and social problems attributable to alcohol consumption, and the implementation of effective policies to address these problems in countries across the continent.

KEY WORDS: alcohol use, alcohol problems, Africa

INTRODUCTION

Alcohol has been a constant presence in African social life for centuries as it has been in most parts of the world. Except where it is banned for religious reasons, large quantities of brewed or distilled drinks are produced in local communities or by modern commercial enterprises to satisfy the tastes of a

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growing number of consumers. Like other aspects of life in the continent, tradition remains strong even as the influence of modernity in the form of western alcoholic beverages has penetrated remote villages (Obot, 2000). Commercially produced beer is the most preferred drink (Obot, 1993; WHO, 2004) and western spirits have usurped the cultural roles reserved for traditional drinks. However, a lot of what is consumed in rural areas and among the urban poor are fermented beverages like *burukutu and pito* or gin-like (sometimes illicit) drinks like *kachasu* in Zambia, *ogogoro* in Nigeria, and *gongo* in Tanzania.

Though interest in the topic has grown in the past two decades, little is known about the levels and patterns of consumption of alcoholic beverages in African countries (Obot, 2000; Room et al., 2002). Also, as in many other parts of the world, there is even less information about the contribution of alcohol to a wide range of physical and mental health conditions, and social problems that affect the drinker, his or her family, and the society at large. This brief review of alcohol consumption and alcohol-related problems in African countries focuses on these two issues: the extent and patterns of alcohol consumption, and the consequences of drinking with regard to health and social welfare. The review utilizes consumption data from the World Health Organization (WHO) Global Alcohol Database (GAD), research published in academic journals and books, and reports of surveillance activities in a few countries in the continent.

ALCOHOL CONSUMPTION AND DRINKING PATTERNS

The data presented in Table 1 show the proportions of male and female abstainers, per capita consumption of recorded and unrecorded alcohol, and drinking pattern scores for many countries in the African region (WHO, 2004).

Adult per capita consumption

For African countries the WHO Global Alcohol Database uses data supplied by the Food and Agriculture Organization (FAO) to make estimates of adult per capita consumption (APC) of recorded alcohol, which refers to the average of alcohol consumed by people 15 years of age or older derivable from official statistics. (APC is a more realistic estimate of the average level of consumption in a country than the overall average since the latter is an average for everyone in the population including children who normally do not consume alcohol). Unrecorded alcohol consumption, on the other hand, refers to consumption of beverages that are not part of official statistics on production and trade reported to the FAO. In this category are traditional beverages made from palm trees, a variety of grains and fruits, and drinks distilled from these local brews. In Table 1, estimates of average per capita consumption of recorded or unrecorded alcohol are in litres of absolute alcohol (or ethanol). Because survey data on unrecorded consumption are sparse what are reported here are likely to change as more research becomes available.

***Recorded consumption*:** Globally, per capita consumption of alcohol is about 5 litres of ethanol per person in the adult population. The highest level of drinking by adults in the world is in Europe where adult per capita consumption is more than 10 litres. Europe has recorded declines in per capita consumption for more than two decades though the trend has been of increasing consumption in some parts of the continent and among young people in general. Overall, the average consumption in Africa is about 4 litres of absolute

Table 1. Percentages of "past year" abstainers, per capita consumption of recorded and unrecorded beverages in the adult population (15+ years), and estimated drinking pattern scores

Countries	Percentage of past year abstainers			Recorded consumption (litres of ethanol per capita)	Unrecorded consumption (litres of ethanol per capita)	Drinking pattern score
	Total	Male	Female			
Angola	-	-	-	2.91	-	-
Benin	-	16.8	14.3	1.22	-	-
Botswana	53.5	37.0	70.0	5.38	3.0	3
Burkina Faso	-	-	-	4.38	3.3	3
Burundi	-	-	-	9.33	4.7	3
CAR	-	-	-	1.66	-	3
Cameroon	-	-	-	3.66	2.0	3
Congo	-	-	-	2.36	-	-
Cote d'Ivoire	-	-	-	1.71	-	-
DRC	-	-	-	2.01	-	-
Ethiopia	-	-	-	0.91	1.0	3
Gabon	-	-	-	7.97	-	3
Gambia	-	-	-	2.27	-	-
Ghana	-	-	-	1.54	-	3
Kenya	55.0	45.0	65	1.74	5.0	3
Lesotho	74.0	47.0	81	1.83	-	3
Liberia	-	-	-	3.12	-	3
Malawi	-	-	-	1.44	-	-
Mali	-	-	-	0.49	-	-
Mauritius	-	-	-	3.16	11.0	3
Mozambique	-	-	-	1.67	-	-
Namibia	-	39.0	53.0	2.39	-	3
Nigeria	75.6	51.3	89.6	10.04	3.5	2
Rwanda	-	-	-	6.80	4.3	3
Senegal	-	-	-	0.48	0.8	3
Seychelles	27.5	10.0	45.0	3.61	5.2	3
Sierra Leone	-	-	-	6.64	-	3
South Africa	69.0	55.0	83.0	7.81	2.2	3
Swaziland	-	-	-	9.51	4.1	3
Tanzania	-	-	-	5.29	-	-
Togo	-	-	-	0.95	-	-
Uganda	54.3	48.2	60.3	19.47	10.7	3
Zambia	-	-	-	3.02	-	4
Zimbabwe	-	-	-	5.08	9.0	4

Sources: WHO (2004); Rehm et al. (2004)

Table 2. Per capita alcohol consumption (in litres of pure alcohol) for selected African countries, 1961-2001

Countries	1961	1971	1981	1991	2001
Angola	5.37	4.90	2.46	2.35	2.91
Benin	0.90	0.99	2.34	1.13	1.22
Botswana	5.90	6.48	3.55	5.12	5.38
Burundi	7.43	8.10	8.44	8.35	9.33
Cameroon	6.68	6.37	6.54	6.04	3.66
Congo	4.40	2.73	4.28	2.78	2.36
Cote d'Ivoire	2.80	2.72	4.15	1.66	1.71
Gabon	5.52	6.17	11.88	9.17	7.97
Gambia	3.18	2.53	0.94	1.47	2.27
Ghana	1.46	2.18	1.64	1.57	1.54
Kenya	3.36	4.11	3.26	2.22	1.74
Malawi	1.60	2.72	1.81	1.00	1.44
Nigeria	4.29	5.01	8.31	6.62	10.04
Rwanda	5.68	7.32	8.05	8.06	6.80
Sierra Leone	5.61	5.52	4.40	4.21	6.64
South Africa	7.43	12.82	13.35	14.21	7.81
Swaziland	7.03	10.70	5.43	4.91	9.51
Uganda	17.31	22.73	13.50	14.01	19.47
Zambia	8.46	8.17	3.81	3.00	3.02
Zimbabwe	4.24	6.48	6.22	2.50	5.08

Source: WHO Global alcohol database (accessed February 2006)

alcohol. Levels of consumption vary widely, ranging from less than 1 litre in Islamic countries of the north to more than 10 litres in Nigeria and Uganda.

One feature of alcohol consumption in Africa is the high rate of abstention in every country. Available data show that more than 50% of adults are past year abstainers, i.e., people who did not drink any type of alcoholic beverage in the twelve months preceding the survey, including lifetime abstainers. Among women the proportions of abstainers are much higher, often as high as 80%.

Table 2 shows per capita consumption for twenty countries at nine data points between 1961 and 2001. In most countries there are no clear trends in the level of consumption from decade to decade. However, when annual data are used to plot per capita consumption, trends might be more discernible within decades and across the forty year period. As stated earlier, the pattern for Africa as a whole has been that of upward trend in recorded consumption up to 1978 and a slight decline since then.

***Unrecorded (or undocumented) consumption*:** As shown in Table 1, traditional drinks (from home brews to distilled beverages) contribute significantly to the overall consumption of alcohol in all African countries where drinking is a common practice. These drinks are not included in official records of alcohol production and consumption; they are often one of the hidden dimensions of drinking problems in these countries. The overall estimate of unrecorded alcohol consumed in African countries is 50 percent (WHO, 2004) of all alcohol

consumed. In countries like Kenya, Rwanda, Seychelles and Zimbabwe unrecorded consumption accounts for much more of the total consumption. Apart from locally produced beverages, unrecorded alcohol includes drinks brought into the countries by citizens returning from trips abroad, and drinks smuggled in for commercial purposes, though in Africa these sources will account for a very small part of undocumented consumption. This unreported aspect of consumption is obviously an area demanding greater attention as countries develop and implement policies to reduce the harm associated with alcohol.

Pattern of drinking

The last column in Table 1 shows estimates of the patterns of drinking in African countries where data for the specialized analysis were available. A pattern score is a numerical representation of the way in which alcohol is typically consumed in a country based on sample surveys and responses provided by key informants (Rehm et al., 2004). Specifically, the score is an estimate of the level of hazard that might result from drinking, following from the underlying assumption that the consequences of alcohol consumption are related to volume consumed and how, when, and where consumption takes place. Some of the indicators used in determining drinking pattern are: number of heavy drinking occasions, high usual quantity of alcohol consumed, drinking in public places, and drinking at community festivals. Pattern scores range from 1 to 4, where 1 represents the least hazardous pattern of drinking and 4 the most hazardous.

What Table 1 shows is that in most African countries the pattern score is 3, and in two it is the highest possible score of 4. What this means is that though the per capita consumption of alcohol is generally low (compared with consumption in Europe), the most common way of drinking is one with high potential for causing health or social harm. While the estimates need refinement with better data, this general conclusion is supported by data from population surveys showing that drinking tends to be an “all-or-nothing” affair (Partanen, 1990; Obot, 1993; Obot, 2002). For example, in a major survey in central and southern Nigeria, 52% of male and nearly 40% of female respondents reported heavy episodic drinking in the past year, and among drinkers heavy consumption was common practice (Ibanga et al., 2005). A similar survey in Uganda showed that 46% and 17.6% of male and female drinkers, respectively, engaged in heavy episodic drinking (Tumwesigye & Rogers, 2005). (Data for these two countries are from a recent World Health Organization supported project while data for the other countries in Table 3 are from various surveys). In an earlier study in the Republic of Cameroon, the average volume of consumption was nearly six drinks per day among drinkers (Yguel et al., 1990). The tendency, therefore, is for drinkers to consume large quantities in short time, to drink outside meals, to drink frequently, in other words, to drink in order to get drunk. This pattern of drinking is not peculiar to Africa; it is also common in other parts of the developing world (Room et al., 2002) and is found among young people and other groups in European countries. How alcohol is consumed in a country or within a group (i.e., pattern of drinking) is an important determinant of types and levels of problems associated with drinking. Since the average volume of alcohol consumed by drinkers in one country tends to be similar to the

volume in others (WHO, 2004), attention must be paid to both level and pattern of drinking in attempts to reduce alcohol-related problems.

Young people and alcohol

Much of the debate on alcohol in Europe and North America has concentrated on the problem of heavy episodic (or binge) drinking by young people. Rapid increases in social problems often associated with drinking to intoxication by youth and young adults (from disorderly conduct to violence and injuries), have been a source of heightened concern in these societies in recent years.

In Africa there has been a longstanding interest by researchers in studying the drinking behaviour of adolescents in different countries, though most of these studies have focused on the behaviours of urban youth and students in secondary schools. For example, one of the earliest studies conducted in Nigeria showed that 40% of the secondary school students surveyed said that they had consumed alcohol in the past year (Oshodin, 1981). In another survey conducted around the same time in seven schools 21% of the students reported lifetime consumption of alcohol (Anumonye, 1980). Nevadomsky (1985) found a lifetime rate of 60% among the students he surveyed and current drinking status was reported by 24-49% of the teenage students studied in different cities (ICAA, 1988). A more recent study in a different part of the country showed that among secondary students who reported drinking in the past year 25% drank everyday (Obot, Karuri & Ibanga, 2003). These studies were all conducted in the southern part of the country, and little attention was paid to level of consumption or the harmful consequences of drinking.

The extent of hazardous consumption of alcohol by young people in Africa can be gleaned from available survey data. Surveys among young adults aged 18-24 years show that, compared to young people in some South American and European countries, few of them engage in heavy episodic or "binge drinking," i.e., consume five or more drinks in one setting at least once a week (WHO, 2004). For example, the proportion reporting this pattern of consumption is 9.3% in Chad, 6.4% in Burkina Faso, 5.4% in Namibia, 2.8% in Zimbabwe, 2% in Ethiopia and less than 1% in many countries. Compared to 20% in the Czech Republic, 17.8% in Slovakia and 15.3% in Brazil, these are relatively low rates of risky drinking. However, it is important to note that data for many countries are from small surveys using samples that are not representative of the country and, therefore, of limited value in national comparative analysis.

Gender differences in alcohol consumption

In terms of differences between men and women the picture in Africa is similar to what has traditionally been reported from other parts of the world. More women than men are abstainers, defined in this case as people who did not drink any type of alcoholic beverage in the year preceding the survey (including lifetime abstainers). As shown in Table 3, higher proportions of men also consume five or more drinks occasionally in one sitting. However, Table 4 shows that at least in some countries, the difference between men and women disappears when the focus is on drinkers only and when a pattern of regular consumption of large volumes of alcohol is considered. For example, in Nigeria, South Africa and Ethiopia, more women drinkers than men reported regular consumption of volumes of alcohol that exceed what can be defined as moderate drinking.

Table 3. Percentages of male and female heavy episodic (or binge) drinkers in the adult population and among young adults

Countries	Heavy episodic drinking in the adult population		Heavy episodic drinking among 18-24 year-olds	
	M	*F*	*M*	*F*
Burkina Faso	28.3	11.2	8.4	5.1
Chad	17.2	7.9	13.7	5.6
Congo	8.3	2.5	6.4	2.2
Cote d'Ivoire	28.8	0.9	6.9	0.3
Ethiopia	7.7	0.4	4.2	0.2
Ghana	2.5	0.4	1.0	0.3
Namibia	9.5	4.0	10.6	2.0
Nigeria	52.0	39.6	1.7	0.6
Uganda	46.0	17.6	-	-
Zimbabwe	10.1	0.9	6.6	0.3

Source: WHO (2004)

Note: Heavy episodic (or binge) drinking is the consumption of a large quantity of alcohol ranging from 5 to 7 drinks on any one occasion within a specified period of time (e.g., in the past week or month).

Data for most countries are from regional surveys.

Table 4. Percentages of adult male and female heavy drinkers

Country	Total	Males	Females
Burkina Faso	11.6	10.0	13.2
Chad	11.0	12.8	9.5
Ethiopia	9.3	8.1	10.6
Ghana	1.9	2.1	1.7
Namibia	4.1	3.1	4.9
Nigeria	-	27.8	36.1
South Africa	7.6	7.0	8.8
Uganda	-	40.1	20.3
Zimbabwe	2.7	5.8	1.0

Source: WHO, 2004

GENACIS Project: Two recent studies in Africa provide a much clearer picture of alcohol use and problems associated with drinking by gender and other socio-demographic characteristics. These are studies conducted as part of a multi-country project on gender and alcohol. GENACIS (Gender, alcohol and culture: an international study) was initiated by the International Research Group on Gender and Alcohol (IRGGA) with the aim of collecting comparable data on gender differences in different aspects of the alcohol experience, including patterns and contexts of drinking, and prevalence of alcohol problems. More than 30 countries

from all parts of the world participated in the project, with Nigeria and Uganda among the seven low-income countries in Africa, Asia and South America funded by the World Health Organization.

The two African studies in the project utilized large regional samples of randomly selected participants made up of near-equal numbers of adult males and females aged 18 years and above. There were 2,099 participants in the Nigerian survey and 1,479 in Uganda.

In the Nigerian survey (Ibanga et al., 2005) 32.5% of the people interviewed were drinkers (41.5% of men and 22% of women), less than reported in an earlier study conducted in some of the areas covered by this survey (Obot, 1993). A lower proportion of 18-29 year-olds were less likely to drink than people in older age groups for both men and women. Also associated with being a non-drinker were having no formal education, living in an urban area, and having a high level of household income. As stated earlier, 28% of males and 36% of females reported heavy episodic drinking in the year preceding the survey, as distinct from the pattern of frequent heavy drinking found among more females than male drinkers.

The survey in Uganda showed that 47% of the 1,479 people interviewed were drinkers (55% of men and 40% of women), 22.3% engaged in frequent or infrequent heavy drinking, and a third drank daily (Tumwesigye & Kasirye, 2005). Compared to older age groups, men in the 18-29 age-group were more likely to be abstinent than women in the same age group. Most drinking occasions took place in bars or at parties during weekends, indicating the social nature of drinking in this and other African countries. Alcohol drinkers in the Ugandan survey reported more financial and physical health problems than nondrinkers. Sixty-six percent of the drinkers also had some kind of social problem in the past year, including problems with the law, family, and work or studies. Being a frequent drinker was strongly associated with quarrelling, having more than one sexual partner, smoking, and experiencing physical aggression.

HEALTH AND SOCIAL BURDEN OF ALCOHOL

Alcohol is a recognized risk factor for morbidity and mortality globally. According to the World Health Organization, 4% of global health burden (measured as disability adjusted life years – DALYs) and 3.2% (or 1.8 million) of all deaths in 2000 were attributable to alcohol (WHO, 2002). Though most of the health burden is found in developed countries (9.2% of DALYs), alcohol is the leading risk factor in those developing countries with low rates of child and adult mortality. In these countries with rapid economic growth and rising levels of per capita income (e.g., Brazil, Argentina, Thailand, and Republic of Korea), alcohol accounts for 6.2% of the health burden.

About sixty disease categories have been identified in which alcohol is a contributing factor. Alcohol contributes to or is the sole cause of chronic and acute health problems because of its direct toxic effects on organs (as in alcohol liver cirrhosis), its intoxicating properties (as in accidents and injuries), and because it is a dependence producing substance (Babor et al., 2003).

Two related surveillance initiatives in Africa provide some insight into the contribution of alcohol to health problems seen in health care settings. The South African Community Epidemiology Network on Drug Use (SACENDU) and the Southern African Development Community (SADC) Epidemiology

Network on Drug Use (SENDU) have served as a source of data on alcohol and drugs in South Africa and SADC countries, respectively, for many years. SACENDU was launched in 1996 and SENDU in 2000 as networks of researchers and professionals working together to collect and report data on the alcohol and drug situation in the coverage areas. The findings illustrate the important and persistent involvement of alcohol in treatment demand.

For example, in 1994 alcohol was the substance most often associated with admission in all five SACENDU project sites, ranging from 38% to nearly two-thirds in the different specialist treatment centres. The average age of clients reporting for treatment in these centres ranged from 37 to 41 years, and as the consumption data would suggest, more than 75% were men (SACENDU, 2004). Data for 2005 and for years before 2004 lead to the conclusion that harmful consumption of alcohol carries with it a heavy burden on health in South Africa.

This assessment is not limited to South Africa, as revealed from SENDU reports and studies in other parts of the African continent. For example, in Lesotho, Mauritius, Mozambique, Namibia, the Seychelles and Swaziland, alcohol played a significant role in treatment demand in both general and psychiatric hospitals, with 62% of admissions into psychiatric hospitals in Swaziland and up to 80% in Mauritius related to alcohol as the primary substance used (SENDU, 2004). Outside southern Africa, where there is a developing tradition of regular surveillance, the situation is not much different. For example, several studies have shown that alcohol is second only to cannabis as the primary substance associated with admissions into Nigerian psychiatric hospitals (Ahmed, 1986; Obot & Olaniyi, 1991; Ohaeri & Odejide, 1993). Of course, many of these admissions are for co-morbid conditions where alcohol use disorders are part of the mix, so it is not clear how much role alcohol (or cannabis, for that matter) plays in the psychiatric morbidity resulting in hospitalization. What the WHO Global Burden of Disease project has shown is that the high burden of alcohol is partly due to a strong link to depression (Rehm et al., 2004).

In terms of social harm, studies conducted in Kenya, Zambia, South Africa, Uganda, Ghana, and Nigeria and other countries point to a close association between alcohol and several categories of social problems, including domestic violence, family disruption and workplace problems (WHO Global Alcohol Database, 2004). The overall social and economic cost of alcohol to society has been calculated for many developed countries showing substantial monetary costs. Where such analysis has been conducted for an African country (South Africa), the total cost estimate is $1.7 billion, accounting for 2% of the country's GDP. In spite of its social benefits and long history as a cultural artifact in most African countries, alcohol in all its forms is a commodity with high potential for negative health and social consequences.

CONCLUSION

What this brief review of drinking and alcohol-related problems in Africa shows is that while much remains to be known (Obot, 2000) there is adequate enough information to warrant efforts to address the rising pattern of consumption and problems. In general, abstention rates remain high especially among women, but among male and female drinkers the common practice is to consume large

quantities of alcohol per drinking occasion. This is an important feature of drinking in Africa since drinking that results in intoxication accounts for most of the acute problems like accidents, violence and injury.

These problems and the chronic health conditions that afflict the individual drinker will become more prevalent with increasing levels of consumption; hence there is urgent need to put in place effective policies to reduce the health and social burden they impose on societies. Fortunately, such policies and strategies do exist (Babor et al., 2003) and, though evidence of their effectiveness are from a few developed countries, they can be adapted to fit the needs of nations and communities in the African continent. There is also a clear need for more research into consumption, problems and the special role of non-commercial beverages in all countries in the continent.

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ALCOHOL POLICIES IN AFRICA

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ABSTRACT

This paper reviews studies of the patterns of alcohol use and consumption in Africa. It highlights the findings that alcohol consumption has currently been on the increase with the underage and young persons (ages 10 to 25 years) of both sexes predominating. It was also noted that marketing played a critical role in the globalization of patterns of alcohol use among young people with the production of new alcoholic beverages specially designed for youth markets such as wine coolers, alcopops, malternatives, etc. Excessive drinking by youths was also found to be facilitated by free drinks at social occasions. Apart from the pleasure/fun of drinking, damaging health, social and economic consequences were reported which called for urgent public health intervention measures. The paper then reviews alcohol control policies that have been found effective in the industrialized world and recommends the ones relevant to the African culture that could be added to the existing alcohol policies in different African countries.

KEY WORDS: Alcohol policy, Africa, Nigeria

INTRODUCTION

In the pre-colonial era in Africa, beverage alcohol was produced locally either by tapping it from the palm-tree (palm-wine) or fermenting it from cereals such as guinea corn or distilling palm-wine into 'spirit' (local gin) [Odejide, 1989]. At that time, the use of beverage alcohol was restricted to adult males and it was essentially for pleasure at the end of the day's farming activities (Odejide and Odejide, 1999). Despite the unwritten prohibition of alcohol use by females and children, excessive use by adult males often led to sanctions such as verbal disapproval or enforcement of consumption limits by members of the group.

Unlike the traditional use of alcohol, western traders in the latter part of 19th century who doubled as slave traders brought industrialized (trade) spirits (e.g. rum) into Africa (Pan, 1975). According to Pan, "alcohol was part and parcel of the commerce which constituted the basic tie between Europe and Africa. It was an article of the barter system through which European goods were exchanged for African slaves." By 1844, one traditional ruler in the area now called Nigeria was reported to have cried out "… rum has ruined my country; it has ruined my

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people. It has made them become mad." He therefore begged the Queen of England to prevent the bringing of trade spirit (rum) into his land. The traditional ruler advocated the policy of prohibition, similar to that which obtained in the industrialized world in the early part of 20th century (Paulson, 1973).

More recent events like those in Nairobi, Kenya, where a homemade alcohol product fortified with methanol killed 121 people; left 495 hospitalized, and blinded 20, have led to a clamour for the promulgation of policies restricting illicit alcohol distillation and the unlicensed sale of alcoholic beverages (Nordwall, 2000).

In the light of the foregoing, this paper reviews the current situation of alcohol use in Africa particularly the upsurge in its use and abuse by youth of both sexes. The paper also discusses culturally relevant evidence-based effective alcohol policies and programmes to control the use and abuse of alcohol in Africa.

CURRENT SITUATION OF ALCOHOL USE IN AFRICA

Several studies from Africa have noted the increasing consumption of alcohol particularly by the youth (Parry et al, 1999; Odejide et al, 1987; Adelekan et al, 1993; Odek-Ogunde et al, 1999). The authors noted that within the last three decades, adolescents and young adults who constitute the largest proportion of the population of African countries have become the target audience for alcohol marketing. In the WHO Global Status Report (2001) of alcohol and young people, it was remarked that marketing plays a critical role in the globalization of patterns of alcohol use among young people which reflects the revolution that is occurring in marketing in general (Jernigan, 2001). Alcohol advertising is now designed to embed brand names and products in the everyday activities of the target audience. Thus, these activities are designed to make beverage alcohol an integral part of the lifestyle of young people, thereby creating an intimate relationship between the young people and alcoholic beverages (Jernigan 2001). Klein (1999) also remarked that marketers talk about the relationship between the product and the consumer as a spiritual bond, and present their products not as commodities but as concepts, experiences and lifestyles. The goal is therefore to fashion a unique experience, and to identify this experience with the product. For example, beer becomes an essential part of youth experience. As noted by Jernigan (2001), the past two decades have seen several waves of new alcoholic beverages designed for youth markets such as wine coolers, alcopops, pre-mixed cocktails, energy-drinks' and 'malternatives'. Menon (1999) remarked that these generally sweet and fruity beverages are successful because, they get the consumer drunk faster without a feel of alcohol taste.

The use and abuse of beverage alcohol across Africa now covers both local and industrialized types (Riley and Marshall, 1999). The underage group, young persons of both sexes as well as adults use alcohol essentially for pleasure and for overcoming psychological and physical problems (Odejide and Odejide 1999). Parry (2000) in South Africa remarked that alcohol use along with its pleasure and benefits, brings many problems for developing societies, including trauma, violence, organ system damage, various cancers, unsafe sexual practices and injuries to the brain of the developing foetus. These are in addition to negative economic and social consequences.

Similarly, young persons in a focus group discussion on alcohol use claimed

that occasional use of alcohol was the pattern and that at times, they go out deliberately to get drunk (drinking excessively). They claimed that drinking excessively was facilitated by such factors as free drinks and drinking competitions (Odejide et al, 2005). Rocha silva (2001) had made a similar observation in South Africa when he noted that heavy illicit drug use has for example spread from urban and historically advantaged groups to rural areas and disadvantaged groups i.e. poor communities. The author remarked that youngsters from poor communities tend to associate alcohol use with fun, enjoyment and survival. In most drinking situations cited, industrialized beer has become most popular with adolescents and young persons. This is followed by spirits such as gin, whisky/gin mixed with fruity juices. The use of local (traditional) alcohol beverages such as palm-wine, palm-wine distillate, or alcohol from cereals appears to be declining. Despite the occasional pattern of beverage alcohol use by the adolescents and young persons, complications that commonly occur are vehicular accidents, violence, uncontrolled sexual behaviour with its attendant consequences, and drinking to stupor, (Parry et al 2004). Among the adults, social, physical and psychological complications arising from persistent excessive alcohol use are loss of job, marital disharmony, delusional jealousy, alcoholic hallucinosis, liver cirrhosis, brain damage and a downward trend in social status (Asuni, 1974; Odejide 1978).

Numerous studies have shown that availability of these alcoholic beverages to children and youth in general has become a source of concern to scientists across Africa (Amayo, 1996, Kebede et al 1993, Meursing et al 1989, Parry 1997, Adelekan et al 1993; Acuda and Eide, 1994, Odejide et al, 1987, Eke, 1997). In virtually all the studies, early onset of drinking (ages 10-16) appeared to be the pattern. Studies from sub-Saharan Africa, found that young persons believe that drinking is an essential component of their notion of having a good time (fun), and that their purpose in drinking is to get drunk (Meursing and Morojele 1989, Strijdom, 1992, Odejide et al 2005). Excessive alcohol consumption by young persons has been reported to result in violence, vehicular accidents and unsafe sexual practices (Parry et al 1999, 2000, Jernigan 2001). The socio-economic and health consequences of alcohol consumption by adolescents and youths in general across Africa, make it imperative to design intervention measures for alcohol consumption in Africa.

Key dimensions of changes that have taken place in alcohol consumption in Africa

- There has been replacement of traditional and locally produced alcohol beverages with industrial beverages, in particular, western-style commercially produced beer (Riley & Marshall, 1999)
- Youths have become the high-risk group for alcohol consumption
- Prevalence rate of alcohol use by females is increasing (change in pattern of gender use)
- Heavy drinking has become a sustainable pattern among the youths who are most often occasional drinkers
- A high intensity mass marketing and promotion of alcohol beverages by multi-national corporations is now in vogue
- Alcohol serves as a dependable source of tax revenue for governments in Africa.
- Alcohol beverage industries in Africa are recognized by

governments as providers of formal and informal employment

It is evident therefore that individual and population examples of alcohol-related harms abound in different parts of Africa as is shown in studies by (Asuni et al, 1986; Ohaeri et al., 1993; Odejide et al 1987 and Parry et al, 1999). Findings from these studies draw attention to the search for appropriate policies that will protect health, prevent disability and address the social problems associated with the use and/ or misuse of beverage alcohol. Such policies whether population or individual-based have to be authoritative decisions by governments or non-government groups to minimize or prevent alcohol-related consequences. Population-based approaches deal with groups, communities, and nations to improve the allocation of human and material resources to prevention and curative services. They also provide epidemiological data to monitor trends, design better interventions and evaluate programs and services (Barbor et al., 2004). On the other hand, individual approaches are oriented toward patients and they can be effective in treating disabilities.

Factors that impact on alcohol policy formulation in Africa

Africa is a continent made up of 53 countries consisting of divergent races in North Africa (Arab countries) and Sub-Saharan Africa (mainly the black race). Apart from ethnic diversity, religion plays a dominant role in the production, distribution and consumption of alcohol in these African countries. While Islamic religion forbids the production, distribution and use of alcohol, Christianity is rather ambivalent on the subject. Other factors of note are economic status (Odejide et al., 1987), and level of industrialization of each country (Riley et al, 1999), availability of beverage alcohol (Adelekan et al., 1993), societal attitude to alcohol use (Odejide et al., 1999) and the frequency of alcohol-related harm to the society (Parry et al., 2004). Also, the enforcement of existing alcohol policies and the formulation of new alcohol laws and regulations in line with new research findings would reduce alcohol consumption at individual and country level (Gruenewald et al., 1992). Therefore, whatever alcohol policy is contemplated must take into consideration the effects of alcohol on the individual, the family and the society i.e. the approaches should be both population and individual-based.

ALCOHOL POLICY IN AFRICA

Alcohol policy is subsumed under public policies which as Longest (1998) said are authoritative decisions made by governments through laws, rules and regulations. When public policies pertain to the relation between alcohol, health and social welfare, they are considered alcohol policies. Therefore, alcohol policy can be broadly defined as any purposeful effort or authoritative decision on the part of the government or non-government groups to minimize or prevent alcohol-related consequences (Babor et al., 2004, p. 95).

Prior to the introduction of commercial (industrialized) alcohol beverages to the continent of Africa, informal alcohol policies existed in many African countries. In the South Western Nigeria for example, children and females were forbidden from taking alcohol. As pointed out by Odejide and Odejide (1999), adult males who got drunk were barred from drinking for a certain period. These could be said to be restriction policies existing in that particular community in Nigeria in the pre-colonial era.

With the introduction of industrial alcohol to Africa, new sets of alcohol policies were formulated into laws and regulations. The most prominent was pricing and taxation of alcohol beverages. It could be said that the original intention was not to control the consumption of alcohol; rather, pricing and taxation were to source for revenue for the governments. Alcohol was therefore treated as an ordinary commodity.

However, as in the industrialized world, African countries soon realized the socio-economic and health consequences of alcohol consumption. Despite the enormous revenue generated by governments from alcohol production, distribution and consumption, the necessity to regulate alcohol consumption by different age groups and sexes became inevitable. Attempts have therefore been made by African governments to borrow from the industrialized world, policies that have been found to be effective and also culturally relevant to the African society (Parry, 1997). In addressing alcohol misuse and public health in South Africa, Parry (1997) suggested a 10-point action plan which can serve as a basis for alcohol policy formulation. These include:

- Increasing the real price of alcohol products by increasing excise taxes
- Restricting alcohol consumption by controlling the availability of alcohol through use of measures such as:
    - raising the minimum drinking age
    - restricting the number of outlets and hours of outlets serving or selling alcohol
    - restricting the location of outlets to non-residential areas
    - improving the training of servers of alcohol
    - restricting the public settings where alcohol may be consumed.
- Deterring alcohol-related harm through measures such as drink-driving laws
- Increase access to affordable and effective treatment and rehabilitation facilities
- Instituting work place interventions to address alcohol misuse
- Restricting or forbidding the advertising of alcohol beverages
- Placing strict controls on product safety including home-brew alcohol and placing strict controls against illicit production and sale of alcoholic beverages
- Community development in general, including upgrading infrastructure in communities (recreational facilities, job creation, skills development initiatives such as adult literacy training).
- Education and persuasion aimed at high-risk group e.g. teenagers, pregnant women or persons who work with high risk groups – the police, servers at liquor outlets.
- Public education programmes aimed at the community at large e.g. mass media and social marketing campaigns.

Similarly, Gregory Singer (2003) explained how the National Drug Master Plan as a public policy document has a broad reach and contains the mechanisms necessary to make a significant impact on the alcohol problem in South Africa. Also in the WHO Global Status Report on Alcohol and Young People, Jernigan (2001, p. 39-42) discussed policies to alleviate alcohol-related problems among young people. He advocated for brief interventions or advice for young people

with hazardous levels of alcohol consumption. However, this paper borrows from Parry's (2001) 10 point action plan and Babor et al's (2004) work on the analysis of alcohol policies based on research evidence that highlight policy-relevant strategies that are effective. Some of the 10-point action plan of Parry (2001) are already in practice and found effective in few African countries e.g. education and persuasion, public education programmes using mass media and blood alcohol level for drink-driving.

From these two reports, an attempt has been made to discuss the following alcohol policies as:

* Regulation of alcohol taxes and prices.
* Regulating the physical availability of alcohol.
* Modifying the drinking context.
* Drinking-driving counter measures.
* Regulating alcohol promotion.
* Education and persuasion strategies.
* Treatment and early intervention services.

Regulation of Alcohol Taxes and Prices

Despite religious barriers that may forbid the use of alcohol in some Islamic states in Africa, most African countries produce and distribute alcoholic beverages as a means of revenue generation. Alcohol taxes and prices can therefore be a ready tool for use to control availability and use of alcohol. As remarked by Babor et al. (2004), economic studies conducted in many developed and some developing regions of the world have demonstrated that increased alcoholic beverage taxes and prices are related to reductions in alcohol use and related problems. Consumers of alcoholic beverages respond to changes in alcohol prices by reducing their alcohol consumption. Therefore, as in industrialized countries, alcohol taxes can become an attractive instrument of alcohol policy in Africa both to generate direct revenue and to reduce alcohol-related harm. However, there is the need to exercise caution in raising alcohol taxes in order not to promote greater demand for traditional (informal markets) alcohol beverages. The production and distribution of local alcoholic beverages in most African countries are not under government control. The Kenyan situation earlier cited (Nordwall, 2000) in which informal alcohol products marketed to the public killed 121 people with another 495 people hospitalized should be a lesson. So, for taxation and pricing to become an effective alcohol policy in Africa, efforts must be made to establish a systematic way of regulating local alcohol production to ensure purity, safety and accurate description of the product. Regulation also will facilitate tax collection on the products as obtains for industrial alcohol beverages produced by multi-national companies.

Regulating the Physical Availability of Alcohol

Physical availability refers to the accessibility of the product. This has policy implications for preventing alcohol-related problems through controls of the conditions of sale to the consumers. Availability of alcohol beverages is amenable to effective control at different stages from production, distribution and sale outlets (Paulson, 1973). It could be total or partial ban of the production and sale of alcohol as happens in Islamic countries or states. In Nigeria, for example, the sale and consumption of alcohol are prohibited in sharia states e.g., Zamfara, Kano, Sokoto. The State Sharia laws forbid the sale and consumption of

alcohol in the state. Other existing regulations that can be fashioned into alcohol policies are:

- limiting the location of alcohol sales outlets to avoid bunching
- forbidding the location of sales outlets near a school or place of worship
- controlling the density of outlets by limiting the number of outlets in a defined space
- regulating retail outlets for alcohol sales: the 'off-premise' and 'on-premise' licences approved by governments or local authorities can be used to influence the act of drinking, the drinking occasion and the potential consequences of alcohol consumption. There could be regulations on the type, strength and packaging of alcohol beverages. In on-premise sales, the staff should receive server training in responsible alcohol use
- restricting the days and times of alcohol sales. This restricts the opportunities for alcohol purchasing and may reduce heavy consumption
- minimum alcohol purchasing age laws. The most common minimum age for legal purchase of alcoholic beverages is 18 years though it varies from ages 16 to 21 years.

Examples of African countries with laws that set minimum ages for alcohol purchase or consumption are Egypt (age 21, bans consumption); Kenya (age 18, bans sale); Morocco (age 16, bans sales); Mozambique (age 18, bans purchase), South Africa (age 18, bans sales), United Republic of Tanzania (age 16, bans presence on premises where alcohol is served). It is a challenge for African countries where such control policy is not yet in place to set the machinery in motion for the promulgation of such a policy. For young people, laws that lower the minimum legal drinking age reduce sales and alcohol problems among young drinkers. This strategy is said to have the strongest empirical support (Grube and Nygaard, 2001). Evaluation studies need to be carried out to determine the effectiveness of the policy in African countries where it is presently in operation.

Modifying the Drinking Context

This seeks to modify or limit the drinking or the drinking environment so that potential harm is minimized (harm reduction). In this instance, measures would be taken to target the drinking environment where alcohol is sold and consumed such as licensed premises. Licensed premises have been identified as drinking locations that are especially high risk for alcohol-related intoxication, drinking driving, aggression and violence (Babor et al., 2004, p.141). In the study of Parry et al (2000) in South Africa, alcohol consumption was found to be associated with aggression and vehicular accidents. The control of alcohol consumption in licensed premises should therefore serve as prime targets for alcohol policies in Africa in order to effectively prevent alcohol-related problems. Policies focusing on high-risk environments such as licensed premises have a broader impact than policies aimed at persons who are at high risk.

The policies in respect of alcohol control in licensed premises require community participation. The community can be mobilized to focus on licensed drinking premises to promote responsible drinking habit. Also, the staff in drinking premises (bars, restaurants etc) can be trained to enforce regulations around serving and be aware of legal liability of bar staff and owners for the actions of those they serve. Though this practice is

already existing in industrialized societies, they would still be relatively new to the continent of Africa. However, because of their proven effectiveness, policies to control the use and abuse of alcohol on drinking premises should be given strong consideration in African nations. They can be useful options in the mix of strategies for preventing alcohol related problems. However, for such a policy to be implemented in any African country, the quality of education of those employed as servers should improve, the number of licensed and unlicensed alcohol outlets in the community should be known and there must be the political will to enact and enforce such laws. In this instance, the cooperation of the law enforcement agents becomes essential.

Drinking-Driving Counter Measures

These are designed to reduce alcohol-related harm through measures such as drinking-driving laws and legal liability for serving alcohol to intoxicated persons. As previously remarked, alcohol industries have multiplied in many African countries thereby increasing alcohol availability and consumption by the adolescents and youths (Odejide et al., 1987). In a focus group discussion by these authors (2005), episodic drinking mostly at weekends or at social gatherings was the pattern resulting at times in excessive drinking. This was thought to contribute to the rate of road traffic accidents resulting in morbidity and mortality.

There is therefore the need to establish drinking-driving laws in countries where they do not presently exist and improve on the enforcement of such laws where they exist (e.g. South Africa and Nigeria).

Examples of such drinking-driving laws are:

- Determination of blood alcohol concentration/BAC using breathalyzer or laboratory estimation of blood specimen.
- Random breath testing or selective breath testing.

Permissible BAC is usually in the range of 0.05% to 0.08%. For young persons, it can be lowered to 0.01% to 0.02% (zero tolerance level). Research to date suggests that the effects of BAC laws are mostly positive, long-term and cost effective (Mann et al, 2001). As for random breath testing (RBT), Shults et al. (2001) in a review of 23 studies of RBT and selective testing found a decline of 22% in fatal crashes.

The advantage of the use of BAC is its simplicity. All it needs is the purchase of breathalyzers and other laboratory equipment to measure blood alcohol level. It would also require the training of law enforcement agents to enforce the laws and effect immediate punishment where it is necessary. Some punishments that have been found effective are suspension of driving license, comprehensive treatment including counseling and graduated licensing for novice drivers which limits the time of driving during the first few years. To some extent, Parry et al. (2004) have put this policy in operation in South Africa. However, the effectiveness of the policy is yet to be determined.

Regulating Alcohol Promotion

Alcohol marketing is now a global industry in which the largest corporations have an international reach across industrialized countries and reaching aggressively into new markets in developing nations (Jernigan, 1997; Parry 1998; Riley and Marshall, 1999; WHO, 1999).

In African countries, industrialized alcohol brands targeted to local markets have been subjected to aggressive marketing, using integrated

mix of strategies such as television, radio, print advertisements and point of sale promotions. These brands are usually associated with a range of sports and lifestyles through movies and consumer identities. Such advertisements do shape young people's perception of alcohol and drinking norms. Therefore, there is a need for government agencies working with alcohol industries in Africa to establish policies to control alcohol advertisements. Examples of policy in this area that have been found effective in developed countries are:

- Industry self-regulation of alcohol advertising standards.
- Legislation against alcohol advertising on broadcast media.

As Bargott (1989) remarked, self-regulation is most commonly adopted by industries under threat of government but being against self-interest, tends towards under-regulation and under-enforcement. In line with this viewpoint in Nigeria, there is the regulation against alcohol advertisement on radio and television before night time (9 pm Nigerian time). However, the implementation of the regulation was not sustained for long before the media reverted to alcohol advertisement at any hour of the day.

Since industry self-regulation as a policy does not favour alcohol industry, the tendency is for the industry to adopt a lukewarm attitude to its implementation. The governments and alcohol industries need to work out a system where industry's self-regulation policy can be put into operation if it will ever work.

Education and Persuasion Strategies

Education and persuasion strategies are common in African countries. They are prevention measures assumed to affect individuals and societies through:

- improved knowledge about alcohol and its related harm
- changing attitudes with regard to drinking in order to lower risks
- changing drinking behaviour itself

The methodology usually adopted to achieve the objectives are:

- mass media and counter-advertising
- warning labels
- low-risk drinking guidelines
- school based programmes
- community level interventions.

School-based prevention programmes have been practised in Nigeria. It was introduced by the National Drug Law Enforcement Agency (NDLEA) in 1992 in form of clubs averse to alcohol use but engaged in creative leisure activities. The goal of such programmes is to change adolescent's drinking beliefs, attitudes and behaviour. Such programmes rely mainly on providing information about alcohol use/abuse and its related consequences. Though evaluation studies have not been conducted on these programmes in Nigeria, research findings from the western world have shown that they are not very effective (Botvin et al., 1995). Norman et al. (1997) even claimed that such information may serve to arouse curiosity in those who are risk takers or who seek adventure. If education strategy has to be used, it has to be in combination with other effective strategies discussed earlier. Education alone may be too weak a strategy to counteract other forces that pervade the environment (Babor et al., 2004).

As Parry (2000) remarked, education and persuasion aimed at school-going youths should go beyond knowledge and involve resistant skills training and values

clarification and should be targeted broadly at life skills rather than narrowly at alcohol. While reasonable time should be given for the training, parallel initiatives should be established for parents and the broader community. There should be general community development programmes such as upgrading infrastructure (e.g., recreational facilities) to encourage alternative activities to drinking. Efforts must be made by the governments, alcohol industries and non-governmental organizations to create jobs for the unemployed and provide skills development such as adult literacy training for the youths.

Treatment and Early Intervention Services

Most African countries lack specialized facilities for treating people with alcohol-related problems. Such facilities should be made available and accessible to people with alcohol problems as a secondary prevention measure. Since primary health care (PHC) is a philosophy adopted by several African nations, PHC should be strengthened to grapple with such problems. Unfortunately, as a result of lack of government ability to train primary health care workers in many African countries, for example in Nigeria, workers in primary health care centers that was established in 1992 are yet to receive adequate training on how to identify and treat people with alcohol-related problems. There should be access to detoxification services in public hospitals and brief intervention therapy in primary health care (PHC) services to change excessive drinking behaviour. There is the need to establish training programmes for PHC workers, medical doctors and nurses working in alcohol and substance abuse units in general and teaching hospitals. Also, Non-Governmental Organization (NGO) workers interested in the programmes should be trained.

As Babor et al. (2004) observed, treatment interventions are principally designed to serve the needs of individual patients and clients but there are a number of ways that these interventions may have impact at community and population levels through raising public awareness of alcohol problems, influencing national and community agendas, involving health professionals in advocacy for prevention and providing secondary benefits to families, employers and automobile drivers.

CONCLUSION

Developing countries, particularly in Africa, are witnessing an upsurge in alcohol production, distribution and consumption. Contributing to this upsurge are free trade, and free markets that have globalized alcohol markets and dismantled traditional alcohol control measures such as restriction of alcohol use by women and adolescents. Although the burden of illness attributable to alcohol in most African countries is relatively small compared with industrialized countries (Babor et al., 2004), alcohol nonetheless accounts for a considerable amount of premature deaths, acute alcohol problems, injuries and disabilities. These untoward health consequences contribute to alcohol-induced social and economic problems for individuals, families and the society. This therefore is the appropriate time to attach importance to the formulation and implementation of alcohol policies in Africa. Each African country needs to assess their own policy experiences, carry out scientific testing of the policies earmarked as appropriate, legislate on the

ones which are culturally relevant and financially feasible to the nation. In order to implement alcohol policies, in different parts of Africa, it might be helpful to table and discuss alcohol-related problems and prevention policies and strategies at the annual meeting of the Head of Narcotic Drug Law Enforcement Agents in Africa along with other drug demand reduction programmes.

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A PUBLIC HEALTH APPROACH TO ADDRESSING ALCOHOL-RELATED CRIME IN SOUTH AFRICA

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ABSTRACT

South Africa is reported to have one of the highest levels of alcohol consumption per drinker in the world. This article provides a brief review of the role played by alcohol in crime in general, and focuses specifically on the burden of alcohol in South Africa in terms of crime, violence and injury. Strategies likely to be effective in reducing the level of alcohol-related harm are discussed, with particular emphasis being given to initiatives aimed at restricting the physical availability and accessibility of alcohol, restricting alcohol advertising and marketing, placing restrictions on certain alcohol products/containers, introducing counter-measures to more effectively address drinking and driving, and ensuring effective treatment for drink-driving offenders and persons incarcerated for certain crimes. The paper concludes with some comments on the need for the effective translation of strategy into action.

KEY WORDS: alcohol, crime, injury, violence, prevention, South Africa

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INTRODUCTION

According to the World Health Organization (2002), in 2000 the global burden of alcohol in terms of death and disability was between 1.6% (for high-mortality developing countries) and 9.2% (for developed regions) of total disability adjusted life years lost, accounting for 4.5 billion years lost. While South Africa is a high mortality developing country, a preliminary estimate of the total burden of alcohol to South Africa is 6-7%, ranking third after unsafe sex and interpersonal violence (Bradshaw et al., personal communication). The data on global burden of death and disability has been interpreted to imply that as countries develop the burden of alcohol abuse will increase.

Countries differ dramatically in terms of adult per capita absolute alcohol consumption, with countries/regions such as Argentina, Ireland, Western Europe, much of Eastern Europe and the Russian

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Federation having alcohol levels in excess of 13 litres per adult per year in 2000 (Rehm et al., 2003). It has been estimated that the per capita consumption of alcohol in South Africa is between 10.3 and 12.4 litres, with the higher level reflecting the amount including homebrewed alcohol (Rehm et al., 2004). However, in interpreting per capita consumption it is important to remember that countries also differ in terms of the proportion of the population who drink and who abstain from alcohol. According to the World Health Organization (2002), 45% of men and 70% of women in Afro Region E (which includes countries like Ethiopia and South Africa) abstain from drinking alcohol. Therefore, while consumption per adult is only 7.1 litres of pure alcohol per year in this region, consumption per drinker is 16.7 litres per year (Rehm et al., 2003). It has been estimated that per capita consumption amongst drinkers in South Africa is likely to be even higher than the regional average (Parry, 2005). This gives South Africa one of the highest levels of alcohol consumption per drinker anywhere in the world, putting it at a similar level as countries such as the UK and the Ukraine (Rehm et al., 2004).

Countries also differ in terms of hazardous patterns of drinking. The WHO study ranked countries on a four point scale in terms of whether the pattern of drinking was hazardous or not. Although Western Europe has among the highest levels of per capita alcohol consumption in the world, it has one of the least hazardous patterns of drinking. Hazardous patterns of drinking are indicated by the level of the population drinking first thing in the morning, drinking to intoxication, drinking apart from meals, etc. South Africa falls into that group of countries exhibiting the most hazardous pattern of drinking (Rehm et al., 2003; Parry, 2005). This is not unexpected given the findings of research on both adults and young people in the country. For example, according to the 1998 South African Demographic and Health Survey, between a quarter and a third of drinkers drink at risky levels over weekends, and drinking to intoxication is common (Parry et al., 2005). With regard to young people, 29% of males and 18% of females between grades 8 and 11 were found in the 2002 National Youth Risk Behaviour Survey to report past month binge drinking (Reddy et al., 2003).

In the past decade South Africa has also consistently had one of the highest rates of recorded homicide in the world, and other categories of both violent and property crime have been recorded at similarly high levels (Schönteich & Louw, 2001). In the first nine months of 2001, for example, rates of murder were estimated to be 33.3 cases per 100 000 population, rape 83.5 cases per 100 000, and housebreaking (residential) 493.9 cases per 100 000 (South African Police Service, 2002). Of the approximately 2.5 million cases of crime reported in South Africa between the period April 2004 to March 2005, violent crimes comprised 36% of cases (South African Police Service, 2005). While the incidence of crimes like murder, attempted murder, assault with intent to inflict grievous bodily harm, and carjacking appear to be decreasing over time, the incidence of violent crime remains unacceptably high.

The purpose of this paper is to briefly review the role of alcohol in violence and crime, and more specifically, to review data on the particular burden of alcohol to South Africa. The second half of this paper focuses on those strategies likely to be most effective in reducing the level of alcohol-related harm in terms of crime, violence and injury. The paper concludes with comments on the need for more effective translation of strategy into action.

ALCOHOL'S ROLE IN VIOLENCE AND CRIME

While alcohol's close association with violent events (interpersonal violence and self-imposed injuries) has been well documented from prison studies, studies of sexual violence, etc., an association does not necessarily imply causality. A stronger link between alcohol use, crime and violence has, however, been established by three groups of researchers using meta-analysis to collate the findings from several cross-sectional studies. Using this technique, English et al. (1995) concluded that 47% of homicide or purposeful injury could be attributed directly to alcohol use. Their findings mirror those of Schultz & Rice (1991) who found that 46% of homicide or purposeful injury could be attributed to alcohol use. However, Single et al. (1998) reported a lower attribution at 27%.

McClelland & Teplin (2001) directly observed 2365 police-citizen encounters in the USA. Observers used the Alcohol Symptom Checklist to determine the level of alcohol intoxication or impairment of principal actors involved in the encounters. Encounters were indicated as "alcohol-involved' if one or more of the principals were intoxicated (blood alcohol concentrations (BACs) greater than or equal to 0.05g/100ml) or if any of the principals were not present and intoxication was judged to be a contributing factor. Overall, 34% of police-citizen encounters were judged to be alcohol-involved, with the following percentages reported: violent crime and sexual assault (43%), spousal assault (43%), robbery (39%), public order/vandalism (46%), and other non-violent encounters (23%). McClelland & Teplin (2001) also distinguished between whether the suspects, victims or both were intoxicated. Overall the odds of a suspect being intoxicated compared to a victim were 4.3:1 (26% for suspects vs. 7% for victims). Levels were highest for public order/vandalism (O.R.=12.9, 38% vs. 5%) followed by other non-violent encounters (O.R.=6.3, 17% vs. 3%), spousal assault (O.R.=4.9, 25% vs. 6%) and violent crime and sexual assault (O.R.= 2.9, 27% vs. 15%). They found no difference between robbery suspects and robbery victims in terms of the likelihood of being intoxicated (O.R.=0.8, 15% vs. 18%).

Alcohol is viewed as playing a role in violence and crime in a number of ways, and Graham et al. (1998) have specifically put forward various mechanisms for how this might occur: (i) societal and cultural attitudes, explanations and norms, (ii) "person factors", for example, personalities predisposed to aggression, (iii) the pharmacological effects of alcohol itself, (iv) the effect of specific drinking contexts, and (v) the interaction of these factors. Societal and cultural attitudes, explanations and norms refer to the way in which drinking, drunkenness and the effect of alcohol on behaviour are framed within different societies. The pharmacological effects of alcohol itself include the suppression of various neurotransmitters that would normally inhibit aggression by causing anxiety or fear. The drinking context refers to the mediating effect of situational variables associated with the various settings in which drinking takes place and which might inhibit or encourage the occurrence of a criminal act or injury. The argument has, however, been made that even if the perpetrators of crime or violence are under the influence of alcohol at the time of the offence, that blame cannot be laid solely on alcohol as there are other covariates (e.g. "social, psychological and other interactional causal processes") that need to also be taken into account (Pernanen, 1993, p. 897).

DATA ON THE ALCOHOL-CRIME/INJURY NEXUS IN SOUTH AFRICA

There is a wealth of research coming out of South Africa indicating a very strong association between alcohol, crime and injury. In 1997 the Institute for Security Studies reported on the results of research into alcohol and violence conducted in the Northern Cape. Alcohol was linked with violence, particularly child abuse and rape, and the role of shebeens (unregistered drinking establishments) in the commission of violence was outlined in some detail (Shaw & Louw, 1997). The link between alcohol and shebeens and violence (especially murder) was also identified in a study undertaken by the South African Police Service in the Western Cape in 1996. Among other things, it was reported that in 64% of cases in which the motive was known, and in 24% of cases in which the circumstances surrounding the murder were known, the crime had been committed after an argument and/or during a fight in which alcohol was involved (South African Police Service, 1997). A broader study undertaken in six Johannesburg neighbourhoods by the University of South Africa in 1998 reported that violence in these communities could be attributed to various factors including unemployment, poor housing, environmental conditions and excessive alcohol consumption (Butchart et al., 2000).

In a docket analysis finalized by the South African Police Service in 2001, it was noted that 9.1% (37/408) of child sexual offence cases in the Western Cape province involved an offender under the influence of alcohol. This compared to 3.8% nationally (127/3326) (Crime Information Analysis Centre, personal communication). In 2003 the Institute for Security Studies undertook a national victim survey of persons who were victims of serious assault and reported even higher levels of alcohol intoxication. In 40% of cases victims believed that the assailant was under the influence of alcohol or other drugs at the time of the assault, and a third of victims conceded to having been under the influence themselves at the time of the assault (Omar, 2004).

Data from the Non-Natural Mortality Surveillance System (NNMSS) in 2002 indicated that 46% of non-natural deaths in South Africa involved persons with blood alcohol concentrations (BACs) greater than or equal to 0.05g/100 ml (Matzopoulos et al., 2003). NNMSS data for 2003 indicated that for all causes of death, 49% had positive BACs and the mean BAC overall was 0.18g/100ml (Harris et al., 2004). Levels of BAC positivity were high for both homicides (51% positive, with a mean BAC of 0.17g/100ml) and suicides (35% positive, with a mean BAC of 0.15g/100ml). Turning to non-fatal injuries, in 2001 39% of trauma patients in Cape Town, Durban and Port Elizabeth had breath alcohol concentrations (BrACs) greater than or equal to 0.05g/100 ml (Plüddemann et al., 2004). Levels of alcohol positivity were particularly high for persons injured as a result of violence (73% for Port Elizabeth, 61% for Cape Town and 43% for Durban). In the early 1990's the Medical Research Council (MRC) conducted studies of persons receiving services for traumatic injuries at a wide variety of facilities in the Cape Metropole, and it was reported that 70% of domestic violence cases were alcohol-related (Peden, 1995). Research has also been conducted by the Department of Transport into the issue of drinking and driving, and the national daily average of persons driving under the influence of alcohol has been found to have increased

from 1.8% in 2002 to 2.1% in 2003 (Arrive Alive, 2005). Drinking and driving is an alcohol-defined offence and alcohol therefore has a direct role in the commission of this particular crime.

A national study of prisoners and parolees conducted by the Human Sciences Research Council in 1996 furthermore found that just under half had taken alcohol or other drugs just prior to the crime for which they were incarcerated (Rocha-Silva & Stahmer, 1996). Drinking was especially linked to rape and housebreaking offences. Subsequent research conducted by the Medical Research Council and the Institute for Security Studies has also shed some light on the relationship between alcohol use and crime in South Africa. A study was carried out in Cape Town, Durban and Johannesburg in three phases between 1999 and 2000 (Parry et al., 2004). The main focus of the study was the link between drug use and crime, but arrestees in the three cities were also asked whether they were under the influence of alcohol at the time that the alleged crime took place. Overall, for 15% of the alleged crimes, arrestees indicated that they were under the influence of alcohol at the time the alleged offence took place. Regarding violent offences, arrestees indicated that they were under the influence of alcohol for 25% of weapons-related offences, 22% of rapes, 17% of murders, 14% of assault cases and 10% of robberies. Levels of alcohol-related crime were particularly high for family violence offences at 49%. Arrestees also indicated that they were often under the influence of alcohol in cases involving property offences, for example, 22% of cases involving housebreaking and 12% of cases involving the theft of a motor vehicle. When asked why they consumed alcohol or other drugs in relation to crimes, many arrestees indicated they consumed these substances in order to give them courage to commit the crimes (Parry et al., 2004).

INTERVENTIONS TO REDUCE ALCOHOL-RELATED CRIME AND INJURY

There is no single strategy available that can magically reduce the burden of alcohol–related crime. According to the World Health Organization, both individual and population-based approaches targeting high-risk groups and situations, and aimed at reducing per capita consumption of alcohol in general, are needed (Parry & Bennetts, 1998). The reason for this is that alcohol-related crimes (including the crime of drinking and driving) are not only caused by individuals who are high-risk drinkers and regularly drink to excess, but are also caused by individuals who occasionally drink at risky levels and do things that they would not normally do when not intoxicated. While the probability of their committing an alcohol-related crime is lower, the numbers involved make the latter a significant group to which public health interventions should be aimed. Babor et al. (2003) in their book "*Alcohol: No ordinary commodity*", and Mosher and Jernigan (2001) in "*Making the link: A public health approach to preventing alcohol-related crime and violence*", have put forward a number of interventions that could be useful in addressing alcohol-related crime. In the following section these interventions shall be critiqued, with particular regard to whether they are likely to be effective in South Africa.

Within the public health model of intervention, intervention strategies fall into three broad categories, those focusing on the *agent*, those focusing on the *host*

and those focusing on the *environment*. With regard to alcohol intervention, the agent is alcohol itself. Strategies aimed at the agent focus on interventions around reducing the alcohol content of different beverages. The host is the consumer of alcohol, and there are a range of interventions that deal with persons who abuse or are at risk of abusing alcohol. Environmental strategies are broader than those focusing on the agent and the host and they deal with the context within which alcohol is marketed, distributed and consumed in society. Interventions at the environmental level are likely to have greater potential for reducing alcohol-related crime and violence than interventions at other levels (Mosher & Jernigan, 2001). The emphasis of the following section shall therefore primarily be on environmental strategies.

Environmental Strategies targeting "place"

A number of environmental strategies deal with the place in which alcohol is consumed or sold (Table 1). These tend to focus on reducing or regulating the physical availability of alcohol. One strategy that has been proposed in many countries and that has been found to be effective involves restricting the hours of sale of alcohol and the days of the week during which alcohol may be sold (Babor et al., 2003). However, in a country like South Africa where there are many unregulated outlets, efforts in this regard are unlikely to be successful unless they are accompanied by innovative efforts to draw the many unregulated outlets into the regulated market. It will also be important in a country like South Africa to strengthen community inputs into the process of allocating liquor licenses, dealing with complaints and determining the hours and days of sale (Parry, 2005). In general, effective mechanisms for handling community complaints also need to be provided. It is essential that communities have access to information about violations and complaints and the manner in which they are addressed be increased. One recommendation is that an annual report focusing on these matters be presented to the provincial government (Parry, 2005).

Table 1. Strategies for reducing alcohol-related crime, violence and injury

Place: Restricting Physical Availability and Facilitating More Responsible Retail Practices
• Restrict hours and days of sale and bring unregulated outlets into regulated market
• Restrict outlet density and outlet location
• Require responsible beverage service programmes and codes of conduct
• Establish accords between licensees, police, local authorities and community organisations in trouble spots
• Encourage server liability in cases where alcohol has been served to intoxicated persons who go on to harm themselves or others
• Conduct routine enforcement programmes to ensure compliance with laws prohibiting sales to minors/intoxicated persons, and to control public nuisance activities
• Conduct Last Drink Surveys in order to identify "problem premises" for intervention
• Increase community access to information regarding violations and complaints

- Prohibit/restrict alcohol availability in public settings (e.g. beaches, parks, sporting events)
- Discourage free or heavily discounted drinks
- To reduce underage drinking establish a mechanism of referral for dealing with young persons who use false or altered identification to enter licensed premises, improve training of and require certification for crowd controllers at bars/clubs, and establish alternative alcohol-free entertainment to young people
- Encourage community organisations to implement alcohol-safe environmental policies

Price: Restricting Accessibility

- Increase alcohol excise taxes and adjust annually to reflect inflation

Promotion: Restricting Advertising and Marketing

- Advertising not permitted when 15% of viewing audience is between 10 and 18 (legal drinking age)
- Eliminate advertising with a substantial appeal to underage consumers
- Match level of alcohol advertising with equivalent exposure to health and safety messages
- Institute rotating health warning labels that are conspicuous and easy to read
- Prohibit outdoor advertising and billboards where children are likely to be present or in high crime areas

Product Restrictions

- Restrict size of alcohol containers to that of one standard drink (e.g. 340ml of beer) or multiples thereof
- Impose special labelling and bottling requirements so that alcoholic products are easily distinguishable from non-alcoholic products
- Move towards packaging alcohol in safer materials and dispensing alcohol in safer materials (e.g. plastic) – especially in high-risk locations

Drink-Drive Counter-Measures

- Increase the use of random breath testing
- Introduce a graduated licensing system for novice drivers

Treatment

- Introduce mandatory treatment for repeat drink-drive offenders
- Introduce alcohol/drug treatment for persons incarcerated for certain crimes

The benefit of increasing community input in the management of conflicts arising as a result of social disruption associated with liquor outlets has been demonstrated in the regional city of Geelong, Australia. The “Local Industry Accord”, designed to promote a range of harm minimisation strategies aimed at reducing alcohol-related violence and crime, involved the collaborative participation between police, local licensed premise operators, Liquor Licensing Commission representatives and other relevant agencies and individuals. To achieve the objectives of the accord the following practices were strongly discouraged: free and heavily discounted drinks, unsatisfactory standards of crowd controllers not interested in checking bona fides of patrons leading to underage persons entering licensed premises, and all-age events with the availability of large volumes of alcohol. Over time a number

of additional strategies were implemented to combat alcohol-related problems. These included requiring all crowd controllers to be licensed and when working to display identification to this effect; improving the training of bar staff, security personnel and new licensees; offering all licensed premise operators a mechanism of referral for dealing with young persons who pass false or altered identification to gain entry into licensed premises; establishing alternative alcohol-free entertainment (e.g. discos) in a supervised venue for young people; allocating eight hotels or nightclubs to one police sergeant who would assist licensees with problems they might have and to work with them in dealing with incidents occurring in or around their premise; and having the local authority enact a by-law prohibiting persons from having open containers of alcohol in public places. Breaches of the latter attract a $100 spot fine and are actively enforced by local council officers and police. Since the adoption of the accord in 1991, crime and violence associated with intoxicated parties is reported to have decreased significantly (Turning Point, 1998).

Another strategy rated highly by Babor et al. (2003) involves instituting restrictions on outlet density. The argument is that decreasing the density of liquor outlets reduces the availability of alcohol, which in turn will lead to a reduction of alcohol-related problems, including crime. This particular strategy would be difficult to implement in a country like South Africa, where 80-90% of outlets are unlicensed and many are situated in residential areas. It would first be necessary to encourage existing unlicensed outlets to become licensed and to move into business nodes/corridors. Thereafter development incentives to upgrade facilities could be given to those outlets serving alcohol in a responsible manner. The intention is that this would lead to less responsible retail outlets going out of business. Outlets near schools should also be restricted or opposed. Here too it will take some time to see the effect of any changes in this area, but movement on this issue is required in order to effect change in the longer term (Parry, 2005).

It has also been recommended that responsible beverage service programmes, such as safer bar programmes, be implemented (Mosher & Jernigan, 2001). This would involve working with the distributors of alcohol to develop operational policies and to implement training programmes that will improve responsible beverage sales. These operational policies might include discontinuing sales of alcohol in large containers, placing limits on the number of drinks per customer per hour, not serving alcohol to intoxicated patrons, implementing a minimum age for persons selling alcohol, having strategies around preventing and managing incidents which have the potential for becoming violent and also increasing the provision of food in drinking outlets. One example of where the retail sector moved forward on this on their own accord can be found in the township of Meadowlands near Johannesburg. Here shebeen owners joined together to form the Tavern Owners Against Crime (TOAC) group (Mkhuma, 2001). A code of conduct for tavern owners was drawn up, restricting, among other things, the sale of alcohol to minors and intoxicated persons. Through this initiative, the number of assaults reported in the area is reported to have decreased significantly. Three neighbouring township areas have since adopted the strategy (Mkhuma, 2001). The liquor industry is keen to encourage such programmes but it is preferable that

such programmes should be mandated by law rather than left up to the retail sector to implement in a voluntary manner (Parry, 2005).

Another strategy that has been recommended involves increasing the likelihood of owner/server (civil) liabilities for damages being awarded in cases where alcohol has been served to persons who were clearly intoxicated, and who then went on to harm themselves or others. In South Africa this option might work in the formal sector, but it is unlikely to be effective in many situation involving unregistered outlets which often have very little to lose and in a country with an already overburdened justice system (Parry, 2005).

The role of law enforcement in ensuring that environmental strategies have an effect has been stressed (Mosher & Jernigan, 2001). It is recommended that routine, effective law enforcement programmes ensure compliance with laws prohibiting the sale of alcohol to minors and intoxicated persons, and control public nuisance activities. In South Africa, such programmes would need to be integrated with reforms in the area of liquor licensing, and would require greater commitment on behalf of the police service to intervene in this area. Greater commitment would also be required from provincial departments of economic affairs (responsible for liquor licensing issues) to provide the resources needed to facilitate the activities of an independent inspectorate that would work alongside the police service in closing unlicensed premises and in ensuring that licensed operators operate in line with municipal regulations (and community accords).

It would also be useful to set up an information system whereby the police could collect and collate information regarding the "place of last drink" in the case of motor vehicle and pedestrian injuries, as well as violence/public disturbance where alcohol is deemed to have been involved (Parry, 2005). Such projects enable efforts to be focused on areas in which interventions are likely to be most effective. In Australia and New Zealand, the Last Drink Survey (LDS) has remained a widely used initiative by liquor licensing coordinating committees since its introduction in 1991 (Alcohol and Public Health Research Unit, 2002). Data collected by police are forwarded to these local committees, which meet regularly to discuss licensing issues. Licensed premises identified as "problem premises" are targeted for host responsibility training (Hill, personal communication, August 25, 2000). It is reported that the LDS has seen a decline in police call-outs to problem premises, as well as a reduction in data identifying problem premises (Alcohol Advisory Council of New Zealand, 2005).

Other strategies that have been used include prohibiting or restricting alcohol availability in public settings such as parks, beaches, recreation centres and at certain community events (Mosher & Jernigan, 2001). There has been anecdotal evidence of the benefits of a ban on alcohol use on beaches in Cape Town that has been enforced for a number of years, resulting in a reduction of negative incidents involving alcohol over the Christmas season. Community organizations, including faith-based organizations, social clubs and sports organizations also need to be encouraged to implement alcohol safe environmental policies. For example, at organisational functions, lower strength and non-alcoholic beverages should be available and promoted, the excessive or rapid consumption of alcohol should be discouraged (e.g. no drinking competitions), food should be offered

where alcohol is served, alcohol consumption by parents/coaches/ instructors should be discouraged and alcohol should not be used for prizes/awards. In general, it has been recognised that the community's acceptance and active backing of community-level interventions is a prerequisite for the effective implementation of any public health policy (Mosher & Works, 1994). Social movements targeting alcohol consumption specifically have often resulted in substantial reductions in alcohol-related problems (Room et al., 2002). Such movements tend to be particularly effective in the short term as enthusiasm sustaining them wanes. However they often result in the adoption of beneficial, new customs or institutions which are of longer duration (Room et al., 2002). For example, in the early 1990's a women's movement in the Indian state of Andra Pradesh resulted in a statewide ban on Arrack, a clear liquor distilled from molasses. The state had previously had the highest consumption rate of Arrack in India, and the women felt that they bore the brunt of the men's drinking. The ban on Arrack was followed by a statewide ban on alcohol, and the movement spread to six neighbouring states. While the prohibition was partially repealed after two years, the prohibition on Arrack remains. Liquor is currently only available at limited outlets that have tightly restricted hours of sale (Room et al., 2002).

Environmental strategies targeting "price"

Another environmental strategy likely to be effective in reducing alcohol consumption and alcohol-related problems in general involves increasing the retail sale price of alcohol through increasing alcohol excise taxes (Babor et al., 2003; Mosher & Jernigan, 2001) (Table 1). It has been recommended that the level of alcohol excise taxes be reviewed annually in order to ensure that the taxes are regularly adjusted to reflect inflation (Parry, 2005). There is some evidence that alcohol tax increases reduce crime (Chaloupka & Saffer, 1992; Cook & Moore, 1992; 1993), industrial injuries (Ohsfeldt et al., 1990) and motor vehicle fatalities (Chaloupka et al., 1993). The National Treasury in South Africa has set as its target the increase of the total tax on beer, wine and spirits to 33%, 23% and 43% of the retail sales price respectively (Parry et al., 2003). This is certainly a step in the right direction, however it is still less than the international averages of 37%, 33% and 54% for these products respectively. South Africa has also dropped behind in terms of taxing sorghum beer, a product that accounts for about a quarter of the absolute alcohol consumed in South Africa. The effectiveness of any strategy aimed at increasing price through increasing excise taxes depends on government oversight and the control of alcohol production and distribution. High taxes can increase smuggling and illicit production, and these negative consequences need to be taken into account (Parry, 2005). The effect of tax increases in reducing alcohol-related crime/injury is less direct and more difficult to measure but nonetheless deserves careful consideration as part of a broader base of intervention strategies.

Environmental strategies targeting promotion

A further set of environmental strategies focuses on the promotion of alcohol, and deals specifically with restrictions on alcohol marketing and the implementation of counter-advertising strategies such as warning labels

(Table 1) (Mosher & Jernigan, 2001). Among other things it has been recommended that alcohol advertising should only be allowed when no more than 15% of the viewing audience is between the ages of 10 and the legal drinking age (Jernigan, Ostroff & Ross, 2005). This could hold for sporting events, print media and radio advertising. It has also been recommended that all advertising with a substantial appeal to under-aged consumers should be eliminated (e.g. use of cartoon characters) and that there should be restrictions on product placements in movies rated "all ages", as well as TV shows with less than a 75% adult audience (Mosher & Jernigan, 2001). These restrictions might be useful in reducing the sale of alcohol to underage youth. As selling alcohol to underage youth is a crime, this could therefore be seen as a crime prevention strategy. Given the level of exposure received by pro-drinking messages from the liquor industry, it is suggested that this level be matched with equivalent exposure for *active* pro-health and safety messages (e.g. around drinking and driving and using other machinery). With regard to warning labels (passive counter-advertising), opinion is mixed as to their effectiveness. If warning labels are instituted, they need to be easily read and conspicuous and should include pictures. They should also be rotated so that consumers do not become immune to the particular message (Parry, 2005). A further recommendation is the prohibition of outdoor advertising and billboards in areas where children are likely to be present. If the intention is also to reduce crime in communities in which high levels of crime are suspected to be alcohol-related, then there might be a case for restricting such forms of advertising in these areas. To date, however, there is little hard evidence regarding the impact of bans on outdoor advertising on health and social problems. A national study undertaken in South Africa in 2001 found that 45% of respondents believed that the government should ban billboard advertising of alcohol products (Parry, 2002).

Environmental strategies targeting the product

With regard to product restrictions, a number of recommendations have been made which should be considered as part of a broader crime prevention strategy aimed at dealing with the link between alcohol and crime (Mosher & Jernigan, 2001). It has been proposed that there should be restrictions on the size of beer, wine and spirits containers with, for example, only 340 ml containers of beer being permitted (1 standard drink), and that there should be no place for selling sachets of spirits or 5 litre plastic containers of cheap wine (papsakke) (Parry, 2005). Selling beer in units of one or two standard drinks, if accompanied by education campaigns, might assist drinkers in keeping track of what they have drunk and this could in turn help them to determine whether they are under the drunk driving limit. Restricting the sale of alcohol to smaller containers may also reduce alcohol consumption and this in turn may reduce alcohol-related problems of various kinds. Many people in South Africa, for example, drink beer in quart bottles (750 ml) and tend to think of one of these bottles as one standard drink, whereas in fact they comprise of 2.2 standard drinks. Restrictions could also be placed on the alcohol content of beer products, with beer containers not being allowed to comprise more than 5.5% absolute alcohol. All containers of alcohol should include the number of standard drinks on the container label in addition to the caloric content and other

ingredients (Parry, 2005). There is also a need to impose special labelling and bottling requirements so that alcoholic products are easily distinguished from non-alcoholic products (Mosher & Jernigan, 2001). A move towards packaging alcohol in safer materials (e.g. alternatives to glass bottles for beer) has also been recommended. Restricting or reducing the sale of alcohol in bottles (particularly beer) is likely to play a role in reducing the number of incidents where persons are injured with a beer bottle. One proposal is that licensed premises should be requested to dispense alcohol only in plastic glasses and bottles (Cusens & Shepherd, 2005). While this might not be appropriate for all venues it might be useful in venues with a high risk for violence and other injuries. Consideration also needs to be given to the prohibition or restriction of the sale of products with a clear appeal to youth (Mosher & Jernigan, 2001).

Drink-Driving counter-measures and alcohol treatment

A number of other strategies, which are likely to be useful in reducing alcohol-related crime, have also been recommended (Table 1). With regard to drinking and driving it has been suggested that countries increase the random breath testing (RBT) of drivers – a practice which has proven to be particularly effective (Babor et al., 2003). As compared to sobriety checkpoints where only motorists who are judged by police to have been drinking are asked to take a breath test, in RBT the alcohol levels of motorists are checked at random (Parry, 2005). It has also been recommended that countries implement programmes of graduated licensing for novice drivers. In particular, novice drivers could be restricted from having any alcohol in their systems for three years after first receiving a driver's license. This could easily be implemented and would probably have widespread political support, given the strong link between alcohol use and injury amongst young drivers (Parry, 2005).

Countries also need to implement mandatory treatment for repeat drink driving offenders. It has been found that successful programmes are well structured and go beyond just providing information, run for at least ten weeks and have court enforced rules of attendance. These programmes should include the suspension of the driver's licence, to be lifted upon completion of the programme (Babor et al., 2003). There is also evidence to suggest that providing drug/alcohol treatment to persons who have been incarcerated for crime can reduce levels of crime (Gossop et al., 2000). There is particular evidence for the effectiveness of substance abuse treatment for acquisitive crimes (e.g. robbery). There is little information pertaining specifically to the effectiveness of alcohol treatment on recidivism, however, research from the United States indicates that the diversion of drink-driving offenders into intervention programmes has been associated with an 8-9% reduction in drink-driving recidivism (Hall, 1997). The modesty of this benefit is reported to reflect the minimal nature of the interventions, which tend to be brief (running over hours or days) and aimed at breaking the link between drinking and driving as opposed to treating offenders' alcohol problems. The limited research suggests that more intensive alcohol treatment programs are likely to produce larger reductions in recidivism (Wells-Parker et al., 1995).

There are various alcohol strategies and policies that have generally been found to be ineffective (Babor et al.,

2003). These include strategies aimed at regulating the physical availability of alcohol, and which focus on *voluntary* codes of bar practice. Also included here are broad strategies dealing with education and persuasion, such as alcohol education in schools, colleges and public information campaigns. This is not to suggest that there is no place for alcohol education (for example in schools), but no strong evidence showing the efficacy of such programmes has been found. The efficacy of designated driver programmes and ride service programmes has also not been demonstrated in research (Babor et al., 2003).

CONCLUDING COMMENTS

Building an effective response to alcohol problems involves far more than the design of good intervention programmes. South Africa's current response towards dealing with alcohol, and specifically its association with crime, is highly fragmented. This fragmentation exists between different governmental departments, as well as between different levels of government (local, provincial and national). This issue clearly needs to be addressed in order for a coherent response to the burden of alcohol to be implemented (Parry, 2005). The importance of effective implementation cannot be stressed enough. Having public health professionals build strong alliances with law enforcement personnel is critical, as is community mobilisation. Both are needed if an implementation agenda is to succeed. While there is value in individual intervention strategies (e.g. alcohol treatment), the key to addressing the link between alcohol and crime is likely to be found in environmental strategies. In particular, at a national level, there needs to be greater emphasis on strategies such as increasing alcohol taxes, placing restrictions on alcohol marketing and the use of certain alcohol products (e.g. glass bottles and "papsakke"). Provincially, the emphasis needs to be on ensuring a healthier retail sector (dealing with issues around the location of alcohol outlets and the hours of sale), while at a local level greater emphasis on law enforcement and active community involvement is needed.

The policy climate for addressing alcohol related issues has begun to shift in 2006. Among other things the Minister of Health has indicated that she is ready to implement the already drafted regulations on alcohol warning on alcohol containers and this year taxes on all alcoholic beverages (excluding traditional African beer) increased by at least 4.8% in real terms. The Department of Health has also initiated a campaign to stop the brewing of dangerous homebrewed concoctions. The second drug master plan, which also includes alcohol, is due for release in 2006 and it contains a much greater focus on policy implementation. However, the actual capacity to implement interventions at local and provincial level is much more variable. At a provincial level, 2006 has also seen the Department of Community Safety and Health in the Western Cape Province working together to develop a strategy for reduction of abuse of alcohol.This year has also seen the launch of South Africans Against Drunk Driving (SADD), a grassroots organisation aimed at creating awareness of the drinking and driving problem in South Africa, and pressurizing the government to be more proactive in this area. This latter move is especially encouraging as community mobilisation is likely to be key to the success of any efferts to reduce alcohol-related crime and injury in South Africa (Parry & Bennetts, 1998).

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THIRSTING FOR THE AFRICAN MARKET

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ABSTRACT

The overall per capita consumption of alcohol in the African continent remains low though rates in some countries are among the highest in the world. Africa, therefore, is one of several untapped markets in the world that have attracted attention from the alcohol industry in recent times. This paper reviews the prospects for global alcohol companies in the continent, examining the value of the African market to the industry as well as a range of political, social and economic factors which are associated with the growth of the market for commercial alcoholic beverages. To highlight and illustrate the activities of the industry, two case studies are presented focusing on marketing and promotional activities of key industry players in South Africa and Nigeria. The paper concludes with a call to African governments and the alcohol industry to become more aware of the public health and social dangers posed by alcohol consumption and to respond through prevention efforts aimed at limiting the exposure of young people to alcohol advertising and promotion.

KEY WORDS: alcohol marketing, promotion, Africa

INTRODUCTION

Why would global alcohol companies be interested in African markets? What are their prospects there? What form does or will their presence likely take in African nations? What implications does a growing global presence of alcohol companies in African markets hold for the continent, in terms of economics, development and public health? This article will address these questions, looking first at the overall situation for alcohol companies in Africa, and then exploring case examples of what alcohol producers have actually done, both at the company and at the country and brand level.

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What makes Africa interesting to alcohol companies

Many Africans abstain from alcohol but those who drink, drink a lot. This is most true in sub-Saharan Africa, since many of the North African countries are largely Muslim. According to the World Health Organization's *Global Status Report on Alcohol 2004*, several sub-Saharan African countries – Uganda, Nigeria, Swaziland and Burundi – rank among the 30 countries with the highest levels of per capita alcohol consumption in the world (World Health Organization, 2004). Although as much as half of consumption in Africa is of "unrecorded" alcohol, such as home production or production of traditional beverages such as sorghum beer or palm wines (Rehm, Rehn et al., 2003), the "recorded" segment of the market is the portion of greatest interest to global alcohol companies, because this is the segment that generally includes their commercially-available, industrially-produced beverages. From 1970 to 1980, consumption of these beverages – recorded per capita alcohol consumption – grew rapidly in Africa. As Figure 1 shows, in the 1970s the trajectory of recorded alcohol production in the African region (SSA) was similar to that of Southeast Asia and Oceania (OAI) and China (CHI): consumption rose steadily, and looked to be about to do the same into the 1980s. With a large population that appeared ready to shift over to commercially-produced beverage, and a middle class in its infancy likely to adopt westernized beverages (Eide, Acuda et al., 1998), Africa lay in the sites of alcohol producers in search of expanding markets to make up for the declining consumption in the "mature" markets of Europe and North America

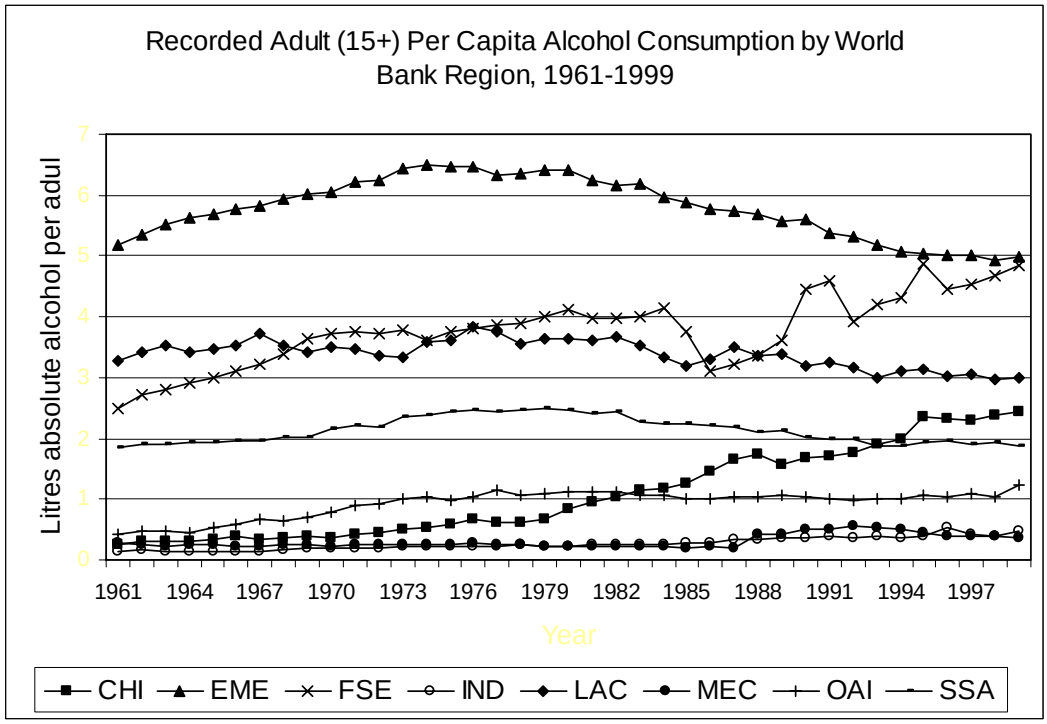

Figure 1. Recorded Adult (15+) Per Capita Alcohol Consumption by World Bank Region, 1961-1999
Source: WHO Global Alcohol Database, unpublished data

However, rather than continuing to increase, like China, or flattening or increasing slightly, like Southeast Asia and Oceania, consumption in Africa in 1980 began to fall, and fell steadily right up until 1999. This trend certainly did not eliminate the global alcohol industry's interest in sub-Saharan Africa, but it did mitigate it, as two case studies below will show. But first, what happened to create this trend in Africa? The effects of the global recession of the 1980s were amplified by three key factors: military conflicts, corruption and HIV. These three have combined to depress dramatically economic growth rates in the region. This is critical, because, other factors being equal (e.g. absent the influence of abstemious religions such as Islam) recorded alcohol consumption tends to rise with economic growth (Room, Jernigan et al., 2002).

What happened in the African alcohol market

Military conflicts. In the past 30 years, there have been military conflicts in Algeria, Angola, Burundi, Chad, Cote d'Ivoire, Democratic Republic of Congo, Djibouti, Eritrea, Ethiopia, Guinea-Bissau, Liberia, Libya, Mauritania, Morocco, Mozambique, Namibia, Niger, Nigeria, Rwanda, Sierra Leone, Somalia, South Africa, Sudan, Togo, Uganda and Zimbabwe. Instability on the continent continues to this day. Some of these conflicts have been over natural resources; others may have resulted from an unusually high by global standards level of ethno-linguistic fractionalization. These conflicts have transcended national boundaries, to such an extent that "there are substantial indications that African boundaries are no longer sacred, and that intervention in states like Congo, with its wealth of natural resources and its implications for geopolitical security, may be drawing Africa into an extended military contest over boundaries" (McMichael, 2000, p. 228).

Corruption. The "informal" economy in Africa is often considered to be rural, based in indigenous production of agricultural goods, barter and so on. In fact, however, there are complex "informal" networks that facilitate large amounts of economic activity in the region. Castells (1998, 178) has argued that these networks are in fact "…an essential feature of the new global economy….Complex financial schemes and international trade networks link up the criminal economy to the formal economy." This economy can be crucial to survival, as Hecht and Simone (1994, p. 21) argue:

> …government policies [in Nigeria and Benin] in the areas of tariffs, banking laws, currency values, and import regulations confound official trade….Meanwhile, the border is the site of rampant smuggling, where unregistered markets provide a livelihood for many of the people living between Lagos and Cotonou/Porto Novo. The illicit exchange is crucial to the economies of both countries….Such illicit activities further impede effective governance and economic development but, for the moment, they set up an informal regional economic integration by default…

Thirty years of conflicts, with periods of open war alternating with uncertain peace, have fed this complex array of networks. In atmospheres of strife and political uncertainty, with "formal" lines of supply and commerce interrupted as thousands of people are displaced and physical and economic structures and infrastructures destroyed, the ability to "get it done" triumphs, and this ability breeds and encourages this "extra-state"

organization of commercial activity. War zones further encourage the development and proliferation of these networks, for they often provide the only reliable access to necessities as well as luxury goods for the bulk of the population. Nordstrom (2004, p. 98) quotes a "businessman's" description of such trade in Southern Africa:

> On one of the "uncharted" cargo runs you can find a veritable global supermarket. Look at a typical run for today: (German-made) cars and lorries stolen in the capital city and neighboring countries, (French- and Japanese-made) industrial equipment for their factories and (Russian-made) weapons for the militias guarding their interests, some (United States-made) computers and (Chinese-made) electronic equipment both for their own use and to sell or barter, and luxury items like (European) alcohol, (American) cigarettes, (western and Indian) videos, and (globally produced) clothing and foodstuffs.

For Nordstrom (2004, pp. 191-192), the term "war" itself has become associated "…not only with military actions, but with questionable if not illegal industry, land takeovers, and international wildcatting…based in international business concerns that can be legal, indeterminately legal, or downright illegal – but that yield quick, and often vast, profits, commonly in the context of political instability." While Nordstrom argues that these networks may be the most reliable motors of economic growth in war-torn areas like sub-Saharan Africa, the lack of rational economic institutions and a clear ladder for social mobility has contributed to increasing income inequality both within countries and across the continent, with the result that "the people who would have to implement the legal, social and economic reforms that could potentially turn Africa around do not seem to suffer much from the current situation" (Artadi and Sala-i-Martin 2003, p. 4) and thus may have little motivation for change. However, this does not promote the development of larger markets for the products of global alcohol producers. The rich can be counted on to consume such luxury products, but the numbers of the rich shrink as income disparities grow.

HIV. By 2005, 2.4 million people had died from AIDS in Sub-Saharan Africa, and 25.8 million people – adults and children – were living with HIV. In ten countries – Botswana, Central African Republic, Lesotho, Malawi, Mozambique, Namibia, South Africa, Swaziland, Zambia and United Republic of Tanzania – more than one in ten adults was infected. In three countries – Kenya, Uganda and Zimbabwe – prevalence appeared to be declining, although this could be the result of a "grievous equilibrium," in which roughly equal numbers of people are dying and being newly infected (UNAIDS/WHO, 2005).

The impact of this epidemic on the continent of Africa is incalculable. According to the United Nations Development Programme (UNDP), by the period 1995-2000, in the 35 highly-affected countries in Africa, life expectancy at birth stood at 48.3 years, 6.5 years less than it would have been in the absence of AIDS. In some of the worst-affected countries, close to half of children who lose a parent to HIV/AIDS drop out of school. Households that lose a breadwinner have seen their incomes drop by as much as 80 percent, and in one country, the proportion of people living below the poverty line has increased at least five percent as a result of HIV/AIDS. The labor force in sub-Saharan Africa is projected to be between 10 and 30 percent smaller by 2020, and

reduced food production is already being reported in some areas (United Nations Development Program, 2001).

Effects on economic development. The impact of these and other factors on the economic development of sub-Saharan Africa has been clear. By 2001, per capita gross domestic product in sub-Saharan African was 200 dollars less than it had been in 1974. Growth rates in this region were zero between 1980 and 1985, less than 0.5% in the second half of that decade, negative 1.5% in the first half of the 1990s, and by 2002 had edged just slightly over 1%. The rest of the world was growing over this entire period at an annual rate of close to 2% (Artadi and Sala-i-Martin, 2003).

Artadi and Sala-i-Martin term Africa's growth performance "the largest economic disaster of the XXth century" (2003, p. 18). In the midst of this disaster, how did global alcohol producers function, and what can we learn about this for alcohol problems in sub-Saharan Africa should the region begin to recover? Two case studies will help address these questions. An examination of the largest global alcohol producer in the region, South African Breweries (now SABMiller), will provide insight into the first question, while a look at global producers – Heineken and Guinness/Diageo – in the Nigerian market will help to answer the second.

CASE STUDY: SOUTH AFRICAN BREWERIES/SABMILLER

By the early 1990s, the global brewers had divided the world up into geographic spheres of influence. Carlsberg and Heineken were dominant in Asia, Anheuser-Busch dominated North America, a handful of Latin American breweries held monopoly or oligopoly positions in most countries in that region, and South African Breweries dominated sub-Saharan Africa. Eastern Europe and China were emerging battlefields, with the major global brewers actively seeking investments and jockeying for dominance.

South African Breweries at this time was poised to expand into the rest of Africa. In 1994, SAB's chief executive Meyer Kahn predicted that a major source of future business for the company would be

> …sub-Saharan Africa, which has 400 million people. Most are very poor, with incomes a third of blacks here [in South Africa]. So we reckon this 400 million has the purchasing power of 100 million low-income South Africans. That's an enormous export market for our beer and soft drinks....Talk about potential. In South Africa, with 40 million people, we sell 23 million barrels of beer annually. In Tanzania, with 30 million, the brewing capacity was a mere 500,000 barrels [prior to SAB's entry in 1994]....We know more about Africa's developing consumer markets than anybody. The guys at Budweiser in St. Louis probably don't even know where Tanzania is (Edgerton 1994, p. 110).

But this market was not to be the motor of SAB's growth. The company had survived the economic slowdown of the 1980s by concentrating and expanding its holdings in South Africa itself, diversifying into retail, hotels, packaging and a variety of other industries. By the end of the apartheid era in 1994, South African Breweries (SAB) was South Africa's largest non-mining conglomerate and largest consumer goods company. But the end of the capital controls and sanctions that had accompanied apartheid, along with the negative factors for African economies described above, sent

SAB elsewhere for its growth.

SAB had grown into the position of the dominant brewer in the region by virtue of its long history of brewing in the region, and the consolidation of its near-monopoly position in its home market over the years. SAB or companies owned by it were responsible for the creation of Zimbabwe's clear and opaque beer industries. SAB founded Rhodesian Breweries in 1910 in Salisbury (Harare). In 1951, "Rhobrew" established a brewery in Zambia. In 1952, the company added a brewery in Bulawayo in southern Zimbabwe. In 1956, after an excise tax increase by the South African government cut consumption and imperiled the survival of its two largest competitors, SAB consolidated control over 90 percent of the South African market by acquiring the competitors, the Ohlsson's and Chandlers Union Breweries groups.

Strong alliances with other major multinational brewers shored up SAB's regional dominance in the 1960s. In 1964 SAB received a license to brew Guinness Stout in South Africa, the first such license ever granted by Guinness outside of Ireland. In 1965, SAB received the local license to brew Amstel (now part of Heineken). In 1966, the company acquired the sub-Saharan license to brew Carling Black Label. In 1973, the company built breweries in Botswana and Angola. In 1976, SAB bought Swaziland Breweries. In 1979, following a bruising battle for beer drinkers between another South African brewing group and SAB, the South African liquor industry was restructured at the government's behest. SAB agreed to purchase the other group's beer interests, ending up with nearly 99 percent of the domestic "clear beer" market. It cut its investment in wines and spirits, and that same year made its first foray into fruit juices, by purchasing 49 percent of Appletiser from its Italian founder; in 1982, Coca-cola sold the rest of the company to SAB.

Meanwhile, the company continued to expand its foreign holdings. In 1980, at the request of the Botswana government, SAB acquired control of a second brewery there. In 1981, it purchased controlling interests in Lesotho Brewing Company and Maluti Mountain Brewery. In 1986, SAB moved into dominance in fruit juices through a joint venture with Ceres Fruit Juices. In 1988, after an abortive attempt at expansion into the U.S. (the company brought the languishing regional brew Rolling Rock to national prominence in the late 1980s, then quickly sold out to a Canadian brewer in fear that the brand would be destroyed if its association with South Africa became known), the company acquired brewing interests in the Canary Islands, as well as an investment in fruit juices in the UK.

In 1990, the company embarked on a major expansion in South Africa, planning megabreweries at three sites. In 1991, Heineken granted the company a license to brew Heineken Lager. In 1994, as a result of the new democratization of South Africa, the company was invited to revitalize the beer industry in Tanzania, and to re-enter the beer markets of Zambia, Mozambique and Angola.

By 1994, SAB was selling approximately 99 percent of the clear (European-style malt-based) beer drunk in South Africa, and its subsidiary Traditional Beer Investments (TBI) accounted for about 10 percent of opaque (or sorghum-based) beer sales. Under apartheid, with South African capital limited by sanctions from traveling to or investing in many other countries, complex systems of cross-ownership, holding companies and so on developed, such that (as of 1995) four giant holding companies controlled more than half of

the shares on the Johannesburg Stock Exchange. This concentration was partly the result of the historical development of capital in South Africa, in which resources concentrated in the hands of the few at the start and, in the absence of anti-trust legislation such as broke up the huge trusts in the United States beginning in the late 19th century, remained in those hands (O'Meara, 1983). It was then further reinforced by economic isolation resulting from international sanctions under apartheid, and restrictive exchange policies adopted by the apartheid-era government to prevent capital flight.

A member of the Anglo-American group of companies in 1994, following the fall of apartheid South African Breweries (which later became SABMiller) embarked on a series of refocusings and restructurings, ultimately defining beverages as its core business, and divesting itself of its other activities. In the process, the company went on a buying and alliance-building spree that transformed it from the dominant player in southern African brewing with a few small interests outside the region, to the third largest brewer in the world with the majority of its turnover coming from its interests outside of southern Africa.

This move outside of the company's regional base began with the end of the apartheid era in sight in the early 1990s after the unbanning of opposition parties and release of political prisoners in 1990. In 1993, SAB acquired Hungary's largest brewery in what the company called in a promotional brochure a "beachhead move" into central Europe. That same year, it took joint control of China's second largest brewery with China Resources, a privatization arm of the Chinese government. In 1994, the company estimated overseas production at 10 million hectoliters. In its annual report for that year, it claimed total company output of 34 million hectoliters, which at the time made it the 5th largest brewer in the world. Fourteen percent of these came from its international holdings.

SAB protected its base and near-monopoly position in South Africa, but taking advantage of capital raised by divestiture of "non-core" activities, as well as funds raised on international capital markets particularly after it moved its primary listing to the London Stock Exchange and joined the FTSE 100 in 1999, within ten years it was a transformed company. By 2001, 42% of its turnover came from international operations. By 2005, activities in Europe and the Americas alone would account for 57% of its turnover, according to figures published in the company's annual report for that year. The re-named SABMiller largest single shareholder was Altria, the successor to the American cigarette company Philip Morris, with 36% of ownership and 24.9% of voting shares. SABMiller held the position of second largest brewer in the U.S., in India and in South America. Via direct ownership or joint ventures, it counted among its holdings 47 breweries in China and India, 18 breweries in Europe, 26 breweries in the Americas, and 21 breweries in Africa.

What might SABMiller have done differently had circumstances been more favorable in Africa? Certainly the company maintained its interest in controlling and expanding its markets in sub-Saharan Africa, and certainly it had an appetite for aggressive expansion in promising markets. Close examination of the activities of the company and its allies in a single southern African country – Zimbabwe – in the mid-1990s showed that SAB was willing and able to bring the full complement of modern marketing technologies to bear on its southern African base markets. Couponing and

sweepstakes, grafting of beer brands onto cultural and historical symbols and holidays, sports sponsorships, as well as advertising on radio, television, billboards, in cinemas, and on mobile cinema vehicles in rural areas where there were no cinemas were all part of its marketing mix (Jernigan, 2001).

However, the fact of the matter was that growth lay elsewhere, and Zimbabwe is a good example of why this was the case. Erratic policies on the part of the Mugabe government interfered with SAB's ability to control and grow the market, and these policies worsened after the turn of the millennium, resulting in runaway inflation, a disastrous land reform program, and rampant political unrest. In the midst of this upheaval came the HIV epidemic, to the extent that by 2004 one in five pregnant women were infected. The forced displacement of several hundred thousand Zimbabweans in 2005 as result of political policies and instability threatened to make matters even worse (UNAIDS/WHO 2005). Thus elsewhere is where SAB elected to shift the majority of its attention and resources. In 1999, it raised 300 million pounds on international capital markets to fund its expansion. This money did not go back into Africa – it went rather to eastern Europe, to China and India, and to North and South America.

While Nigeria is home to more people living with HIV than any other country in the world, with the exception of South Africa and India, the prevalence of HIV among pregnant women in that country is far lower, appearing to have leveled off at around 4 percent (UNAIDS/WHO 2005). Although the country has certainly not been without internal civil strife and corruption, it has enjoyed political stability relative to many of its neighbors over the past three decades. Examination of what global alcohol producers have done in this more stable environment provides a glimpse of what might happen elsewhere in Africa, should countries recover from current political and health challenges and economic growth begin to take off.

CASE STUDY: ALCOHOL MARKETING AND PROMOTION IN NIGERIA

Though traditional drinks like *burukutu*, palm wine, *pito* and *ogogoro* remain popular in rural areas and among the urban poor, commercial beer is the favorite drink of Nigerians in all parts of the country (Gureje, 1999; Obot, 1993). There are no production figures for traditional drinks and the level of their use in the country is not accounted for in data on consumption. However, government statistics show that production and consumption of commercial beer and other western beverages increased significantly between the early 1970s to about the middle 1980s (WHO, 1999). The declines observed from around 1988 were due to worsening economic conditions and government policies (particularly a ban on imported malt barley), which affected the productive capacities of many of the breweries established in the early 1970s (Obot, 2000).

Attempts in recent years by the Federal government to revive the economy with the introduction of liberal trade policies have had the effect of increasing availability of foreign-produced alcoholic beverages and a resurgence of local production of beer, in particular. Beer is the most often consumed beverage in the past year and past month when compared to other types of alcoholic drinks, according to survey data (Obot et al., 2001). The popularity of beer cuts across all social and economic

groups, but there seems to be substantial consumption of wine and expensive liquor among people in the higher socio-economic groups, and traditional beverages among the poor and residents of rural areas. In this context, it is understandable that most of the activities of the alcohol industry in Nigeria are concentrated in the production and marketing of beer.

The first commercial brewery was established in the country in 1945. Now known as Nigeria Brewing (NB) Plc, today the company has six brewing sites scattered across the country and produces three lager brands (Star, Gulder, Heineken) and one stout (Legend). Not long after production began at the first commercial brewery, a company was formed to import Guinness extra stout into the country from Ireland. The popularity of this brand led to the establishment of a Guinness brewery in Lagos in 1962. It is noteworthy that this was the first Guinness brewery outside the United Kingdom and only the third in the world. A mark of its success in Nigeria lies in the fact that today it has three breweries in the country and, apart from its flagship stout product, also produces a popular lager brand – Harp lager beer.

These two companies – NB Plc and Guinness Nigeria – are the two largest capitalized companies in the Nigerian stock exchange. With 6.2% of the total market capitalization of the stock exchange, NB Plc leads the list of 188 companies. It is more than two and a half times the size of Guinness Nigeria (Nevin, 2004). Their products, especially Star beer and Guinness extra stout, are staple products in the Nigerian market. Both companies often boast of their significant contributions to the economy, in particular, through the taxes they pay into government coffers. Neither is truly Nigerian: NB is controlled by Heineken with a 54.2% ownership share, while Guinness Nigeria is part of Diageo, the world's largest spirits marketer as well as the brand owner of Guinness. The companies' size enabled them to weather the economic storms of the 1980s which forced the closure of many smaller Nigerian breweries, and today they dominate Nigeria's beer industry. They are, however, fierce competitors, and this is exemplified in the unique and ingenious ways they have developed of marketing and promoting some of the country's most popular alcoholic beverages. Many of these activities are oriented towards young people. They include sponsorship of the following events and programmes (Obot & Ibanga, 2002):

- National Annual Essay Competition for young people;
- Fashion shows and beauty contests on campus, for example Miss and Mr. Campus;
- Sports events, including interfaculty football matches, national university games, etc.;
- Musical segments of radio programmes. For example, the prime music time on radios in many parts of the country is between 8 and 10 p.m. This has become the alcohol (and tobacco) time on some Nigerian radio stations. It is not unusual on some days for the time devoted to advertising these products to be almost as long as time devoted to music, and one message can be repeated back to back three or more times;
- Personality 'Showcase': a Nigerian who has succeeded in his field is showcased in an event and his success story is, therefore, associated with drinking a

particular beverage;

- Radio call-in shows, in which questions are asked about a particular brand of beverage and right answers attract prizes. Both Guinness and Bacchus Tonic Wine have engaged in this form of promotion through 'public enlightenment';
- Performance by foreign musical stars. In recent years, under the sponsorship of Legend brand, *Naughty by Nature* has performed to sold out crowds of youth in different parts of the country and *Shaggy* has toured the country for Star;
- End of year carnival at the beach or park where alcohol is the centre of attraction.

Other promotional activities have included:

- Lottery-type free drinks, cash or souvenirs won by consumers if they purchase a specially marked bottle of beer;
- 'Buy five and get one free' promotions;
- Discounted drinks especially when new brands are introduced;
- Sponsored articles, often in the form of advertorials;
- Newspaper articles touting the health benefits of beer. For example, readers are informed that beer is rich in antioxidants which help in warding-off cancer. Hence it is a 'health tonic' when consumed in moderation;
- "Treasure hunt" in which prizes are awarded for the "discovery" of a new-look bottle;
- Seminars on brewing and the role of the brewing industry in Nigeria's economic growth which often give free admission to members of the public;
- Donation of space to organizations to advertise their events. This is in the form of payment for the advertisement. In return the brewer places at the bottom of the announcement a short statement like: Space donated by [the brewer];
- In-bar promotion for customers through discounted drinks;
- Fun fare: For the period covering 20-23 December 2001, Heineken organized a party in 23 locations around the country. Major attractions at these fun fares were music, karaoke, food, lucky dip draws, prizes and 'lots of Heineken to enjoy.' For Easter 2002, parties in 14 locations were announced in colourful double-paged advertisements in a major daily newspaper. The parties were held in places like night clubs, plazas, a university senior staff club, and a bus stop, and, again, the attractions included music, prizes and 'lots of Heineken to enjoy.'

Most of the promotional activities listed above are targeted at particular sectors of the Nigerian society. In recent years, the alcohol industry has also expanded mass media advertising that is aimed at the general public. The mass media for advertising have been radio and television, billboards, newspapers and magazines.

Nigerian Brewery: Star and Legend

Nigerian Breweries produces Star beer, the most popular lager in the country. When it changed the design of Star's bottle in 2001, it made Star one of the most visible structures in selected Nigerian cities, by displaying in strategic urban locations a bottle of Star so large that it could be seen from miles away.

From a sales point of view, the new bottle strategy seems to have been effective, although in one city negative reactions to the display led to a dismantling of the bottle. According to the company, sales went up when the bottle was introduced. "The introduction of the new bottle brought a sudden revival in consumer interest for *Star*" making it Nigeria's favorite beer and, according to the marketing director of the company, "*Star* is now the beer of pleasure, fun, leisure and shared drinking" (The News, 2001). Long-term, NB wants to dominate the Nigerian beer sector like SABMiller dominates South Africa. NB currently has 80% of the lager segment of the brewing industry but wants 98%.

It is also challenging Guinness' thirty years of dominance of the stout category with its own stout called Legend. NB re-launched the brand in 2001 with the theme: 'Torch of inspiration' using an Olympics torch logo, in a continued effort to appeal to the youthful segment of the market. The campaign by the brewers of Legend to reposition the brand was estimated to cost the company N120 million (about USD$1 million). This amount was spent on prizes for competitions; gifts like CD players, T-shirts, pens, caps and mugs, and free drinks. Legend's promotional materials emphasize its superior characteristics, which seem to go far beyond a simple beverage: it is the "modern and youthful beverage," a "fun stout" and "goes down well with the body," with has no hangover effect, fortified with essential vitamins, "energetic, independent and dependable," and with a profile of "strength and character, strong commitment, courage and leadership drive" (Ikoro, 2001).

In Legend's 2002 campaign, known as the 'Cool breeze promotion,' the company promised to distribute 2.4 million prizes of different types. The Hotspot Scheme was one of its most imaginative marketing strategies. Like Coca-Cola and British American Tobacco, NB Plc planned to open up to 500 hotspots or Legend consumption centers around the country to bring the drink closer to the people.

Guinness and the legend of "Michael Power"

Despite NB's dominance of the beer market, Guinness has held onto the lead position in stout. Nigeria is the third largest market in the world for Guinness, after Ireland and the United Kingdom, according to *Advertising Age* (Britt, 2003). In the year ending June 30, 2003, Guinness grew in Africa by 10%, at the same time that worldwide consumption grew by only 2%, and in Ireland fell by 4% (Howard, 2003). According to David Armstrong, commercial director for Diageo Africa, this growth has been driven by a single campaign: Michael Power.

Michael Power (not his real name) is one of the most well-known figures in Nigeria. On billboards, radio and television, he has become the leading salesman for Guinness extra stout. Not much is known about him. His real identity is a closely-kept secret at the headquarters of Guinness Nigeria. What little is known about him is that he is an actor, a model, of African descent and lives in the U.S. What is certain is that Michael Power is a creation of Guinness. The *nom de guerre* was chosen to enhance the long-standing image of Guinness extra stout, an image of strength and power, in all senses of the word. Even before Power added his charm to the marketing of the brew, Guinness was associated with strength and sexual virility. It is not surprising, therefore, that among the many lovers of the drink,

Guinness is called 'black power' or Viagra, among many other suggestive names.

Using Michael Power as the point man, the company embarked in 1999 on an intensive marketing campaign totally different from what the industry has ever seen. Instead of a straightforward sales pitch, Power was made the hero in a series of mini-adventures on radio and television, all of which were aimed at highlighting the "good qualities" of the beverage, namely: strength, friendliness, intelligence, responsibility and reasonableness. In 2003, Guinness released a full-length feature film starring him, "Critical Assignment." The film played across Africa, going into general distribution where movie theater chains existed, as in Kenya, but elsewhere playing in town halls or mobile cinemas, often giving people their first experience of watching a movie on a large screen. Diageo offered the film for free, and spent an estimated $42.4 million on the brand in Africa in 2003 (Howard, 2003). The film promotes clean water – a cause championed by the Diageo Foundation in Cameroon, Ghana, Kenya and Nigeria, top targets for the film (Britt, 2003). Guinness stout is also prominent in the film: characters drink from Guinness as they chat in a bar, and a Guinness truck is featured in one action scene. There is no study yet of the effectiveness of Power as a spokesman for Guinness but it is clear that he has been a big hit among young people in Nigeria and in other African countries where he has been used to promote the Guinness brand. Guinness has also launched a television channel in Africa – Guinness TV – which shows documentaries about great Africans who have triumphed over adversity, among them Nelson Mandela and sports heroes.

CONCLUSION: THE NEED FOR PUBLIC HEALTH-ORIENTED ALCOHOL POLICIES

By global standards, Africa is a young continent, and the HIV epidemic is making it even younger. For example, approximately 54% of Nigerians are below the age of 20 years, and a sizeable proportion of these young adults will seek to become part of the global economy. Hundreds of thousands graduate from universities and high schools each year and move to large urban areas to seek employment. While most do not find regular work, the industry can count on them to fill the stadium for a *Shaggy* concert or the plaza for an Easter party where beer is often offered free or at reduced prices and where brand loyalty is nurtured. It can count on them to be drawn to its free feature films and television programming, promoting its brands in the guise of profiles in courage.

Alcohol producers' interest in Africa waned during the difficult years of the 1980s and 1990s. If Africa recovers, the industry will be poised to resume its growth there. Already there are signs of increased competition in the bellwether economy of South Africa, where Heineken and Diageo are apparently positioning themselves to take on SABMiller (EIU ViewsWire, 2003). The Nigerian case shows how innovative the companies can be, in a setting where few restraints exist on advertising, promotion or even availability of alcohol. Many of the industry's strategies have strong appeal to young people. Yet Nigeria today has no enforceable legislation to control the production, marketing and consumption of alcoholic beverages in the country.

If the youth survive HIV, military conflicts, and the corruption endemic in many national economies, marketing

strategies more sophisticated and ubiquitous than those allowed in developed nations will present alcohol – particularly beer – to them as an emblem of success, a symbol of virility, the embodiment of courage and heroism. Without clear policies and a strong public health voice, there will be little mention of the dangers of early onset of drinking (now well established in the U.S. public health literature), the fact that alcohol's toll on global disease and disability nearly matches that of tobacco, and other potential negative consequences of heavy alcohol use. The tragedies of the past three decades in Africa have limited the growth of alcohol markets and alcohol consumption there. The opportunity exists now to exercise the power of prevention, through actions by industry and governments to balance and limit the marketing and promotion of alcohol to young people.

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World Health Assembly Resolution on PUBLIC HEALTH PROBLEMS CAUSED BY HARMFUL USE OF ALCOHOL

The Fifty-eighth World Health Assembly,

Reaffirming resolutions WHA32.40 on development of the WHO programme on alcohol-related problems, WHA36.12 on alcohol consumption and alcohol-related problems: development of national policies and programmes, WHA42.20 on prevention and control of drug and alcohol abuse, WHA55.10 on mental health: responding to the call for action, WHA57.10 on road safety and health, WHA57.16 on health promotion and healthy lifestyles and WHA57.17 on the Global Strategy on Diet, Physical Activity and Health;

Recalling The world health report 2002,[*] which indicated that 4% of the burden of disease and 3.2% of all deaths globally are attributed to alcohol, and that alcohol is the foremost risk to health in low-mortality developing countries and the third in developed countries; Recognizing that the patterns, context and overall level of alcohol consumption influence the health of the population as a whole, and that harmful drinking is among the foremost underlying causes of disease, injury, violence – especially domestic violence against women and children – disability, social problems and premature deaths, is associated with mental ill-health, has a serious impact on human welfare affecting individuals, families, communities and society as a whole, and contributes to social and health inequalities;

Emphasizing the risk of harm due to alcohol consumption, particularly, in the context of driving a vehicle, at the workplace and during pregnancy;

Alarmed by the extent of public health problems associated with harmful consumption of alcohol and the trends in hazardous drinking, particularly among young people, in many Member States;

Recognizing that intoxication with alcohol is associated with high-risk behaviours, including the use of other psychoactive substances and unsafe sex; Concerned about the economic loss to society resulting from harmful alcohol consumption, including costs to the health services, social welfare and criminal justice systems, lost productivity and reduced economic development;

Recognizing the threats posed to public health by the factors that have given rise to increasing availability and accessibility of alcoholic beverages in some Member States;

Noting the growing body of evidence of the effectiveness of strategies and measures aimed at reducing alcohol-related harm;

Mindful that individuals should be empowered to make positive, life-changing decisions for themselves on matters such as consumption of alcohol;

Taking due consideration of the religious and cultural sensitivities of a considerable number of Member States with regard to consumption of alcohol, and emphasizing that use of the word "harmful" in this resolution refers only to public-health effects of alcohol consumption, without prejudice to religious beliefs and cultural norms in any way,

[*] *The world health report 2002. Reducing risks, promoting healthy life.* Geneva, World Health Organization, 2002.

1. REQUESTS Member States:

(1) to develop, implement and evaluate effective strategies and programmes for reducing the negative health and social consequences of harmful use of alcohol;

(2) to encourage mobilization and active and appropriate engagement of all concerned social and economic groups, including scientific, professional, non-governmental and voluntary bodies, the private sector, civil society and industry associations, in reducing harmful use of alcohol;

(3) to support the work requested of the Director-General below, including, if necessary, through voluntary contributions by interested Member States;

2. REQUESTS the Director-General:

(1) to strengthen the Secretariat's capacity to provide support to Member States in monitoring alcohol-related harm and to reinforce the scientific and empirical evidence of effectiveness of policies;

(2) to consider intensifying international cooperation in reducing public health problems caused by the harmful use of alcohol and to mobilize the necessary support at global and regional levels;

(3) to consider also conducting further scientific studies pertaining to different aspects of possible impact of alcohol consumption on public health;

(4) to report to the Sixtieth World Health Assembly on evidence-based strategies and interventions to reduce alcohol-related harm, including a comprehensive assessment of public health problems caused by harmful use of alcohol;

(5) to draw up recommendations for effective policies and interventions to reduce alcohol related harm and to develop technical tools that will support Member States in implementing and evaluating recommended strategies and programmes;

(6) to strengthen global and regional information systems through further collection and analysis of data on alcohol consumption and its health and social consequences, providing technical support to Member States and promoting research where such data are not available;

(7) to promote and support global and regional activities aimed at identifying and managing alcohol-use disorders in health-care settings and enhancing the capacity of health-care professionals to address problems of their patients associated with harmful patterns of alcohol consumption;

(8) to collaborate with Member States, intergovernmental organizations, health professionals, non-governmental organizations and other relevant stakeholders to promote the implementation of effective policies and programmes to reduce harmful alcohol consumption;

(9) to organize open consultations with representatives of industry and agriculture and trade sectors of alcoholic beverages in order to limit the health impact of harmful alcohol consumption;

(10) to report through the Executive Board to the Sixtieth World Health Assembly on progress made in implementation of this resolution.

Ninth plenary meeting, 25 May 2005

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"Public health problems caused by harmful use of alcohol"

COMMENTARY

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The World Health Assembly deserve congratulations for a resolution that has the potential to exert a major impact on the public health problems caused by the harmful use of alcohol. Specifically, the drafters of the resolution did a good job in mounting a convincing case for the pervasive and substantial adverse consequences of alcohol use, and in conveying a sense of optimism about the existence of evidence-based strategies and interventions to reduce alcohol-related harm.

There are however two related issues that do not receive sufficient attention, the first of which is that insufficient attention is given to the causes of harmful use of alcohol. One framework that can be applied in understanding the causes of harmful use of alcohol was presented by Eaton et al. (2003). According to this framework, harmful use of alcohol is determined by three ecological levels that mutually influence each other. At the level of the *person*, harmful use of alcohol is influenced by personal attributes such as low self-esteem, psychopathology such as depression, sensation seeking, and genetic factors. At the level of the *proximal context,* harmful use of alcohol is influenced by interpersonal factors (such as peer pressure, relationship difficulties with family or friends, and negative responses of health care providers when alcohol-related health problems are identified) and the physical and organisational environment (such as inadequate recreational facilities). At the level of the *distal context*, harmful use of alcohol is determined by cultural factors including norms that promote alcohol consumption and structural factors such as poverty and urbanisation. These levels interact with each other in a synergistic manner to promote the inappropriate use of alcohol. For example, norms that promote alcohol consumption may make it more difficult to resist peer pressure, which may reduce self esteem, which may in turn increase the likelihood of alcohol abuse.

The second issue that receives insufficient attention is what can actually be done to reduce the prevalence of harmful alcohol use. This is related to the observation above that insufficient attention is given to the causes of harmful alcohol use, since the development of a comprehensive approach to interventions is most likely against a backdrop of a comprehensive grasp of aetiology. Thus, interventions need to address all three

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ecological levels mentioned above. For example, social norms can be addressed through media campaigns and opinion leader approaches; negative response of health care providers can be addressed though training; and psychopathology can be addressed by increasing access to and the quality of mental health services. It is generally the case that the focus of intervention efforts is on the level of the person. This approach is implicit in some of the statements about intervention in the resolution, for example that "individuals should be empowered to make positive, life-changing decisions for themselves on matters such as the consumption of alcohol". While this is certainly the case, there is an implied focus on the level of the person to the exclusion of other levels. This is unfortunate, as long-term reductions in rates of inappropriate alcohol use are most likely to be achieved by changes in the distal context.

Conversely, there is an issue that receives too much attention, namely that the Director-General is requested to devote a large amount of resources to activities such as "conducting further scientific studies pertaining to different aspects of possible impact of alcohol consumption on public health"; conducting a "comprehensive assessment of public health problems caused by harmful use of alcohol"; and strengthening "global and regional information systems through further collection and analysis of data on alcohol consumption and its health and social consequences …". Clearly, it is necessary to have data about the burden attributable to the inappropriate use of alcohol. However, there is the danger that the resolution will have the effect of the allocation of substantial resources to generating these data. We have sufficient knowledge of the burden caused by the harmful use of alcohol. Now is the time to focus on reducing the extent of alcohol abuse. This can be achieved through developing, implementing and evaluating interventions at the levels of the person, the proximal context and the distal context.

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"Public health problems caused by harmful use of alcohol"

COMMENTARY

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The recent WHO resolution (WHA 58.26) is a landmark resolution for developing countries particularly the continent of Africa. Research reports in the last half of the 20th century in Africa show alcohol consumption to be on the increase in the populations of both young and old (Odejide et al., 1987; Parry, 1999) with industrial beverages replacing traditional and locally produced beverages (Gureje, 1999). Also, public health problems (social, psychological, physical and emotional) are increasing without a corresponding increase in treatment resources (Ohaeri & Odejide, 1992). Similarly, within the last four decades, a high prevalence rate of alcohol use and abuse has been reported among young persons with early onset of drinking age (10 -13 years)(Parry et.al. 1999; Odejide et.al., 2005) .Alcohol availability, peer pressure, family use of alcohol and advertisement of alcohol beverages have been found to be associated with early alcohol use (Odejide et al.,1989). Occasional use was reported to be the pattern of alcohol use among young persons with excessive use when alcohol is free (Leggett, 2004). Excessive use (intoxication, binge drinking) has also been associated with the development of neuro-psychiatric conditions, physical injuries, unsafe sexual behaviours, and the use of other psychoactive drugs.

Most of these findings from different African countries were from localized studies, not borne out of national systematic studies. As was observed in the WHA resolution, we need to know if alcohol is the leading public health risk factor in Africa. In the hierarchy of disease burden in Africa, what position does alcohol consumption hold and what is the disability adjustment life years (DALYs) lost, due to alcohol in Africa? What is the contribution of alcohol consumption to diseases, injuries, disabilities, and premature deaths in Africa? What is the economic loss to societies resulting from harmful alcohol consumption such as cost to health services, social welfare, criminal justice systems, loss of productivity and reduced economic development? These are areas of research challenges to African scientists.

The WHA resolution also highlights the relevant evidence-based alcohol policy formulation, cost-effective intervention measures and best prevention practices. As for alcohol policy formulation, African nations lean more towards policies on alcohol production, distribution and marketing. This appears understandable since the emphasis is on

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boosting the economy of the respective African countries (Parry, 2000). Alcohol-related harm among people misusing alcohol is less appreciated. Hence, the apparent lack of enforcement of minimum drinking age for children, the limit of alcohol use when driving, and the control of availability. There is also no political will to make the cost of alcohol prohibitive to the populace. These are some of the alcohol prevention measures listed in the resolution but poorly established in many of the African countries. Since African countries are members of World Health Assembly, equivalent resolutions ought to be formulated in their respective countries for the purpose of implementation.

The alarm raised in the resolution on the trend towards hazardous drinking, particularly by young people has been substantiated in many African countries (Parry, 2000; Jernigan, 2001; Odejide et al., 2005) .Youths are the future of any nation ,and they form 30 to 40 % of any African nation. Therefore, no effort should be spared in formulating policies and programmes that will prevent young people from being exposed to uncontrolled use of alcohol. Onset of drinking should be delayed until later adolescence when right decisions on the use of alcohol can be made.

The contribution of the resolution on alcohol intervention measures for dealing with alcohol–related problems is noteworthy for African countries. It is important to place alcohol needs on other national and local planning agendas. Furthermore the "10 best practices" advocated by the WHO expert Committee (2001) can be a useful guide to African countries. Some of these are minimum legal age to buy alcohol, restrictions on hours or days of sale, restrictions on the density of sales outlets, taxes on alcohol, sobriety checks, lowered limits for blood alcohol concentration, suspension of licenses for driving under the influence of alcohol, and brief interventions for hazardous drinkers. For effective prevention measures, it is also necessary to organize open consultations with representatives of industry, and agriculture and trade sectors of alcoholic beverages.

A lot of concern has been expressed on the high prevalence of HIV/AIDS in Africa particularly the Sub-Saharan African countries (Odejide, 2001) . In the WHA resolution, it is said that there is an association between alcohol use and HIV/AIDS. Since there is less of intravenous drug use in Africa and heterosexual practice is the predominant sexual relationship (Adelekan, 2001), it will certainly contribute to knowledge if studies are carried out in Africa to find out the possible association between alcohol consumption and HIV infection. Also, excessive drinking by women of childbearing age may increase the risk of HIV infection, unwanted pregnancies and prenatal exposure of a fetus to HIV and a wide range of birth defects and developmental abnormalities.

Since evidence is now accumulating that the implementation of appropriate strategies and measures can significantly lessen the frequency of alcohol-related problems at local and national levels (Jernigan,2001) , it is only logical for African countries to have a broad network of collaboration with national and international organisations with a view to learning more about 'best practices' and how they are implemented. Through such collaborations, there will be improvement in our system of collecting, compiling and disseminating scientific information on alcohol consumption, preparation of global and regional research and policy initiatives on alcohol and promoting identification and management of alcohol use disorders in primary health care and

other health care settings. It would also enhance the capacity of health care professionals to address problems of their patients associated with harmful patterns of alcohol consumption.

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"Public health problems caused by harmful use of alcohol"

COMMENTARY

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The Fifty-eighth World Health Assembly Agenda item 13.14.25 of May 2005, came at a time when countries in Africa, particularly Uganda are faced with a lot of challenges related to public health problems caused by harmful use of alcohol; and little attention appears to be given to the problems posed.

Uganda is rich in the supply of alcoholic beverages. There are plenty of factory-produced beers; 11-13 million crates of beer, on average, are produced annually contributing to almost 10% of the internal revenue of the government. There are also large amounts of informally produced alcoholic beverages which are unrecorded. It is such alcoholic beverage that are consumed by the majority of the population. Brewing and distilling of alcohol is also an accepted economic activity by the general population. Drinking is central to the economy and social life of the family and community. Presently, brewing and selling of beer are nearly the only economic strategy available to rural women. The money raised is used to pay for school fees and ton meet the day-to-day home expenses. Poverty and lack of income generating activities for women are the principal reasons for alcohol production. Such locally produced beverages include beers and spirits, some of which contain toxic impurities.

The consumption of local alcohol in Uganda needs to be located in a wider context of production relations and changes that have taken place in social, economic, cultural and political life in society. There is evidence to show an association between health outcomes and a history of alcohol consumption including high morbidity and mortality rates, and others have attributed high alcohol consumption to unemployment, cultural and political instability, such as in the northern region which has experienced a 20-year-old civil strife and has the highest proportion of women that drink alcohol.

Drinking alcohol is associated with an increased chance of being infected with HIV (Mbulaiteye et al., 2000), and poor general physical and mental health. Other risky behaviours and violence are also correlates of alcohol consumption. Under the influence of alcohol, people are less careful in choosing sexual partners and less conscientious about the use of condoms or any form of family planning. Domestic violence level is high in rural Uganda and research has linked it to alcohol consumption. Disability and deaths caused by alcohol-related traffic accidents are still un-quantified in

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Uganda although the country is rated second in the number of traffic accidents per capita in Africa after Ethiopia.

In Uganda addressing issues of public health related to alcohol consumption is the function of the health department which focuses more on treating symptoms rather than addressing prevention at various levels. Alcohol laws have not been reviewed since 1964; existing laws are weak, not enforced and the country has no clear policy on alcohol. The cultural acceptability of drinking undermines most efforts by the public and civil society. Uganda was recently taken by surprise when data from the WHO Global Alcohol Database showed the country had the highest level of per capita consumption of alcohol in Africa (WHO, 2004). The coordinator of mental health in the Ministry of Health took notice of this and commented on the lack of a national alcohol policy and the weak and poor enforcement of existing laws.

There appear to be varied interests in issues related to alcohol leading to little attention to addressing problems even when these are acknowledged. The WHO agenda on public health problems caused by harmful use of alcohol is very elaborate and countries like Uganda need to consider them seriously. Efforts should be directed through international cooperation, evidence based strategies and interventions, policies and development of regional information systems and collaboration with civil society. Unless this WHO agenda item is given the attention it deserves Uganda stands a chance of sliding further in gains made in the social and health fronts.

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ANNOUNCEMENTS

ISAJE International Society of Addiction Journal Editors

REVIEWERS NEEDED FROM LOW AND MIDDLE INCOME COUNTRIES

Researchers from low and middle income countries are underrepresented among scientists who contribute papers to or review articles for journals in the addiction field. There is increasing recognition that scholars in these countries can contribute unique perspectives and expertise to the mission of these specialized journals.

The International Society of Addiction Journal Editors (ISAJE) is developing a database of researchers in low and middle income countries whom editors can invite to review papers and provide other scholarly services.

Interested researchers should send their CVs including a comprehensive list of their publications. The following information should appear on the first page of the CV: full name, current position, institutional address, phone and fax numbers, e-mail address, areas of research competence (e.g. epidemiology, pharmacology), editorial board membership(s) and journals for which you have reviewed previously.

This information will be considered for inclusion in a database that will be made available only to editors of ISAJE member journals. All submissions will be assessed by ISAJE and the society reserves the right to reject the application of anyone deemed unqualified for inclusion in the database. Journal editors will then be responsible for the decision to contact any researcher for an assignment.

Please send your application to Mrs Susan Savva, ISAJE Executive Officer, National Addiction Centre PO48, 4 Windsor Walk, London SE5 8AF, United Kingdom. Fax (+44 20 or 020) 7703 5787; s.savva@iop.kcl.ac.uk

International Society of Addiction Journal Editors (ISAJE) and World Health Organization (WHO) announce the

ISAJE/WHO YOUNG SCHOLARS AWARD

The award scheme aims to provide recognition for the contributions to addiction science of young scholars from developing countries and to promote their involvement in the field.

Applicants should be less than 35 years old, must hold an academic or research position in a low or middle income country, and should be the lead author in the paper being submitted for the award. The award is for the best paper published the previous year by a young scholar in a developing country on any topic related to addiction.

The successful applicant will receive a certificate and financial support to attend an international scientific or clinical meeting, to be chosen by the winner in consultation with ISAJE.

Further details including the application procedure may be obtained at www.isaje.net or from the President of ISAJE, Professor Ian Stolerman, Institute of Psychiatry PO49, De Crespigny Park, London SE5 8AF, United Kingdom (i.stolerman@iop.kcl.ac.uk). The full application for the first (2006) award must be submitted to reach to the President of ISAJE by 15 July 2006. Applications for the 2007 award will be accepted after this date.

The award is sponsored by ISAJE, the World Health Organization and Virginia Commonwealth University.

Seventh African Conference on

DRUGS AND SOCIETY

Announcement & Call for Participation

The African Centre for Research and Information on Substance Abuse (CRISA) invites researchers, health care professionals, policymakers, other experts, NGOs and students interested in all aspects of substance abuse (including alcohol, tobacco and illicit drugs) to a conference on the theme:

RESPONDING TO ALCOHOL AND DRUG PROBLEMS:
A FOCUS ON EFFECTIVE POLICIES AND INTERVENTIONS

Date: 26 & 27 July 2006
Venue: Chelsea Hotel, Abuja, Nigeria
Registration: N6000 ($50 for international participants, and N2000 for students)

For participants who wish to present papers at the conference, the deadline for abstracts is 30 May 2006 and the full papers are due on 30 June 2006.

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