World Health Organization
REGIONAL OFFICE FOR Africa

AFR/RC60/4
15 June 2010

REGIONAL COMMITTEE FOR AFRICA

ORIGINAL: ENGLISH

Sixtieth session
Malabo, Equatorial Guinea, 30 August–3 September 2010

Provisional agenda item 7.2

REDUCTION OF THE HARMFUL USE OF ALCOHOL: A STRATEGY FOR THE WHO AFRICAN REGION

Report of the Regional Director

Executive summary

1. Public health problems related to alcohol consumption are substantial and have a significant adverse impact on both the alcohol user and the society. In the African Region, the alcohol-attributable burden of disease is increasing with an estimated total of deaths attributable to harmful use of alcohol of 2.1% in 2000, 2.2% in 2002 and 2.4% in 2004. However, with new evidence suggesting a relationship between heavy drinking and infectious diseases, alcohol-attributable deaths in the African Region could be even higher.

2. No other product so widely available for consumer use accounts for so much premature death and disability as alcohol. Alcohol-related problems and their adverse impact result not only from the quantities of alcohol consumed but also from the detrimental patterns of use. Effective and adequate policy measures and interventions, surveillance mechanisms and public awareness need to be developed or enforced in the Region.

3. The Strategy aims to contribute to the prevention and reduction of harmful use of alcohol and related problems in the Region. It reviews the regional situation and provides a framework for action in Member States and for the Region, taking into consideration the global developments. The Strategy is intended to provide balanced guidance on priority interventions to be implemented, taking into account the Region's economic, social and cultural diversity.

4. The Regional Committee is invited to review and endorse this proposed Strategy.

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ANNEX

INTRODUCTION

1. Public health problems related to alcohol consumption are substantial and have a significant adverse affect on people other than the alcohol user. Intoxication and the chronic effects of alcohol consumption can lead to permanent health damage (e.g. fetal alcohol syndrome, delirium tremens), neuropsychiatric and other disorders with short- and long-term consequences, social problems (e.g. unemployment and violence) and trauma or even death (e.g. road traffic accidents). There is also increasing evidence linking alcohol consumption with high-risk sexual behaviour and infectious diseases such as tuberculosis and HIV.

2. The alcohol-attributable burden of disease is increasing in the African Region, with an estimated total of deaths attributable to harmful use of alcohol of 2.1% in 2000, 2.2% in 2002 and 2.4% in 2004.[1] However, with new evidence suggesting a relationship between heavy drinking and infectious diseases, alcohol-attributable deaths in the African Region could be even higher.

3. In 2007, at the Fifty-seventh session of the WHO Regional Committee for Africa, Member States expressed concern about the impact of harmful use of alcohol[2] on public health and emphasized the need to strengthen response in the Region. At the Fifty-eighth session of the Regional Committee, a set of evidence-based actions that would serve as a basis for developing national policies was adopted[3] and countries called for a Regional Strategy.

4. At the global level, Member States requested the submission to the Sixty-third World Health Assembly, in 2010, of a global strategy to reduce harmful use of alcohol.[4] In the process of collaboration to develop the draft global strategy, the WHO African Region has gathered information from Member States about existing evidence-based strategies and their applicability globally and in the Region, taking into account local needs and various national, religious and cultural contexts including national public health problems, needs and priorities, and differences in Member States' resources, capacities and capabilities.[5]

5. This document analyses the situation in the African Region and proposes a strategy for appropriate action. The strategy builds on existing World Health Assembly resolutions and on discussions at regional and global levels, proposing a set of public health interventions aimed at reducing the harmful use of alcohol.

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[1] Rehm et al. Global burden of disease and injury and economic cost attributable to alcohol use and alcohol-use disorders. *Lancet* 2009; 373: 2223–33.

[2] Harmful drinking encompasses drinking that is detrimental to health and has social consequences for the alcohol user, the people around the alcohol user and society at large, as well as patterns of drinking that are associated with increased risk of adverse health outcomes.

[3] WHO, Harmful use of alcohol in the WHO African Region: situation analysis and perspectives (AFR/RC57/14), Brazzaville, World Health Organization, Regional Office for Africa, 2007; WHO, Actions to reduce the harmful use of alcohol (AFR/RC58/3): Brazzaville, World Health Organization, Regional Office for Africa, 2008.

[4] Resolution WHA61.4: Strategies to reduce the harmful use of alcohol. In Sixty-first World Health Assembly, Geneva, May 2008, World Health Organization.

[5] Report on the WHO Regional Technical Consultation on a Global Strategy to Reduce Harmful Use of Alcohol. WHO Regional Office for Africa, 2009.

SITUATION ANALYSIS AND JUSTIFICATION

6. Although alcohol constitutes an important source of income and its use is part of social and cultural practices and norms in many countries of the Region, alcohol-related health and social costs cannot be ignored. No other product so widely available for consumer use accounts for so much premature death and disability as alcohol. Alcohol-related problems and their adverse impact result not only from the quantities of alcohol consumed[6] but also from the detrimental patterns of use. Public awareness, especially of specific types of harm, is low in many of the countries.

7. Recent studies and surveillance data provide an insight into harmful use of alcohol in the Region.[7] The two main characteristics that describe alcohol consumption patterns in the Region are the high level of abstention in some countries and the high volume of consumption by drinkers, with severe health and social consequences. Overall, the adult *per capita* consumption of alcohol in the WHO African Region in 2004 was estimated at 6.2 L of pure alcohol.

8. In 2008/2009, countries collaborated in the WHO Global Survey on Alcohol and Health. This process showed that out of the 46 countries in the Region, only 10 countries had recent alcohol policies and 16 countries had advertising regulation. In many countries regular and systematic surveillance and monitoring systems with appropriate financial and human resources are still non-existent; basic indicators are not defined; and even when data are available they are often scattered among different departments and therefore difficult to collect.

9. Adequate policies are few and coordination with relevant sectors and within government is lacking. Multisectoral approaches involving the private sector, professional associations, civil society, the informal sector, traditional healers, political and community leaders are not developed. At the community level there is a low level of awareness and nongovernmental organizations are not engaged in addressing the problem.

10. Within the health system, alcohol problems are often not recognized, tend to be minimized or are not properly addressed due to lack of appropriate skills, knowledge, adequate resources or lack of coordination and integration among different health programmes.

11. Although alcohol and illicit drugs share common neurobiological, psychological and behavioural characteristics, their related health hazards are often seen and treated separately, thus increasing the resources needed to address substance abuse in general. In the Region there is a lack of integrated approaches to dealing with substance use disorders.

12. The absence or misplacement (in psychiatric hospitals) of effective and adequate interventions, ranging from brief interventions in primary care to more intensive treatment in specialized settings is a reality in the African Region. Access to prevention, screening and treatment services and

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[6] Estimated mean of 20.24 litres of pure alcohol per resident alcohol user aged 15 or over, higher than the global consumption rate estimated to be 15.8 litres. In Rehm, J et al., Alcohol, social development and infectious disease. Ministry of Health and Social Affairs, Sweden, 2009.

[7] Global Information System on Alcohol and Health – GISAH, http://apps.who.int/globalatlas/default.asp; South African Community Epidemiology Network on Drug Use (SACENDU), http://www.sahealthinfo.org/admodule/sacendu.htm; Roerecke, M., Volume of alcohol consumption, patterns of drinking and burden of disease in sub-Saharan Africa, 2002. African Journal of Drug and Alcohol Studies, 7(1), 2008. Obot IS, Alcohol use and related problems in sub-Saharan Africa, *African Journal of Drug and Alcohol Studies* 5(1): 17–26, 2006.

psychosocial care for patients and families are severely hampered by low or nonexistent budgetary allocations, general weakness of health systems and lack of public health infrastructure.

13. Interventions such as enactment of drinking and driving laws, taxation, restrictions on advertising and community information are already being used in the Region. Even so, they are used in an *ad hoc*, informal and fragmented manner, and frequently lack adequate control and enforcement systems.

14. It is estimated that unrecorded consumption accounts for about 50% of the overall consumption of alcohol in African countries.[8] Despite concerns about the potential health hazards arising from unregulated or illicit production, there is little information on the problem and the issue is often overlooked or not given the necessary consideration in policy development.

Justification

15. The reduction of public health problems caused by harmful use of alcohol and the required interventions by governments to control alcohol-related harm are an essential step to improving the health of the populations in the Region. Important and effective alcohol control measures are available.

16. Therefore, the development and implementation of a regional strategy in the African Region is a timely and needed response. At the Fifty-eighth session of the WHO Regional Committee, in 2008, Member States requested WHO to support the development, implementation and evaluation of national policies and plans to combat the harmful use of alcohol and, to this end, submit a Regional Strategy to the Committee.

17. The magnitude and nature of alcohol-related harm clearly underscore the need for concerted action not only at national level, but also at regional and global levels. Strengthening national and region-wide capacities will enhance the capacity to respond effectively to the magnitude of the problem.

THE REGIONAL STRATEGY

Aim and objectives

18. The aim of this Strategy is to contribute to the prevention or at least reduction of harmful use of alcohol and related problems in the African Region.

19. The specific objectives are:

(a) to provide a platform for advocacy for increased resource allocation, strengthening of action and intersectoral and international collaboration in responding to the problem;

(b) to provide guidance to Member States for the development and implementation of effective alcohol control policies based on public health interests;

[8] WHO, *Global Status Report on Alcohol,* Geneva 2004: World Health Organization Department of Mental Health and Substance Abuse.

(c) to address low awareness on alcohol related harm in the community;

(d) to promote the provision of adequate health-care interventions for preventing harmful use of alcohol and managing the attendant ill-health and conditions;

(e) to encourage the creation of systems of systematic surveillance and monitoring of alcohol production, consumption and harm in countries.

Guiding principles

20. This strategy is based on five key principles which should guide policy development at all levels in countries:

(a) Policies should be based on **best available evidence** and be sensitive to national contexts.

(b) Citizens, specially those at risk, should be **protected** from alcohol-related harm, particularly harm from other people's act of drinking, and from pressures to drink.

(c) Strong **political commitment, leadership and appropriate funding** will ensure that effective approaches to alcohol problems are formulated, taking into account public health principles.

(d) Actions should be undertaken in a **coordinated, strategic and integrated** manner jointly with key agencies and with appropriate involvement of all partners and stakeholders at all stages of decision-making, planning, implementation and evaluation.

(e) **Equitable and non-stigmatized access** to effective prevention and care services should be given to all individuals and families; human rights should be respected.

Priority interventions

21. **Develop and implement alcohol control policies.** Alcohol control policies, legislation and regulations should be based on clear public health goals and best available evidence and should reflect national consensus regarding their implementation at country level. The policies require strong leadership and political commitment and are necessary to ensure transparency, continuity and sustainability of the measures adopted by all the relevant partners. Policy options can be grouped into the following areas:

22. **Leadership, coordination and partners' mobilization.** Coherent, consistent and strong action with relevant actors such as producers, retailers, health workers and communities, is fundamental for effective implementation and reinforcement of national policies and action plans. It is necessary to clearly define partners' areas of contribution, their roles in implementation, their responsibilities and mandates and the relevance of their support in line with national priorities. An appropriate coordination mechanism is therefore important to bring together all intervening agencies, organizations and stakeholders.[9] The capacities of local authorities and the role of NGOs in this drive should be strengthened.

[9] Policies to reduce the harmful use of alcohol must reach beyond the health sector and engage such sectors as development, transport, justice, social welfare, fiscal policy, trade, agriculture, consumer policy, education and employment.

23. **Awareness and community action.** Provision of information for decision-makers and communities should be strengthened in order to increase commitment to public health protection, recognition of alcohol-related harm in the community and active participation in policy measures and in implementation. A dedicated day or week should be established to increase community and political awareness.

24. **Information-based public education**. Providing alcohol education and information to the public, and religious and community leaders is fundamental to support alcohol control policy measures and to increase community participation in their implementation. Efforts are needed to improve its quality and keep it under the responsibility of public bodies.The harmful use of alcohol should be integrated in the school curriculum. Community action programmes should be usefully combined with interventions in schools and other settings such as workplaces to mobilize public opinion to address local determinants of the increasing alcohol consumption and related problems. Local community action should be based on rapid assessment and involve the community and young people in problem identification, planning and policy implementation.

25. **Improvement of health sector response**. Efforts are needed to improve health sector response through adequate training, infrastructures and funding and by strengthening integrated approaches to alcohol problems at different levels of the health system, and in both urban and rural areas. Early detection and management of alcohol-related harms at primary care level and effective treatment of people with drinking-related disorders are vital. Health professionals have an essential role to play in educating the community and mobilizing and involving players within and outside the health sector.

26. **Strategic information, surveillance and research.** Surveillance and monitoring, research and knowledge management play pivotal roles in alcohol control. Countries should establish information systems to monitor alcohol production, consumption and related health, social and economic indicators as well as the application of existing laws and regulations and their effect on the general population. Alcohol indicators with direct relevance to national policy priorities need to be identified and opportunities to integrate alcohol indicators into other surveillance systems should be adequately utilized. New partnerships with research entities should be explored and operational research should be promoted as an integral part of alcohol control in order to map unrecorded drinking patterns and document effective alcohol policy interventions.

27. **Enforcing drink-driving legislation and countermeasures.** Drink-driving countermeasures including setting and enforcing a maximum limit of 0.5 g/l for blood alcohol concentration,[10] frequent random-breath testing by the police and sobriety check-points should be a high-priority intervention. The visibility of such measures, rigorous and sustained enforcement of existing legislation accompanied by regular public awareness and information campaigns have a sustained effect on drink-driving.

28. **Regulating alcohol marketing.** There is a need to regulate the content and scale of alcohol marketing and the promotion of alcoholic beverages, in particular sponsorship, product placement, as well as internet and promotional merchandising strategies. Public agencies or independent bodies should closely monitor the marketing of alcohol products. Effective systems of deterrence should be put in place and enforced.

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[10] Over the years, the stipulated maximum level has been lowered. It is as low as zero or 0.2g/l in a number of countries, and 0.5g/l or lower in most countries in Europe.

29. **Addressing accessibility, availability and affordability of alcohol.** Commercial licensing systems that regulate the production, importation and sale (wholesale and retail) of alcoholic beverages should be put in place. Stricter regulation of the formal and informal sector and licensing of traditional outlets is crucial to ensure that beverages meet safety requirements and that they are controlled in order to protect most vulnerable groups such as adolescents and the low income population. There is a need to enact and enforce legislation on the minimum age at which alcohol drinking and purchasing is authorized and to restrict the times and places of sale. At the point of sale in supermarkets, alcoholic beverages should not be displayed together with water and other non-alcoholic drinks. Taxation should be increased[11] with regular review of prices, based on the inflation rate, income levels and alcohol contents. To that end, adequate enforcement mechanisms should be established.

30. **Addressing illegal and informal production of alcohol.** The illegal and informal production of alcoholic beverages[12] is seen as a major impediment to the adoption of effective policies. Nevertheless, this situation impacts on health and on tax revenues and reduces the ability to control production. This needs to be addressed and included in the national policy response. Some measure of quality control is needed including licensing and training of producers and introduction of appropriate enforcement measures. In addition, it is important to raise awareness among the general population and consumers about the dangers inherent in the consumption of certain forms of alcoholic beverages and to find funding to assist local informal producers to establish alternative income-generating business.

31. **Resource mobilization, appropriate allocation and integrated approach.** Resources are crucial to the implementation of the measures needed to reduce alcohol-related problems. These resources, to be mobilized by governments, from individuals, the private sector and international partners, should be available on sustainable basis and distributed among the different levels of the health system according to relative needs. There is a need to include harmful use of alcohol as a priority in the health development plans of countries. The development of an integrated approach to prevention and treatment can facilitate the use of existing resources in other areas or programmes for implementing the necessary interventions.

Roles and responsibilities

32. Countries should:

(a) develop and implement comprehensive alcohol policies that are evidence-based and focus on public health interest; to facilitate this task a coordination body such as a national alcohol council should be established;

(b) mobilize and allocate resources for alcohol policies;

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[11] Several studies have found mean price elasticities of –0·46 for beer, –0·69 for wine, and –0·80 for liquor, meaning that if the price of beer is raised by 10%, beer consumption would fall by 4.6%; if the price of wine was increased by 10%, wine consumption would fall by 6.9%; if the price of spirits was increased by 10%, consumption of liquor would fall by 8.0%. Anderson, P et al. Effectiveness and cost-effectiveness of policies and programmes to reduce the harm caused by alcohol. *Lancet* 2009; 373: 2234–46.

[12] Illegally produced alcohol refers to alcoholic beverage not produced according to law or not authorized by law; Informally produced alcohol means alcoholic beverages produced at home or locally by fermentation and distillation of fruits, grains, vegetables and the like, and often within the context of local cultural practices and traditions.

(c) create public awareness on alcohol-related harm and mobilize communities to support the implementation of evidence-based policy;

(d) adopt and enforce regulations and legislation aimed at reducing alcohol consumption and related harm and strengthen clinical practices;

(e) promote and strengthen independent research in order to assess the situation and monitor national trends and the impact of adopted policy measures;

(f) reinforce training and support for all those engaged in alcohol control policy activities in an attempt to increase knowledge and skills and facilitate policy implementation;

(g) establish systems for monitoring and surveillance in order to capture the magnitude of alcohol consumption and related health, social and economic harms, provide information on existing laws and regulations and contribute to the exchange of alcohol surveillance information between regions and countries.

33. WHO and partners should support countries by:

(a) developing and providing evidence-based tools and guidelines for policies, interventions and services;

(b) maintaining a regional information system and providing technical support to Member States in surveillance, monitoring and evaluation of alcohol consumption and related problems;

(c) providing them technical support in the development and review of effective and comprehensive alcohol policies and strategies;

(d) facilitating the creation and capacity building of Intercountry networking for exchange of experiences;

(e) facilitating effective linkages**,** cooperation and collaboration among international agencies, partners and stakeholders.

Resource implications

34. Resources are required to support the implementation of this strategy, particularly for the implementation of surveillance and recording systems, policy monitoring including enforcement measures, research and early detection and treatment components. This will reduce costs in the long term. Furthermore, there is a need to ensure the availability not only of trained human resources at different levels of the health care system but also of treatment structures. In most countries in the Region part of the revenues gathered from alcohol taxes should be allocated to support the implementation of this strategy.

Monitoring and evaluation

35. Continuous monitoring and evaluation will be based on progress, outcome and impact measurements, formulated under a regional plan of action, and to be reported every two years to the Regional Committee. Progress monitoring indicators include:

(a) The availability and effective implementation of policies to reduce alcohol consumption and related harm;

(b) The implementation of sustainable national monitoring systems capable of collecting, analyzing and disseminating data for evidence-based policy decisions;

(c) The development and implementation of appropriate health care interventions at all levels of the health system, ranging from early interventions to adequate treatment.

36. Outcome and impact indicators will require the availability of data on trends and alcohol-related harm.

CONCLUSIONS

37. The African Region is faced with the growing burden of harmful alcohol consumption and lacks appropriate mechanisms to respond to this situation. The main challenge is to develop such mechanisms for effective implementation of national actions that will contribute to reducing harmful use of alcohol and strengthen global initiatives.

38. This strategy outlines actions needed to reduce alcohol-related harm and facilitate policy development and implementation at the country level. In order to reduce alcohol-related morbidity and mortality in countries, Member States are invited to take guidance from this document according to their specific needs and situation. This strategy will pave the way for action region-wide including stronger cooperation among Member States, stakeholders and partners. Strong advocacy and commitment at the highest political level are fundamental elements for its success.

39. The Regional Committee is invited to review and endorse this proposed strategy.

AFR/RC60/WP/2
15 June 2010

DRAFT RESOLUTION

REDUCTION OF THE HARMFUL USE OF ALCOHOL: A STRATEGY FOR THE WHO AFRICAN REGION

The Regional Committee,

Having examined the document entitled "Reduction of the harmful use of alcohol: A strategy for the WHO African Region";

Recalling World Health Assembly resolutions WHA58.26 on public-health problems caused by the harmful use of alcohol; WHA61.4 on strategies to reduce the harmful use of alcohol; and the adoption at the Sixty-third World Health Assembly, in May 2010, of the global strategy to reduce harmful use of alcohol;

Having considered the report of the Regional Director on "Harmful use of alcohol in the WHO African Region: situation analysis and perspectives" and on "Actions to reduce the harmful use of alcohol" respectively presented at the Fifty-seventh and Fifty-eighth sessions of the WHO Regional Committee for Africa;

Recognizing that the alcohol-attributable burden of disease is increasing in the African Region and that public health problems related to alcohol consumption are substantial and can adversely affect people other than the alcohol user;

Concerned about the increasing evidence linking alcohol with illicit drugs consumption and with high-risk sexual behaviour and infectious diseases such as tuberculosis and HIV/AIDS;

Noting the lack of public awareness and the low recognition of alcohol-related harm;

Conscious of the need to ensure government leadership in order to protect at-risk populations, youths, and people affected by harmful drinking of others;

Noting the existing opportunities to mobilize the community, the health sector and partners to improve surveillance and develop evidence-based interventions;

Mindful of the need to consider multisectoral approaches and coordinate with key intervening agencies, organizations and stakeholders;

1. ENDORSES the Regional Strategy to reduce harmful use of alcohol in the WHO African Region as proposed in Document AFR/RC60/PSC/4;

2. URGES Member States:

   (a) to acknowledge harmful use of alcohol as a major public health issue and accord it priority in their national health, social and development agendas;

(b) to develop, strengthen and implement evidence-based national policies and interventions and adopt and enforce necessary regulations and legislation in this area;

(c) to mobilize and ensure appropriate financial and human resources to implement national alcohol policies and consider using revenues resulting from alcohol taxes to support the implementation of this Strategy;

(d) to set up the necessary research, surveillance and monitoring mechanisms to assess performance in alcohol policy implementation and ensure regular reporting to the WHO Secretariat;

(e) to ensure intersectoral coordination through the creation of an intersectoral committee bringing together all relevant governmental sectors, agencies and governmental and nongovernmental organizations;

(f) to create public awareness on alcohol-related harm and encourage the mobilization and active engagement of all the social and economic groups concerned in reducing harmful use of alcohol;

3. REQUESTS the Regional Director:

(a) to continue to support and give priority to prevention and reduction of harmful use of alcohol and to increase efforts to mobilize necessary resources to implement this Strategy;

(b) to provide technical support to Member States in building and strengthening institutional capacity to develop and implement national policies and evidence-based interventions to prevent harm from alcohol use;

(c) to support further collection and analysis of data on alcohol consumption and its health and social consequences and reinforce the WHO regional information system on alcohol and health;

(d) to facilitate research on and dissemination of best practices among African countries through conferences and facilitate the implementation of this Strategy by organizing a regional network of national counterparts;

(e) to draw up a regional action plan for implementing this Strategy;

(f) to organize regional open consultations with representatives of the alcohol industry, trade, agriculture and other relevant sectors on how they can contribute to reducing harmful use of alcohol;

(g) to report on progress made in the implementation of the regional strategy to the Regional Committee every two years and at regional or international forums as appropriate.