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
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 sale), 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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