ALCOHOL USE AND RELATED PROBLEMS IN SUB-SAHARAN AFRICA

Isidore S. Obot*
Centre for Research and Information on Substance Abuse
Jos, Nigeria

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

* Address correspondence to: Isidore S. Obot, Ph.D., M.P.H., Centre for Research and Information on Substance Abuse (CRISA), P.O. Box 10331, University Post Office, Jos, Nigeria. E-mail: isobot@hotmail.com
a 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

<table>
<thead>
<tr>
<th>Countries</th>
<th>Percentage of past year abstainers</th>
<th>Recorded consumption (litres of ethanol per capita)</th>
<th>Unrecorded consumption (litres of ethanol per capita)</th>
<th>Drinking pattern score</th>
</tr>
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<tbody>
<tr>
<td></td>
<td>Total Male Female</td>
<td></td>
<td></td>
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</tr>
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<td>- - -</td>
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<td>-</td>
<td>-</td>
</tr>
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<td>-</td>
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<td>53.5 37.0 70.0</td>
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<td>- - -</td>
<td>9.33</td>
<td>4.7</td>
<td>3</td>
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<td>1.66</td>
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<td>3</td>
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<td>-</td>
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<td>1.71</td>
<td>-</td>
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<td>7.97</td>
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<td>0.8</td>
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<td>6.64</td>
<td>-</td>
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<tr>
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<td>3</td>
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<td>3.02</td>
<td>-</td>
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<td>9.0</td>
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Sources: WHO (2004); Rehm et al. (2004)
Table 2. Per capita alcohol consumption (in litres of pure alcohol) for selected African countries, 1961-2001

<table>
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<tr>
<th></th>
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<td>14.21</td>
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<td>4.91</td>
<td>9.51</td>
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<td>13.50</td>
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<td>19.47</td>
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<td>Zambia</td>
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<td>8.17</td>
<td>3.81</td>
<td>3.00</td>
<td>3.02</td>
</tr>
<tr>
<td>Zimbabwe</td>
<td>4.24</td>
<td>6.48</td>
<td>6.22</td>
<td>2.50</td>
<td>5.08</td>
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</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Countries</th>
<th>Heavy episodic drinking in the adult population</th>
<th>Heavy episodic drinking among 18-24 year-olds</th>
</tr>
</thead>
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<tr>
<td></td>
<td>M</td>
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<td>11.2</td>
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<td>Chad</td>
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<tr>
<td>Zimbabwe</td>
<td>10.1</td>
<td>0.9</td>
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</tbody>
</table>


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

<table>
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<tr>
<th>Country</th>
<th>Total</th>
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<th>Females</th>
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<td>5.8</td>
<td>1.0</td>
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</table>

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 (SEN DU) 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 (SEN DU, 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.

REFERENCES


World Health Organization Global Alcohol Database.