South Africa: alcohol today

In 1995 *Addiction* published an editorial on prospects for substance abuse control in South Africa [1]. This paper reflects on where the country is 10 years later.

**HISTORICAL BACKGROUND**

Alcohol has played a central and often controversial role in the life of South Africa since the arrival of European settlers. Initially a refreshment station was established at what was to become Cape Town, so that passing ships could take on supplies. Drunkenness, smuggling of liquor, gambling and violence became part of the daily life among inhabitants of what was nicknamed the ‘Tavern of the Seas’. Alcohol was exchanged for cattle and labour from indigenous populations. It was also used in the education of slaves, and played a pivotal role in ‘managing’ labour in certain sectors of the economy [2,3]. The period between the 17th and 20th centuries saw the growth of large wine and brewing industries that are now important players in the global alcohol market. The growth of illegal outlets (*shebeens*) in the second half of the 20th century served as a form of resistance to apartheid policies instituted to repress the black majority, as did the destruction of the government-run beerhalls in the 1970s. The complex role that alcohol plays in South African society is reflected further in the national Liquor Act of 2003 that aims to promote the development of a responsible and sustainable liquor industry in a way that will facilitate black economic empowerment, while at the same time reducing social and economic costs of alcohol abuse [4].

**LEVEL OF ALCOHOL CONSUMPTION, DRINKING PATTERNS AND TRENDS**

The level of adult, per capita, absolute alcohol consumption in South Africa estimated in 2000 at 10.3 l per year (12.4 l if estimates of unrecorded consumption are included) is substantially less than many countries [5]. However, the amount consumed per drinker is closer to 20 l per adult, among the highest in the world [6]. The South African Demographic and Health Survey of 1998 found that one-third of adult drinkers drink at risky levels over weekends [7]. Other harmful patterns of drinking include frequent drinking apart from meals, drinking in public places, communal drinking (i.e. drinking from a common container that is passed around) and high levels of drinking at community events such as weddings and funerals [3].

Based on production figures, there does not appear to have been any significant increase in overall alcohol consumption between 1994 and 2004 [8–10], but other changes have occurred, including a steady increase in per capita consumption of alcoholic fruit beverages and spirit coolers, and a decline in sorghum (traditional African) beer consumption. There was also an increase in consumption of natural wine, brandy and vodka, but then a decline in recent years to a level lower than in 1994. Malt beer consumption showed a similar trend, but more recently has shown an increase to above 1994 levels.

Comparison of data across different studies conducted at different times suggests an increase over time in the proportion of people drinking during the past 30 days among persons aged 15 and older [7,11], and an increase in life-time drinking among young, black African males and females [12,13].

**CURRENT LEVEL OF ALCOHOL PROBLEMS AND TRENDS**

Roughly one in four adult males and one in ten adult females experience symptoms of alcohol problems, and almost one in four high school students report past month binge-drinking; that is, drinking five or more drinks on one or more days [7,13]. The burden of alcohol-related mortality and trauma is extremely high, with just under half of all non-natural deaths in 2002 having blood alcohol concentrations greater than or equal to 0.05 g/100 ml and up to two-thirds of all cases tested annually at trauma units in three cities between 1999 and 2001 having breath-alcohol concentrations above that level [14,15]. While levels of alcohol-related mortality remained stable over that 3-year period, levels of alcohol-related trauma fluctuated [15].

Levels of fetal alcohol syndrome (FAS) in South Africa are the highest ever recorded. In research conducted in the Western Cape (Wellington), the prevalence of FAS among grade 1 students was found to be 41–46 per 1000 in 1997, rising to 65–74 per 1000 in 1999 [16, Viljoen et al., submitted].

Both qualitative and quantitative studies conducted among adolescents and young adults in Gauteng Province between 2002 and 2003 point to strong links between drinking and engagement in sexual risk behaviours. Specifically, alcohol use frequency, quantities consumed...
and problem drinking are associated significantly with the number of sexual partners a person has had and engagement in sex that was later regretted [17, 18]. Furthermore, almost one in five HIV patients studied at a large infectious disease clinic in Cape Town in 2003 met criteria for an alcohol use disorder. These patients were more likely to have symptomatic HIV infection [19].

TREATMENT PROVISION

Over time there has been a substantial drop in demand for treatment for alcohol-related problems [20]. For example, in Cape Town the proportion of patients in specialist substance abuse treatment centres who had alcohol as their primary substance of abuse decreased from 81% in the second half of 1996 to 39% in the second half of 2003 [20]. This is due mainly to the closure of certain state treatment centres focusing on people with alcohol-related problems and on the increased demand for services by younger illicit drug users [21]. The government’s plan has been to reduce tertiary care services while simultaneously increasing primary care services to patients with alcohol problems. This has generally not occurred, and services remain insufficient to meet demand, poorly distributed geographically and fragmented between health and social welfare sectors.

Since 1994 there has been a dramatic increase in the establishment of private treatment services (both licensed and unlicensed) [22, 23], but these are not widely accessible to the poor. Research has also identified a specific lack of access to services by women and black South Africans [24]. In terms of positive changes, an initiative to develop norms and standards for in-patient treatment centres has recently been completed [25], as well as a study to evaluate the training of health workers in early interventions for problem drinking [26]. Steps have also been taken to institute protocols for managing the detoxification of patients at secondary hospitals in several provinces.

PREVENTION POLICIES

Since 1994 there has been a substantial amount of activity aimed at preventing substance abuse in South Africa. In terms of public education, the government launched several broad initiatives, including, ‘I’m addicted to life’ and ‘Ke Moja’. Specific programmes have also been directed at pregnant women and at drunk drivers. The Department of Health’s Food-Based Dietary Guidelines also includes a section on sensible drinking. This department is also in the process of drafting regulations to restrict alcohol advertisements and to introduce warning labels on containers on the harmful effects of alcohol.

The recently promulgated national Liquor Act [4] outlaws the supply of liquor to people in lieu of remuneration or having the cost of liquor deducted from their remuneration. Applications for a licence to manufacture or distribute liquor require that consideration be given to whether applicants have subscribed to any industry code of conduct and to the applicant’s proposed contribution to combating alcohol abuse. It is expected that most provinces will liberalize restrictions on the retail selling of alcohol to draw into the regulated market unregulated outlets, while at the same time aiming over time to tighten up on various public health concerns (e.g. the sale of alcohol to minors). Steps are also being taken to address the unhygienic sale of alcohol via foil containers (papsakke).

National Treasury has moved forward in its target of increasing excise taxes on beer, wine and spirits over time to 33%, 23% and 43%, respectively, of the retail sales price, but it has reduced taxes on sorghum beer [27]. The Department of Transport has also decreased the permissible alcohol levels to 0.05 g/100 ml for drivers, but enforcement levels remain low.

THE RESEARCH BASE

The base for research on alcohol issues has grown considerably. In particular, the past decade has seen the establishment of the Alcohol and Drug Abuse Research Unit at the Medical Research Council and the Foundation for Alcohol-Related Research at the University of Cape Town. Local funding for research has grown, particularly with support from the Department of Health. However, much of the research has been epidemiological, rather than intervention-oriented. In particular, there is a need for increased funding for treatment and prevention-focused demonstration projects and also for monitoring and evaluation of existing interventions.

International funding for alcohol-related research (and collaboration) from organizations such as the US National Institute on Alcohol Abuse and Alcoholism, the US Centers for Disease Control and the World Health Organization has increased considerably and at least five international substance abuse conferences have been held in South Africa since 1994. The number of peer-reviewed scientific publications on substance abuse-related topics in South Africa has also increased [28].

AWARENESS OF ALCOHOL PROBLEMS AT PROFESSIONAL, PUBLIC AND POLITICAL LEVELS

Researchers and the media have contributed to the growing awareness of alcohol problems by the public and
politicians. While competing priorities have resulted in alcohol issues not being given sufficient attention, this is changing due to increasing awareness of the linkages with national priorities such as HIV/AIDS, crime/violence and development. Should calls for establishing a professional society for addiction professionals in South Africa be heeded, it will probably strengthen intervention efforts.

WHAT NEXT?

While awareness of alcohol problems and the need for action has grown considerably, much more emphasis needs to be given to facilitating policy implementation, including making the necessary resources available, ensuring effective leadership and speeding up the pace of implementation in general. Lower priority should be given to educational campaigns in future, as there is little evidence to support their effectiveness. Instead priority should be given to implementing a coherent liquor outlet policy; increasing random breath testing of drivers, counter-advertising and brief interventions and other forms of treatment for high-risk and hazardous drinkers; and addressing issues of training and accreditation of forms of treatment for high-risk and hazardous drinkers; and addressing issues of training and accreditation of treatment and prevention programmes [29]. Based on present realities it is likely that levels of alcohol consumption will increase in South Africa over the next decade. However, government responses are likely to be based more on best-practice principles and this should result in a stabilization or even a reduction in levels of alcohol-related harm. An increase in intervention-oriented research is also likely to occur and to contribute positively to alcohol-related policy and intervention practices.

References


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