



**Report on Alcohol Policy Seminar
Midrand Gauteng, South Africa
July 18-20, 2006**

Prepared by

Ernst Buning

Monica Gorgulho

Lusanda Rataemane

More information:

Ernst Buning
Quest for Quality
Vijzelstraat 77
1017 HG Amsterdam,
The Netherlands
tel: +31 20 3303449
fax: +31 20 3303 450
info@q4q.nl

Monica Gorgulho
Dinamo
Alameda Madeira, 258 cj 604
06454-010 Alphaville
Barueri- SP, Brazil
Phone/fax +55 11 4195-0335
info@dinamo.org.br

Lusanda Rataemane
Mehadic
P.O. Box 32922,
Glenstantia
0010 South Africa
Tel: 082 371 3915
Fax +27 12 998 5947
lrataema@mweb.co.za

Alcohol Policy Seminar (APS) is a joint project of the International Harm Reduction Association (IHRA), Quest for Quality BV (Q4Q), Dinamo - Reliable information about drugs and related issues (Dinamo) and the International Center for Alcohol Policies (ICAP).

INTRODUCTION

The concept of the **Alcohol Policy Seminar (APS)** was developed by 4 organisations:

- The International Harm Reduction Association (IHRA) – www.ihra.net
- Quest for Quality BV (Q4Q), Amsterdam, the Netherlands – www.q4q.nl
- Dinamo, Reliable information about drugs and related issues, Sao Paulo, Brazil – www.dinamo.org.br
- The International Centre on Alcohol Policies (ICAP), Washington, USA – www.icap.org

Background information about APS can be found on www.alcoholseminar.org

The basic principle of APS is to assist (local) key players to develop effective alcohol policies and interventions through

- (1) an assessment of the (local) situation,
- (2) a three seminar which includes stakeholders from different areas and leads to a concrete action plan
- (3) provide assistance in implementing the action plan.

On July 18-20, 2006, the first APS took place at the Eskom Convention Centre in Midrand Gauteng, South Africa. The local organisation was done by Lusanda Rataemane from Mehadic. The international group was represented by Ernst Buning (Q4Q/IHRA) and Monica Gorgulho (Dinamo/IHRA). Around 60-70 people participated in the seminar, representing a large range of organisations (NGO's, Governmental bodies, Universities and the Alcohol Industry). The Seminar was made possible through a grant from ICAP.

This report summarizes the main findings.

DAY ONE

After the official opening by Lusanda Rataemane, 5 presentations were delivered. Each speaker had 20 minutes followed by 10 minutes for questions and discussion. The sessions were chaired by *Ray Eberlein*.

The speakers were:

1. Ernst Buning (Q4Q/IHRA)
2. Prof. Solly Rataemane (Medunsa)
3. Dr. N. Masilo (Medunsa)
4. Rev Reuben Mapoo and Shamim Garda (SANCA)
5. Ray Eberlein (CAD & CDA)

In the following, brief summaries of the presentations are given. Power Points are available on request.

Ernst Buning: Introduction to APS

The history of APS was provided: when doing work in Latin America around local drug policy development (Latin American Travelling Seminar-LATS) the question about alcohol kept on popping up. Based on this, the 1st International Conference on Alcohol and Harm Reduction was organized in Recife, Brazil, in 2002, followed by a second conference in Warsaw (2004) and a planned conference in Cape Town (October 2006). A book on Alcohol and Harm Reduction was published in 2003. This book was translated into Portuguese and Spanish in 2004. In 2005, a conference report on the 2nd conference was published. The conferences showed a clear need for policy development on a local level. This led to the initiative of APS.

A brief description of the various partners was given and the contributions of each of them in the development of APS (international networks, experiences with LATS,

expertise with harm reduction, work in transitional countries, expertise with organizing conferences and seminars, development of modules on alcohol by ICAP). A brief overview of the modules was given and participants received a print-out of the modules (see www.icap.org)

The objectives of APS are:

- Getting alcohol higher on the public agenda
- Addressing local challenges
- Making use of existing expertise
- Working in partnership (win-win situation)
- Work towards a concrete and practical action plan

In the last part of the presentation, some future developments were mentioned, such as a round table session at the 3rd International Conference in Cape Town, where the experience on APS in South Africa will be presented and the plans for organizing more alcohol seminars in various parts of the world.

Prof. Solly Rataemane: Epidemiology of alcohol abuse in South Africa

Firstly, background information on South Africa was provided: It is a multicultural and multi-religious society with 9 provinces (autonomous), a population of 45 million with 11 official languages. South Africa has a high rate of unemployment, illiteracy and HIV/Aids infection.

There are a number of alcohol research institutes: Medical Research Council, Human Sciences Research Council, CSIR (For Scientific and Industrial Research), FARR (In relation to FAS), Universities / Tertiary Hospitals.

Public Health hazards related to alcohol abuse are:

- Driving offences
- Criminal behaviour
- Other forensic history
- Suicidal behaviour
- Linkages to sexual violence and other forms of violence
- Employment status
- Occupational hazards

Cultural influences on alcohol use are:

- Male > females
- Religion (Christianity/Islam)
- Rights of passage (youth)
- Traditional functions
- In-built age limitations
- Educational status
- Economic status
- Blending with advertising
- Still high number of abstainers and moderate drinkers

Subsequently, data were presented on the demand for treatment for substance abuse in various countries in Sub-Saharan Africa. In South Africa, around 50% of patients in treatment have alcohol as their primary drug of abuse. The numbers were stable in the period 2001 – 2003.

Thereafter, information was provided about the Central Drug Authority of SA (CDA), which is the key implementing authority. Some main points of CDA: it is multi-ministerial and includes representation from NGOs, experts in the field and other organs of civil society. It is hosted by the Minister of Social Development. The CDA is responsible for the implementation of the Drug Master plan, analyses the current situation and has a

range of tasks, amongst others to encourage new interventions, monitor and evaluate existing projects and assist in developing national policy through active participation in mini- drug master plans of various ministries.

Dr Masilo: bio-psycho-social effects of alcohol abuse

An overview was given on the DSM-IV criteria of alcohol abuse and dependence:

Abuse	Dependence
<ul style="list-style-type: none"> ▪ Failure to fulfil major role obligations ▪ Legal problems ▪ Social and interpersonal problems ▪ Hazardous situations 	<ul style="list-style-type: none"> ▪ Physiological effects ▪ Drug seeking behaviours ▪ Uncontrollable drinking ▪ Global impairment in all areas of functioning

There are various reasons to use alcohol, such as a social lubricant, for leisure, peer pressure or cultural norms. It can also contribute to psychological well-being, such as reduction of tension/stress or as a form of self medication e.g. depression and anxiety. There are also some medical beneficial effects of alcohol, such as the reduction of the risk of cardiovascular disease if used in moderation, the use of alcohol as an anaesthetic or antiseptic agent and the use of alcohol in salves and tonics.

Subsequently, the presenter listed adverse effects of alcohol grouped in different categories, such as biological, psychological and social.

Adverse biological effects

- *Central nervous system.* Examples: strokes (hemorrhagic type), dementias amnesic disorders, cerebellar degeneration, peripheral neuropathy, seizures
- *Cardiovascular system.* Examples: hypertension, cardiomyopathy
- *Endocrine system.* Examples: infertility, Foetal alcohol syndrome, gynaecomastia, impotence, pseudo-cushing’s syndrome
- *Hematopoietic system.* Examples: impaired immunity, clotting abnormalities
- *Musculoskeletal system.* Examples: myopathy, Skin, spider naevi, acne, palmar erythema, dupuytren’s contractures, other cancers (mouth, pharynx, larynx and colon)

Adverse psychological effects

Mood disorders – mania/depression, anxiety disorders, suicide, psychosis, sleep disorders, exacerbation of underlying disorders e.g bipolar illness

Adverse social effects

- Family problems, such as frequent fights/arguments, divorce/separation, poor parenting.
- Employment/academic problems, such as frequent absenteeism, job losses, high school dropout rate.
- Financial problems.
- Impulsivity (engagement in unsafe sex, violence/aggression).
- Legal problems, such as arrests for drinking and driving and violence.
- Motor vehicle accidents resulting in death or disability.

The speaker concluded that bio-psycho-socially, alcohol abuse is devastating and that prevention and early identification is thereof of paramount importance.

Rev Reuben Mapoo and Shamim Garda: Local alcohol situation and the intervention there of

Rev. Reuben Mapoo, chairman of SANCA, commenced the presentation with a brief explanation of the structure and work of SANCA. SANCA is a national umbrella organisation consisting of 34 Alcohol and Drug Help Centres, providing over 39 service points/satellite offices in all the nine provinces of South Africa. Each Alcohol and Drug Help Centre functions independently, but is affiliated to SANCA.

Their main goals are:

- to heighten public awareness on alcoholism, alcohol, other drugs, and related problems;
- to enlighten the public and private sector regarding prevention, treatment and research;
- to prevent and reduce chemical substance dependence and related problems
- to provide treatment for alcohol and other drug dependents and their families;
- to advocate the restriction of availability of, and reduction in the demand for potentially harmful chemical dependency forming substances thereby lowering levels of drug related problems;
- to offer specialised training and education programmes and resources relating to prevention and treatment of substance abuse;
- to undertake and encourage research in the field of alcohol and other drugs;
- to mobilize and utilize community resources in the development of community services to address substance abuse and related problems;
- to make available specialised and appropriate knowledge and resources hereby empowering communities in their effort to address their own needs.

After Rev. Reuben's introduction, Shamim Garda, National executive director, further explained the work of SANCA. She started off with giving the audience various statistics on alcohol use in South Africa, pointing out that many young people have used alcohol, which she found alarming.

Subsequently, she reported about a survey which was done within the centres of SANCA, in which each centre was asked to give a brief overview of level and content of alcohol related problems they encountered in their day to day work. In her Power Point presentation, more details can be found.

Ray Eberlein: Life style changes to beat alcohol addiction

Ray Eberlein presented the Survivor's Guide to long-term sobriety.

The Survivor's guide is an assembly of many things and the result of four decades of listening and assembling. It is aimed at dependents and co-dependents who have a need for structure, stability and control. It helps to face accelerations change and increasing complexity of our society where it is difficult to keep control of one's life. Often dependents find themselves in a downward spiral of addiction, where it becomes a whirlpool and they only think of the next hit and their life is out of control.

There is no cure for substance dependence other than abstinence, so that people can re-establish control over their life. They do this with the support of other recovering dependents and best in a support group.

The Survivor's guide provides mechanism to:

- Acknowledge, accept and commit to sobriety
- Define the results to be achieved
- Control achievement of results
- Manage staying sober
- Create supportive environment
- Rebuild trust, competence and support

- Assess balanced living

The Survivor's guide contains 7 points of lifestyle changes (see Power Point for details):

1. Acknowledge, accept and commit
2. Rehab for results
3. Live one day at a time
4. Talk it through
5. Make people count
6. Tap the resources
7. Renew yourself

Working groups

After the presentations in the morning, the audience was divided into 5 working groups, each of them discussing a particular topic. The topics were:

1. Foetal Alcohol Syndrome (FAS)
2. Youth
3. Drinking and driving
4. Public Space
5. Treatment and prevention

Participants were assigned to various groups according to expertise, background and the organisation they represented in order to optimise discussions and outcomes. The first day, the subject of discussion was '**What do we know?**'.

Afterwards, the groups reported about the discussion in a plenary meeting.

DAY TWO

Before lunch break, 5 presentations were delivered to the plenary group by the following speakers:

1. Monica Gorgulho (Dinamo/IHRA)
2. Dr. Neo Morojele (MRC)
3. Dr. A Motojesi (Medunsa)
4. Kirstie Rendall-Mkosi (University of Pretoria)
5. Ntau Letebele (Department of Transport)

The session was chaired by *Ms Shamim Garda*.

In the following, brief summaries of the presentations are given. The Power Point presentations are available on request.

Monica Gorgulho: Building partnerships in the alcohol field: the experience of Latin America

The consumption of alcohol in Brazil is similar to that of other countries in Latin America. The social representation of alcohol and other drugs depends very much on the information the general population receives from the media. The media rely mainly on people who are no experts in this field. A Brazilian study looked into the percentage that various drugs were mentioned in the media. Alcohol scored the highest (40%), followed by cannabis (15%) and tobacco (10%). When looking at behaviour linked to the consumptions of substances, the following was found: violence from users scored the highest (32%), followed by health problems (25%). Violence to substance users (9%) was on the third place.

Media fail to address issues which are related to substance use, such as:

- Reflection about the reasons why people take drugs
- Attention to the economic interests related to alcohol production and commerce
- The relationship with high level of stress, depression, unemployment and social inequality
- The social role of licit substances

In order to change the way the media treat the alcohol issue, *partnership* between the media and the various groups involved in the alcohol field is necessary. This is not only important to change the way the media treat substance use, but is also important when one wants to create more effective alcohol policies and interventions. It is impossible to do it alone, partnership is essential!

As examples on how partnerships were built and turned out to be effective, Monica Gorgulho presented the Latin American Travelling Seminar (LATS) and the first International Conference on Alcohol and Harm Reduction (held in Recife, Brazil in 2002).

Some examples of partnerships:

- Drinking and driving: *NGO's, local government, employees of bars and restaurants, taxi services*
- Drinking at the work place: *employers and employees, local and federal government, civil society*
- Prevention at universities and secondary schools: *students, school direction, international researchers, alcohol sellers, anti-drug bureau, justice system, etc..*
- Attention to special population: *federal government, NGOs, different sectors of the community*
- Prevention of under-age drinking: *alcohol industry, media, police, retailers*

The presenter concluded that partnership is **necessary**, that it means establishing a **dialogue** between different social actors, that it requires the same **commitment** from all partners and that partnership is a **process**.

Dr Neo Morojele: Alcohol and Risky Sexual Behaviour

Dr. Morojele reported on a WHO project regarding alcohol use-related sexual risk behaviour. It concerns a multi-country study, conducted in 8 countries in 4 regions. In Sub-Saharan Africa, Kenya, Zambia and South Africa were involved.

The aims of the project were:

- To determine the nature of alcohol use and sexual risk behaviour in communities
- To identify factors related to alcohol use-related sexual risk behaviour
- To inform prevention, treatment and policy interventions

Dr. Morojele reported on the South African part of the study.

The rapid assessment methods was utilized and involved interviews with key Informant Interviews (10-12), Observations (venues = 7), Focus Group Discussions (4-6), in-depth interviews (10-50) and a Household Survey (160).

They interviewed doctors, police, bar tenders, priests, teachers, sex workers, 'Risky drinkers' and observed bars, shebeens, taverns and hotels.

Regarding alcohol consumption they observed binge drinking at weekends and a gender difference in drinking patterns: both male and female use alcohol to socialize, but men drink more beer (versus females drinking wine and cider). Men drink more in drinking venues versus women at home/parties. Male drinking is associated with notions of masculinity and lack of recreational facilities, whilst female alcohol abuse is more associated with abuse, trauma, sex work/employment.

Findings regarding sexual risk behaviour were:

- Fairly high levels of acceptance of and engagement in multiple sexual relations
 - Low levels of condom use (higher among casual partners)
 - Fairly high levels of knowledge about safe sex, HIV/AIDS
 - Myths: Older people are less "risky" (SA); fat people do not have HIV (Kenya)
- Poverty, lack of skills, gender inequities and *Masculinity* associated with multiple sexual partnerships were underlying factors for sexual risk behaviour.

Alcohol use and sexual risk behaviour was strongly linked with:

- Consumption patterns: Quantity/intoxication
- Consumption settings: Drinking venues (opportunities for meeting partners environment)
- Consuming in the presence of casual partners/prospective partners/sex workers
- Characteristics of consumer: younger, inexperienced, male

The following perceived effects of alcohol consumption were recorded:

- Enhances sexual appeal: desire, pleasure, sense of urgency (including sex workers), performance
- Reduces barriers: risk perception, fears, inhibitions
- Reduces self-efficacy/control: compromises the ability to resist sexual advances and insist on condom use

Dr. Neo Morojele concluded with a number of recommendations regarding the implications of the findings of this study for interventions. Amongst others, she mentioned:

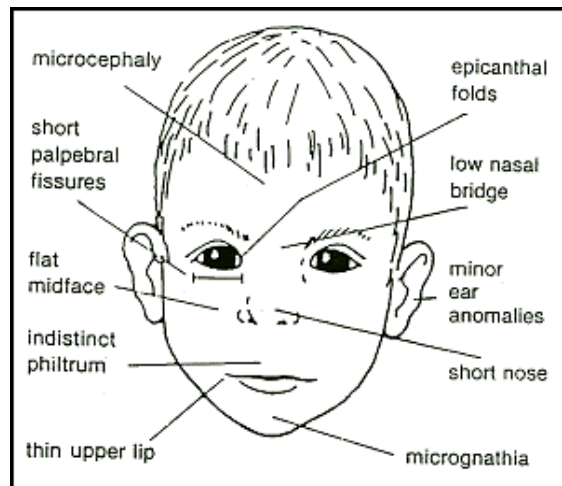
- Community development (recreational facilities, job creation, empowerment of women)
- Facilitate safer sex behaviours (access to condoms, information)
- Restrict availability/access (sales, taxation, times of sales) and alcohol promotions;

- Interventions in drinking venues – e.g. server training, involvement of owners
- Education/awareness campaigns and effective & accessible counselling and treatment
- Influencing cultural norms

Dr A Motojesi Foetal Alcohol Syndrome

Dr. Motojesi started with a concise overview of the various definitions used, such as

- FASDs[Foetal Alcohol Spectrum Disorders]
- FAS[Foetal Alcohol Syndrome]
- FAE [Foetal Alcohol Effects]



FAS is characterized by abnormal facial features (see pictures), growth deficiencies and CNS & neuro-developmental problems, such as:

- Mental retardation
- Developmental delay
- Poor coordination
- Irritability
- Hyperactivity
- Learning disability
- Hearing impairment
- Attention deficit
- Poor impulse control

Subsequently, he presented some epidemiological findings. In different areas of the USA, a prevalence of 0.2 to 1.5 per 1000 live births is found. The figures for South Africa are much higher: in Cape Metropolitan a prevalence of 1 in 10 children attending grade 1 was found, in Soweto township 25 in every 1000 seven yr old tested had a severe form of FAS. It is estimated that 500,000 South Africans suffer from FASDs.

Dr. Motojesi concluded that

- FAS is 100% preventable and also 100% irreversible
- There is a Teratogenic effect of alcohol
- South Africa has the highest prevalence rate of FAS in the world
- The diagnosis is clinical
- The complications of FAS are grievous

Kirstie Rendall-Mkosi: Preventing Foetal Alcohol spectrum Disorders: strengthening local level policies in various sectors to reduce alcohol related harm

Kirstie Rendall-Mkosi started her presentation with an overview of risks factors for alcohol exposed pregnancies.

Individual risk factors are:

- Lower education, skills & income
- Stressful life events & context eg domestic violence
- Poor life skills, & low self esteem
- Mental health problems eg. depression & anxiety
- Poor pregnancy planning & unprotected sex
- Malnourished & underweight
- One FASD child already, possibly undiagnosed
- Poor utilisation of health and social services
- Dependent or binge drinking, smoking

Alcohol is readily available, marketed with attractive taste and colours drunk by sophisticated young women and is relatively cheap (especially poor quality ones).

The sub-culture accepts women drinking. Often women face peer group pressure and/or have a partner who abuses alcohol. Especially in the Cape area, historically women used to receipt alcohol as payment.

When developing prevention measures, various things should be done:

- Although Harm minimisation is appropriate for other alcohol related harm, abstinence or minimal drinking always during pregnancy should be the norm
- Contraception to prevent pregnancy
- Rehabilitation to stop alcohol use for women who abuse alcohol
- Prevent pregnancy and/ or drinking after first FASD birth
- Support for FASD child to reach potential

Different sectors can play an important role in the prevention of FAS. In the following, these roles are given.

Liquor industry and sellers:

- Local restrictions on hours and numbers of drinks, no happy hour or free drinks for women
- Information at point of sale to influence use of liquor in shebeens, pubs, homes & parks.
- Training of sellers in not selling to pregnant women
- General adherence to responsible drinking principles

The labour sector

- Employee assistance programmes (EAP) – identify and support women with alcohol and mental health problems
- Provide better maternity leave and security of employment
- Stricter enforcement of no dop system, or any other free alcohol related to work

Arts and Culture

- Involvement of women, especially marginalised ones, in creative arts and recreational activities
- Protection of cultural practices that respect women and girls
- Promotion of local entertainment opportunities as an alternative to drinking

Educational sector

- Promotion of literacy for all, especially women
- Inclusion of FAS prevention messages in life orientation classes and ABET classes
- Introduction of "Health Promoting Schools" and implementation of drug policy
- Capacity building of educators to better detect FASD learners and adapt teaching accordingly + family support
- Promotion of sport and other activities beyond school

Health sector

- Universal alcohol screening at PHC level, and integrate with VCT counselling
- Use of brief motivational interviewing in counselling for alcohol problems and consistent use of contraceptives
- Referrals and follow-up for 'at risk' and 'dependent women', and suspected FASD cases
- Routine statistics to monitor alcohol related health problems
- Record keeping to improve continuum of care for moderate & high risk women
- Closer co-operation with other health services, NGOs and rehabilitation services

Social development

- Life skills training for at risk women
- Active recruitment of women with alcohol problems into outpatient rehab
- Adaptation of inpatient programmes to better suit women
- Make use of court order to commit women who are high risk for FASD
- Follow-up & support post-rehab

Intersectoral policies and media

- Consistent information and messages to prevent harmful drinking
- Reduction of stigma of women needing counselling/ rehab for alcohol problems
- Banning of alcohol advertising and sports sponsorship
- Promotion of responsible drinking images and behaviour in local film

Finally, Kirstie Rendall-Mkosi spoke about a 3-year research project, which evaluates interventions and processes and involves many different partners. This research project is in its first year and will be an important contribution to policy development, especially in the health and the social sectors.

Ntau Letebele: Alcohol and its Road Safety Implications

In South Africa, the number of traffic accidents per year is relatively high (793.000, of which around 13.000 fatal). The average daily death rate is 34 fatalities. During Christmas season this is even higher (46 per day). Most of the crashes happen at night and over weekends. 40% of the fatalities concern pedestrians and cyclists. Causes of accidents are: inappropriate speed, non-wearing of seatbelts by drivers and passengers and the use of alcohol. Half the victims of road accidents found to have consumed alcohol over the legal limit (47% drivers and 57% pedestrians).

Arrive Alive is the brand name for SA's road safety campaign. Objectives are:

- Communicate the importance of co-responsibility of all road users and stakeholders to reduce the number of crashes on OUR roads;
- Increase road safety awareness to road users (drivers, passengers and pedestrians) to realise they can also be victims;
- Reduce road traffic infringements, and the resultant crashes, injuries and fatalities;
- Combine education, information and enforcement to ensure law compliance.

Since alcohol affects judgment, slows reaction time, blurs vision and gives a false sense of confidence, it may result in speeding, reckless driving and taking life-threatening risks.

By law, the Blood Alcohol Content (BAC) limit is 0.02 for professional drivers and 0.05 for other drivers. Maximum penalties are suspension of drivers licence, six years imprisonment and/or R120.000 fine. The insurance may refuse to pay out claims when driver was under the influence of alcohol. However, there are poor levels of enforcement: more patrol vehicles are needed as well as testing equipment (breath and blood testing). A strategic focus of enforcement followed by communication themes to ensure maximum synergy with television, radio, outdoor and poster advertising would be needed in order to change behaviour;

It is also important to educate the public about the road rules and the benefits of the law.

Working groups

After lunch, the working groups met again to continue their discussions. This time the focus of the discussion was on 'What do we do'. The groups were asked to be as specific as possible about actions being taken in order to get a full picture of what is happening in the alcohol field.

After the discussion, the working groups reported back to the plenary group. Questions were asked and the audience was involved in a lively debate regarding specific issues.

DAY THREE

The morning started with three plenary presentations. The speakers were:

1. Gift Sethunya (United Breweries)
2. Janine Davy (ARA)
3. Ernst Buning (Quest for Quality/IHRA)

The session was chaired by *Rev Reuben Mapoo*. Below, brief summaries of the presentations are provided. The Power Point presentations are available on request.

Gift Sethunya: Sorghum Beer and Illegal Brews United Breweries

Sorghum beer has been the traditional drink of Southern Africa for hundreds of years. It is closely associated with the culture and heritage of people of Southern Africa and it is a must at all traditional ceremonies.

Industrial brewed sorghum beer is brewed with malted sorghum and maize. Good hygiene and quality standards are in place.

It is opaque, relatively viscous, pinkish brown in colour and sour in taste. It is essentially consumed in an actively fermenting state when 2 - 4 days old. It is a low alcohol content food and beverage, which has high nutritional value.

Home made sorghum beer (umqombothi) is produced at home from maize meal, sorghum malt and water. It is used in traditional ceremonies and not for sale.

Sorghum beer brewed at *shebeens* is brewed from normal brewing materials, sorghum malt, maize meal and water. However the facilities used are not very hygienic and can cause health hazard, due to lack of quality / hygienic control.

Concoctions consist of alcoholic beverage containing additives such as snuff, battery acid, chemicals used to clean furniture, etc. Alcohol content can be as high as 10%, such products are seriously injurious to health.

Challenges faced by the Sorghum beer industry are:

- Proliferation of "home brew" shebeens which:
 - lack hygiene
 - lack quality control
 - use non-permissible additives
- Do not have licenses
- Results in poor image for all sorghum beer due to above
- Sorghum beer is the healthiest alcoholic beverage in the market but has not found favour with young consumers in new South Africa due to the above as well as their attraction to more aspirational producers like clear beer, alcoholic fruit beverages, spirits etc.

Janine Davy: (Self) Regulations

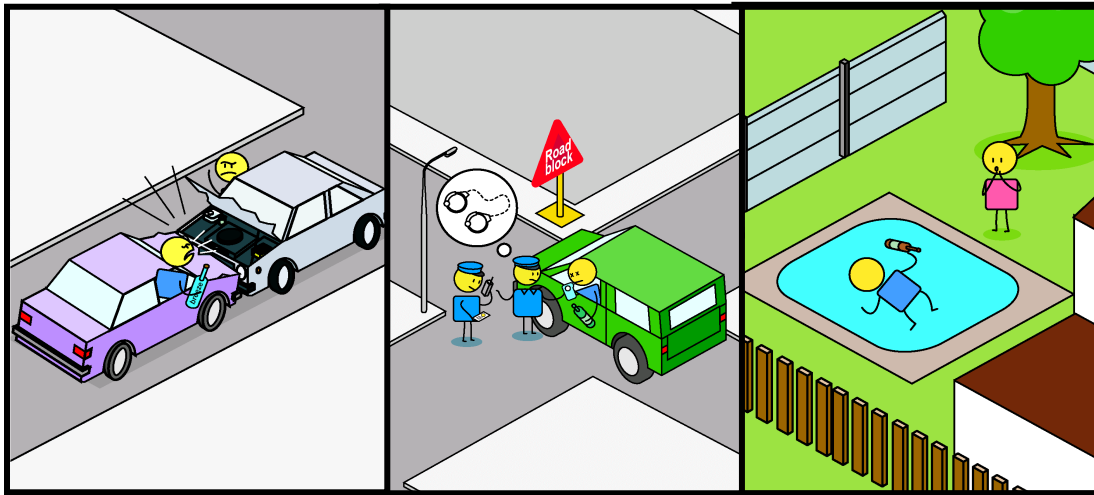
The mission of ARA is to combat alcohol abuse through the prevention of abuse of alcohol beverages, and the promotion of the responsible use of alcohol beverages. Its primary focus is prevention and, in doing so, targeting those most at risk and vulnerable in respect of alcohol abuse

ARA Support Government preference for *self-regulation* rather than regulation, which states (Liquor Act, 2003) "...*regulating manufacturing and wholesale distribution of liquor*), requires that a license applicant must show "proposed contribution to combating

alcohol abuse" and must "subscribe to an industry code of conduct approved by the Minister"

The ARA programmes are the only comprehensive programmes combating alcohol abuse to which industry members can subscribe fully and the ARA Code is in its final stages of approval by the Minister.

Subsequently, Janine Davy presented a number of examples of the work ARA is involved in, such as the Licensee training of retail traders. She showed a number of cartoons, which are used in this training.



ARA has a Commercial Communications code, which includes ad, promo, packaging & media rules and a code of Business Practice, in particular, as applying to the retail trade. Furthermore, there are compliance procedures, which include

- "No supply" clause in members' sales agreements
- Members in-house procedures to ensure compliance (incl. suppliers)
- "Ad complaints" line, which will be launched soon

Other examples given of the work of ARA: developing guidance for parents (*Let's talk*), a poster campaign about FAS, a FAS research and prevention programme, and the Rock Challenge '*Be your best*'. The Power Point presentation gives a good overview of all the projects ARA is involved in (including pictures etc.)

Ernst Buning: Harm Reduction; an innovative and necessary element of local alcohol policies

Although most of the time alcohol is consumed in a responsible manner, there are situations in which alcohol is abused and harm is done to the consumer and/or others. The main objective of alcohol policies is the reduction of such negative consequences. A policy provides a framework for interventions and often is also a prerequisite for (local) governments to provide financial support.

The question was posed whether traditional policies are effective enough. If such policies only embrace the paradigm '*less overall consumption leads to less problems*' and only implement population-wide measures (limitation of availability through restriction on outlets, opening times, and pricing (through taxation), they will mainly affect those who are not problem drinkers and who do not harm themselves or others, and have limited effect on those who are problem drinkers. Given the vast amount of harm associated with the misuse of alcohol, alternative policies should have a place in the overall approach. The Harm Reduction paradigm offers such an opportunity.

The Harm Reduction paradigm implies:

- Reduction of alcohol related harm, not drinking per sé
- Respect for individual choices and a focus on own responsibility
- Inclusion and not exclusion of people at stake
- Striving for realistic and pragmatic interventions
- Accept a 'zero tolerance' for pregnant women, under-aged and recovered alcoholics

Subsequently, *centralized* and *decentralized* policies were discussed. Centralized policies are needed to:

- Define legal drinking age
- Make laws on drinking and driving
- Regulate the retail of alcohol
- Regulate alcohol advertisements
- Implement taxation
- Support national prevention campaigns
- Manage the central budget

Decentralized policies are necessary to address local issues. Local politicians stand closer to the local community and know their needs. They can develop local regulations (for example around a local happening or specific measures in specific areas or for specific group) and support local targeted interventions. Needless to say, that local policies should operate within the framework of national policies.

In the Harm Reduction approach, an important place is occupied by *targeted interventions*. When developing such interventions, the following issues are at stake:

- Who consumes *where, when, how* and *how much*?
- Which interventions lead to less problems rather than merely less consumption
- How can one influence the environment in which harmful drinking occurs as well as attitudes of harmful drinkers

Ernst Buning concluded, that both population-wide measures as well as targeted interventions are needed and that there should be a proper balance between one's own responsibility (individual, community, alcohol/ hospitality industry) on the one hand and effective enforcement on the other hand.

In alcohol policies, the paradigm of harm reduction should be included and one should work with realistic and feasible objectives.

Report from working groups

Following the three morning presentations, each working group was asked to come up with three action points. These action points had to be concrete and describe:

	Description
Name of action point	
Expected outcome	
Target group	
Where in South Africa is should take place	
When it should be done	
Who would be responsible for the coordination	

In the afternoon, the working groups reported on their action points. All 15 action points were discussed and amendments were made if needed. Furthermore, the action points were checked for their consistency and prioritised.

The following action points (see addendum for description of action points) were presented:

FAS

1. Identification of key role players in government
2. Standardized training of service providers
3. Prevention and awareness

Drinking and Driving

4. Law and Regulations to be more consistent
5. Education and awareness interventions are improved
6. Accessible, affordable and reliable public transport system

Youth

7. Identify role players and have a working group that links up with the coordination body(CDA)
8. Audit of prevention and education programmes in and out of school
9. Educate professionals on how to deal with young people with alcohol problems

Prevention and Treatment

10. Alcohol education
11. Early identification and intervention
12. Treatment

Public Space

13. Education
14. Partnership
15. Responsible hospitality

Remarks made:

SANCA has done an audit of their own material. This can be used when carrying out action point 8.

One needs to be clear about which *professionals* are targeted, because it might mean different kind of actions.

Most of the *laws* are okay, but the problem lies in the implementation.

Just talking about *education* is too vague. One should specify how it is done (for example including it in healthy life style programmes, and specify which sector is targeted). Different groups have different needs.

Regarding *treatment* it was brought forward that some young people might not go to treatment centres because it would be too stigmatising. Are there other ways they can be assisted without this stigma?

Priorities

Education was seen as the most important action to take. It was however stipulated, that a differentiation should be made in terms of target groups. Obviously, educating policemen will be different from educating youngsters.

Partnership was seen as a very important element in getting the action points of the ground.

Overall, it was felt, that **enforcement of the existing laws** was not effective and should have a higher priority (especially around drinking and driving).

Finally, the action point about **treatment** received a high priority.

The Task force

After having discussed the action points, the participants discussed practicalities regarding the following steps. It was stipulated that the formulated action points should be put forward to the Central Drug Authority (CDA). They play a crucial role in substance abuse policies in South Africa and their support is crucial. Dr Evodia Mabuza-Mokoko, Social Work Manager, Central Drug Authority was asked to help in this respect and agreed to present the APS action plan to the CDA at their August meeting.

A Task force was formed which would work on the Action Plan and present this to Evodia Mabuza-Mokoko and the CDA in their next meeting. Members of the task force are:

- Shamim Garda (SANCA)
- Gift Sethunya (United Breweries)
- Janine Davy (ARA)
- Lusanda Rataemane (Mehadic)
- Neo Masilo (Medunsa)

The Task force will prepare an interim report by January 2007 and a final report by July 2007. Both reports will be presented to the International coordination group of APS.

It was also agreed that Lusanda Rataemane would be a guest at a round table session during the 3rd International Conference on Alcohol in Cape Town, October 22-25, 2006. In this round table she will report about this APS.

Conclusion

The representatives of the International APS coordination group concluded that this APS was a major success. The input of the participants was of a high level and the overall atmosphere was very constructive.

A lot of work still needs to be done, and the APS group would be very interested in following the further developments and provide advice and support where needed, as well as communicating the experience at the 3rd International Conference on Alcohol and Harm Reduction.

A special thanks was expressed to Lusanda Rataemane for doing an excellent job in making this APS come true.

Addendum

ACTION POINTS APS

**SOUTH AFRICA
July 2006**

Action points group FAS

1. Identification of key role players in government

Expected outcome

Commitment from government

Target group?

Social Dev, Education, Health

where

National

when

31st August 2006

coordinator

MEHADIC

2. Standardized training of service providers

Expected outcome

Professionally trained Social Workers, Health Care Workers, Policy formulators and teachers

Target group?

University of Pretoria, Medunsa, FARR and MRC

Where?

National, Provincial and local

When?

From November 2006 ongoing

Coordination?

Medunsa

3. Prevention and awareness

Expected outcome

Informed community members and harm reduction

Target group?

Trained service providers

Where?

Provincially, special focus on local level

When?

Immediately after the training

Coordination?

Social Development

Action points group Drinking and Driving

4. Law and Regulations to be more consistent

Expected outcome

Bribery and corruption to be eliminated-indicated by increased persecutions,

Convictions and suspension of driver's license

Reduction in road accidents

Professional drivers-BAC reduced to zero.

Graduated license holders (18-21)

K53 revised

Random breathalyzers are consistent and throughout the year

Target group?

Dept of transport

Dept of Justice Dept Safety

Local authorities
CBO/NGO/FBO
Unions
Automobile Association
ARA
SADD
Where?
Launch-nationwide
Meeting with relevant departments
Provincial competencies
When?
August 2006
Evaluation-Feb 2007
Coordination?
Members of the APS group
Eg-CDA
Nominate people from relevant departments

5. Education and awareness interventions are improved

Expected outcome

More focused life skills education at primary schools
All young drivers have knowledge of alcohol and alcohol related harm
Increased voluntary compliance to traffic regulations
General public awareness also targeted

Server training

Target group?

Dept. of Education
Dept. of Transport
National liquor authority (DTI)
Dept. of Agriculture
NGO's, NPO's

Where?

All Provinces

When?

August 2006
Evaluation-Feb 2007

Coordination?

Dept of Education
NPO's and NGO's

6. Accessible, affordable and reliable public transport system

Expected outcome

Various options available for transport
One ticket for all forms of transport
Reduction of motor vehicles on the road

Target group?

Dept of Transport
Dept of Public Works
Dept of Safety and Security
Alcohol retailer associations
DTI

ARA

Retail Motor Industry (RMI)

Where?

Deep rural

Rural
Peri Urban
Urban
When?
August 2006
Evaluation-Feb 2007
Coordination?
Dept of Transport

Action points group Youth

7. Identify role players and have a working group that links up with the coordination body(CDA)

Expected outcome

'Buy-in of all role players

Target group?

Gov' Dept (DoE, DoH, DSD, Sport & Rec, the dti) DPLG, NYC, NGO & FBO

Where?

Local/National?

When?

Two months

Coordination

?

8. Audit of prevention and education programmes in and out of school

Expected outcome

- Assess the impact of the programmes
- Database of the programmes and the role players

Target group?

Key stakeholders

Where?

All levels

When?

November 2006

Coordination

?

9. Educate professionals on how to deal with young people with alcohol problems

Expected outcome

Competent professionals

Target group?

Relevant stakeholders

Where?

Local/National

When?

Ongoing - with quarterly evaluations

Coordination?

SANCA

Action points group Prevention and Treatment

10. Alcohol education

Expected outcome

- reduce risk for harm
- to reach all at risk populations
- to provide skills training with aim of responsible decision making around drinking
- educate to bring about behaviour change
- programs tailor made for specific cultural groups and communities
- coordinate our policies with all other policies e.g BAC, FAS, etc.

Target group?

NGO's

All Govt Sectors

Local health clinics and hospitals

Media

Industry

Research bodies

APS international

Saps

2010 soccer group

Where?

Schools clinics – all areas at risk groups

Hospitals

Public spaces

Media

Industry

Research bodies

Urban

Peri urban

Rural

2010 soccer

When?

Upon request and ongoing and 2010

Coordination?

Representative of all partners

Loc

11. Early identification and intervention

Expected outcome

- to modify behaviour in order to minimize harm and to prevent abusers not to become dependent
- (at increased risk)
- to empower with skills with regard to drinking patterns, relapses and health care
- tailor made screening methods to meet needs of specific groups, e.g youth, pregnant women, elderly

Target group?

Health workers

Social workers

Pharmacists

Health sector

Industry

Public spaces

Schools

Govt sectors

NGO's

Faith based organisations

Clinics

Pharmacies
Industry
Bars, Shebeens
Schools
All educational departments
All govt sectors
All NGO 's
Where?
Urban
Peri urban
Rural
Seminars
Conferences
Churches
When?
Ongoing and upon request
Coordination?
LOC and all partners

12. Treatment

Expected outcome

- To make treatment services accessible to ALL – emphasis on rural
- To have adequate funds, staff, infrastructure to deliver the services
- The effective services will ensure abstinent lifestyles to contribute to a healthy society (South Africa)

Target group?

All dependent populations of all ages in S.A

Where?

Urban

Peri urban

rural

When?

ongoing

Coordination?

LOC

Action points group Public Space

13. Education

Expected outcome

Hygiene, security, FAS, HIV/AIDS, Responsible promotions, identifying a drunk person, promoting good behaviour, codes of conduct. Commitment from education for alcohol policy and curriculum.

Target group?

Servers

Youth (primary, secondary, tertiary)

Parents

Users

Where?

Formal & Informal Outlets, Schools, Extra-Murals, Religious bodies, parents meetings, sport clubs

License registration

When?

ONGOING

Coordination?

ARA

14. PARTNERSHIP

Expected outcome

Common approach to harm reduction which must result in programme implementation

Target group?

All disciplines, core role-players

Where?

Local
departmental
level

When?

Local Action Committee (Nov 2006)

Task team to approach national dept, implement to provinces (end Sep 2006)

Coordination?

National commitment

15. RESPONSIBLE HOSPITALITY

Expected outcome

Responsible, hospitable, safe place to enjoy alcohol.

Target group?

Law Enforcement, servers, owners, users, retail associations

Where?

Informal & Formal outlets

When?

Law enforcement (immediate)

Identification of industry (after APS)

Develop of programme (after APS)

Standard of outlets (after APS)

Coordination?

ARA (adverts about responsible drinking in a responsible environment)