

‘Mind the gap’: Observations in the absence of guidelines for alcohol abstinence among expectant women in South Africa

Executive summary

This policy brief examines the alcohol consumption policies of the National Department of Health’s approach to alcohol use in South Africa. In particular, it focuses on the food-based dietary guideline (FBDG) on alcohol promulgated by the Department of Health in 2001: ‘If you drink alcohol, drink sensibly.’ This guideline was re-evaluated in 2011 and the revised FBDG recommended that there should be no alcohol guidelines at all. The evaluation processes for both meetings comprised an ‘expert working group’ on alcohol consumption and a literature search on alcohol consumption in South Africa with particular reference to alcohol’s known adverse impacts (when abused) and benefits (when consumed as part of one’s diet) on health. There are many adverse effects of heavy alcohol consumption reported (for instance, risk to HIV infection, malnutrition and loss of employment). This brief, however, focuses on four adverse effects of alcohol abuse in relation to the burden experienced by South Africa, namely:

- high alcohol consumption levels;
- fetal alcohol spectrum disorders (FASD);

- health and psychosocial concerns; and
- social effects of alcohol abuse.

High alcohol consumption levels

The per capita consumption at the national level of 9.46 litres per person (all persons, not just drinkers) is high (Parry 2010). According to the *Global Status Report on Alcohol and Health 2011*, the consumption of alcohol per drinker is around 16.6 litres per annum (World Health Organization, WHO 2011). This places South Africa among the nations having the highest consumption of absolute alcohol (that is, ethanol with a low water content) per drinker in the world. High alcohol consumption can lead to alcohol abuse and dependence (Parry 2010).

Fetal alcohol spectrum disorders

In terms of alcohol-attributable disability in South Africa, fetal alcohol syndrome (FAS) and fetal alcohol spectrum disorders (FASD) ranked the highest in the world.

Health and psychosocial concerns

In terms of burden of disease, alcohol accounted for 7.0% of deaths and 7.1%

of all disability-adjusted life years (DALYs) lost in South Africa in 2000, resulting in 1.1 million life years lost. In terms of alcohol-attributable disability, alcohol-use disorders.

Social effects of alcohol abuse

The available evidence consistently suggests a relationship between alcohol, crime and suicide. Associations between alcohol abuse and child abuse have also been reported. According to the South African Police Services (SAPS) *Crime Report 2010–2011*, 65% of social contact crimes, such as murder, attempted murder, rape and assault, are a result of alcohol and, to a lesser extent, drug abuse. The reported prevalence of driving under the influence (DUI) has increased by 2.9% over the past year and road fatalities continue to be associated with DUI (SAPS 2011).

The beneficial aspects of moderate alcohol consumption

There are certain health benefits related to moderate alcohol consumption, which is defined by the Dietary Guidelines for Americans as having up to one drink per day for women and up to two drinks per

day for men. In 2004, the World Health Organization Technical Committee on Cardiovascular Disease proclaimed that the association between moderate alcohol consumption and reduced death from heart disease could no longer be questioned (Costanzo et al. 2010). The benefits also extend to a reduced risk of strokes, particularly ischemic strokes, and diabetes as well as a lowered risk of gallstones.

There are also some economic benefits related to moderate alcohol consumption. For example, South African Breweries employs 8 232 people and the liquor industry contributes R120 million on community partnerships to aid responsible drinking initiatives. This industry also invests an estimated R560 million in advertising (Ataguba 2012).

Introduction

In 2001, the South African FBDG on alcohol, 'If you drink alcohol, drink sensibly', was recommended and accepted by the Department of Health (Van Heerden & Parry 2001). A 2001 qualitative study evaluated the appropriateness of the South African FBDG as a nutrition education tool for adult women (19 to 63 years of age) in KwaZulu-Natal and the Western Cape (Vorster et al. 2001). Overall, the participants appeared to have comprehended most of the FBDGs. However, there was some confusion over the terms 'drink sensibly' and 'in moderation'. The overwhelming majority of the interviewed participants (79.6%) said alcohol was 'unhealthy', 'an unnecessary drug', 'causes problems socially' and stated that consumption was 'against my religion'. Only 20.4% of those interviewed stated that people could drink alcohol as it was 'enjoyable', 'relaxing' and 'socially acceptable', but that this should be done 'in moderation' (Vorster et al. 2001).

On 26 June 2011, the national alcohol 'expert working group' decided that the

South African FBDGs should not contain a message on alcohol corresponding to the food guide, which only shows those food groups recommended for a healthy diet. However, the national working group felt strongly that there should be a short technical paper on alcohol in which recommendations for moderate drinking are explained to health professionals who are using the FBDGs to promote healthy drinking (one drink a day for women; two drinks a day for men) (Jacobs & Steyn 2013).

This policy brief acknowledges the efforts made by the expert groups in 2001 and 2011. Further, it seeks to highlight the need to address the vacuum left by the current policy in an area of serious public health concern, namely the issue of FASD.

Background

The history of alcohol dependence in South Africa can be linked to its racially divided past. In traditional African society, the use of alcoholic drinks was well regulated socially. In 1962, it became legal for black¹ people to purchase alcohol from white-owned liquor stores. According to the 2008 South African National HIV Prevalence, Incidence, Behaviour and Communication Survey, those South Africans who drink alcohol do so at significantly higher levels than other middle-income countries and are at a high risk of becoming infected with HIV (Shisana et al. 2009). In addition, urbanisation causes a shift in food intake with increased intakes of cheaper and more energy-dense food and drinks, which often lack micronutrients. Urban areas not only have a greater availability of cheaper unhealthy foods, but also higher rates of alcohol consumption.

Whilst the setting in which the alcohol FBDG operates should be borne in mind,

it is important to note the legislative context that aims to control the sale and consumption of liquor in the country. The four major alcohol policy initiatives introduced in South Africa between 1994 and 2009 are:

- restrictions on alcohol advertising, and counter-advertising;
- regulation of retail alcohol sales, including no alcohol sales to children under the age of 18;
- control of alcohol packaging; and
- increased alcohol taxation.

Despite those initiatives, alcohol abuse continues to be a significant public health concern.

Review of the literature

Alcohol consumption patterns

Our knowledge on alcohol consumption patterns emanates mainly from the South African Demographic and Health Survey (SADHS) of 2003 (Department of Health and Medical Research Council 2007) and the Youth Risk Behaviour Surveys of 2002 and 2008 (Reddy, Panday et al. 2003; Reddy, James et al. 2010).

With regard to adults, at the national level, 21.4% males and 6.9% females were categorised as being alcohol dependent (Reddy, Panday et al. 2003). This was highest in coloured males (31.2%) and African males (21.6%) and lowest in white (10%) and Indian (11%) males. Between 2002 and 2008, the number of children who started drinking before the age of 13 years remained almost unchanged at 12% in 2002 and 11.9% in 2008 (Reddy, Panday et al. 2003; Reddy, James et al. 2010). At the national level, binge drinking amongst the youth increased by an alarming 6% in the 2002 to 2008 period (Reddy, James et al. 2010). These figures indicate that high alcohol consumption is a serious concern in South African youth and adults, being most severe in males. Even though there has been an expected variation within the 2002 and 2008 surveys (28% in

¹ The construct 'black' is used as all-encompassing of racial categories (African, Coloured and Indian) not categorised as 'white'.

2002 and 26% in 2008), which indicates a decrease in youth binge drinking episodes, there has been an increase in recreational drinkers (19% in 2002 and 24% in 2008) (Shisana et al. 2009). These trends are supported by a study reporting that binge drinking among female youth is steadily increasing.

Although the per capita consumption of alcohol in SA is lower than the consumption figures in Europe and the Americas, it is high in comparison to other African countries and double the consumption of Nigeria, Algeria, Angola and Gambia (Department of Health and the Medical Research Council 2007).

Fetal alcohol spectrum disorders

Fetal alcohol spectrum disorders (FASD) is an overarching term used to categorise the range of effects an individual may have because of exposure to alcohol in utero. The most severe diagnostic category is fetal alcohol syndrome (FAS). Other categories comprise partial FAS (PFAS), alcohol-related neurodevelopmental disorder (ARND) and alcohol-related birth defects (ARBD), as reported by the Foundation for Alcohol Related Research (FARR).² The FARR also reports that in South Africa, FAS- and FASD-related research has been limited to a few at-risk areas (for example, Wellington and De Aar). The available research indicates that children living in rural areas are at higher risk than urban-dwelling children (May et al. 2008). In certain rural parts of South Africa, FAS and FASD prevalence rates rank among the highest in the world.

In the Western Cape (Wellington), the prevalence of Grade 1 learners affected with FAS and FASD were 46 per 1 000 in 1997 and 75 per 1 000 as reported in 2008 (May et al. 2008). Alarming, according to a FASD situation and gap

analysis conducted in 2008, FASD is inter-generational. This term refers to a woman who was exposed to alcohol in utero, and who had life exposure to an environment of excessive alcohol use. Such a person is therefore at a higher risk for early alcohol abuse and unplanned pregnancies, with the higher risk of having a child with FASD. FASD in South Africa is complex, difficult and expensive to diagnose and there is no FASD surveillance programme in the country, compared to international best-practice FASD standards. This gap in research and policy action is a key area for this policy brief.

Health and psychosocial concerns

Nearly every tissue in the body is affected by the chemistry of alcohol, including those in the central nervous system. The brain becomes dependent on alcohol after prolonged exposure to it and drinking steadily and consistently over time can produce dependence and cause withdrawal symptoms during periods of self-restraint. People with alcohol dependency may present possible health and psychological distress such as malnutrition, liver disease (cirrhosis), increased risk of HIV infection, depressive episodes, severe anxiety and insomnia.

It is estimated that 44.6% of suicide cases are associated with alcohol dependence. Approximately one in three South Africans who commit suicide are under the influence of alcohol at the time of death. With regards to the burden of disease, alcohol accounted for 1.1 million life years lost in South Africa.

With a per capita consumption of 9.46 litres per person (all population groups) and considering that approximately half the population does not drink, the consumption of absolute alcohol per person drinking is estimated to be around 16.6 litres per annum. According to the *Global Status Report on Alcohol and Health 2011*, this places South Africa among the nations having the highest consumption of absolute alcohol per person in

the world (WHO 2011). Studies have documented the association between alcohol abuse and poverty, low education levels and poor mental health, including suicide attempts (Reddy, Panday et al. 2003; Reddy, James et al. 2010). Children of alcohol-dependent parents are at greater risk for eating disorders, learning disorders, teen pregnancy and suicide.

Contextual factors identified by research include abject poverty, unemployment, low education levels, childhood within dysfunctional family environments, early debut in alcohol use and current alcohol dependence. Other factors include previous and current interpersonal conflict and violence, a sense of hopelessness and the absence of coping mechanisms. Depression affects an estimated 5% to 6% of the South African population. From a nutritional point of view, people with alcohol dependency frequently replace meals with alcohol.

Social effects of alcohol abuse

Drinking can have adverse social effects on people and communities. The main negative social effects of alcohol consumption are crime, violence and road accidents. This has a bearing on society as a whole in terms of resources required for law enforcement, healthcare and rehabilitation, among others. Road accidents have been a consequence of DUI and or walking under the influence of alcohol (WUI). There has been a significant increase in the reported prevalence of WUI among youth – from 10.6% in 2002 to 18.1% in 2008 (Reddy, Panday et al. 2003; Reddy, James et al. 2010).

Other available evidence suggests a relationship between alcohol and crime such as child abuse. Studies report that parents become physically and emotionally violent towards their children because their cognition becomes impaired while under the influence of alcohol. Drinking can impair judgement and cause serious interpersonal violent

² More information on FASD is available from the FARR website at <http://www.farrsa.org.za/#library>.

episodes. It has been reported that 42.8% of interpersonal violence by males can be attributed to alcohol. The figure for females is 25.9%. The Crime Research and Statistics component of SAPS Crime Intelligence reported that approximately 80% of murders, 60% of attempted murders, 75% of rapes and 90% of all assault perpetrators were under the influence of alcohol (SAPS 2011). Given the association between alcohol use, crime, violence and traffic fatalities, reducing the high levels of alcohol consumption in South Africa will require inter-sectoral primary prevention efforts that address injury-related mortality, root causes of violent and accidental deaths, suicide, depression, poverty and child abuse.

Positive and beneficial aspects of moderate alcohol consumption

There are reported positive health and economic benefits associated with moderate alcohol consumption.

Health benefits

Moderate alcohol intake, as defined by the Dietary Guidelines for Americans, has been shown to decrease risk of myocardial infarction and coronary heart disease mortality with a maximum protection being derived from a consumption range of 5 to 10 grams of alcohol per day. Alcohol in moderation increases sub-fractions of HDL cholesterol, providing a protective cardiovascular effect. The benefits are not limited to reductions in heart disease or cholesterol but include other benefits such as a reduced risk of strokes, particularly ischemic strokes, a lowered risk of gallstones and a reduced risk of diabetes.

Economic benefits

The South African Breweries' contribution to the alleviation of unemployment and the liquor industry's community partnerships to aid responsible drinking,

such as 'Dop-Stop', can be seen as a positive benefit to communities. Since 2003, the South African wine industry's annual contribution to the economy has grown to R26.2 billion or 2.2% of gross domestic product (GDP) in 2008. However, the benefits to the economy are swayed by the detrimental consequences of alcohol abuse and its negative impacts.

Recommendations

Having taken cognisance of the reported health benefits of moderate alcohol consumption and considering that alcohol abuse in South Africa is associated with major and significant adverse impacts on health and psychosocial conditions, the decision by the Department of Health not to include alcohol guidelines in the revised FBDGs is commendable. In lieu of the guidelines, a policy recommendation would be the need to focus on the subject of maternal health with a specific policy focus to address alcohol usage during pregnancy. This policy recommendation should also include the role of other stakeholders, such as the alcohol and media industries, to ensure comprehensive public education on the dangers of FASD. These recommendations should be seen within the broader context of current priority policies to improve maternal and child health in the country. This policy brief supports the removal of alcohol guidelines in the FBDG and recommends the following changes to the 2001 FBDGs on alcohol consumption:

1. Positive interventions should be made, particularly at community levels, to stop the system of alcohol for wages practised in some sectors of the economy. To this end, strong local monitoring systems by the Department of Labour and the Department of Health must be put in place. As good labour practice, it is imperative that employers do not use alcohol as remuneration. This is particularly essential for the wine-making and farming sectors. The Department of Labour and related

workers' associations should monitor employer compliance in all sectors to ensure complete eradication of this system.

2. The Department of Health in conjunction with the Department of Social Welfare should implement more efficient monitoring systems of FASD-affected communities with particular reference to the Western Cape, where intergenerational FASD is reported. The Department of Basic Education should also contribute through school-based surveillance and monitoring of ECD (early childhood development) and young learners to collect data on symptomatic FASD. A more integrated approach to maternal health monitoring to include alcohol use monitoring should be part of basic healthcare for women presenting for antenatal care.
3. The limited but overwhelming evidence of public perceptions on the role of alcohol in society is a subject for further research. There should also be more focus on the impact of FASD on maternal and child health.
4. The liquor industry's role in explicit alcohol advertising without appropriate messaging for pregnant women should lead to interrogation of current regulations to ensure that strong public education campaigns are supported in communities with a history of alcohol abuse. In terms of campaign messaging, it is imperative that more investment is made in multimedia campaigns to promote safe pregnancy among women vulnerable to alcohol abuse. In particular, the alcohol industry and media industries' advertising campaigns promoting alcohol should include more visible and equally well developed and presented campaigns on the dangers of alcohol for girls, young women and expectant women. Such campaigns should be informed by evidence-based behaviour change and public health education

messaging from the Department of Health.

5. Based on the evidence that FASD is a growing concern in South Africa, and the silence of the current guidelines on the well-documented adverse effects of drinking among women who become or are pregnant, it is recommended that the Department of Health should:
 - create and disseminate education materials and awareness campaigns for the public and promote service provider compliance with health safety messaging;
 - improve access to and encourage effective use of contraception;
 - identify women at risk for alcohol-exposed pregnancy (AEP) for interventions;
 - implement strategies (counseling, for example) to prevent AEP in high-risk settings; and
 - establish and monitor FASD surveillance programmes to prevent alcohol use among women of childbearing age.

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