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CONTENTS

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Page

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Green Paper 2

PROVINCIAL NOTICE

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Western Cape Alcohol-Related Harms Reduction Policy Green Paper

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Contents

Executive summary.....	3
List of Acronyms.....	6
Introduction	8
Background	9
Problem Statement.....	10
Context of alcohol-related harms reduction	10
The need for an alcohol-related harms reduction approach in the Western Cape.....	16
Principles, approach and policy context	19
Purpose and goals of the policy	20
Chapter 1: Pricing and the economy.....	21
Who benefits and who pays the costs?	21
Demand.....	22
Supply.....	25
Chapter 2: Unlicensed liquor outlets and the illicit liquor trade	31
Chapter 3: Enforcement.....	34
Chapter 4: Alcohol and the Road Environment	41
Chapter 5: Health and social services	47
Chapter 6: Community-based action	51
Chapter 7: Education and awareness	55
Chapter 8: Information, data collection, monitoring and evaluation.....	61
Chapter 9: Institutional arrangements	65
Conclusion.....	71
Bibliography	75
Annexure 1: Selected detailed indicators and data requirements on consumption and harm	83
Annexure 2: Information from local, liquor and SAPS authorities with regard to licences, transgressions and actions.....	84

Executive summary

During 2015 the Western Cape Provincial Cabinet agreed that an Alcohol-Related Harms Reduction Policy should be developed to guide the Western Cape Government's approach to the regulation of alcohol. A diverse public sector working group was established to drive the process of developing the draft Alcohol-Related Harms Reduction Green Paper.

The policy begins by providing a brief *background* section. It considers the emphasis of the current legislative framework where legislation largely relates to regulating the activities of licensing and enforcement of the production, distribution and sale of alcohol, and the shortcoming that the general focus does not adequately consider the impact of alcohol-related harms on society and address the consequences.

The *problem statement* section sets out the nature of the problem and provides the basis of the policy. It discusses the context of alcohol-related harms in South Africa. It notes that South African drinkers consume comparatively high amounts of alcohol and do so in risky patterns. It is the third leading risk factor for death and disability and contributes to the top two. Alcohol related harms includes brain development impairment in children and adolescents, is linked to increased violence, transport related deaths and suicide. The financial cost to the South Africa's economy is estimated as a net loss of approximately 7-10% of GDP, or R165-236 billion. The *problem statement* then focuses on the Western Cape specifically. It argues that due to the alcohol-related risks and harms to individuals and communities, caused by its high levels of abuse generally, and specifically by school-going youth, there is a need for an alcohol-related harms reduction approach in the province.

The *principles, approach and policy context* section affirms that the policy was guided by the principles of an open opportunity society for all. An international and domestic evidence-based and whole-of-society approach, along with a cooperative governance and a rights based approach, were undertaken in developing the policy. The international, national and provincial policy context in which this policy is embedded is also highlighted.

The *purpose and goals* section provides the policy purpose to target specific alcohol-related harms issues and ancillary matters, with the goal of contributing to the reduction of alcohol-related harms in the Western Cape.

Chapters 1 to 9 provide the target policy areas and proposed interventions.

Chapter 1: Pricing and the Economy, acknowledges the importance of the alcohol industry, particularly in the Western Cape. The economic contribution is however dwarfed by the costs of alcohol-related harms necessitating a revised policy focus aimed at reducing alcohol-related harms. To address demand drivers, the policy proposes lobbying for a national ban on alcohol advertising that is visible to any persons under the age of 18. On the provincial level, in the event that a total ban is not achieved, the WCG should prohibit advertising, marketing and promotion of alcohol products and companies at all public facilities and events organised by the WCG. A budget for alcohol-related harms interventions at all public health and social service facilities in the Western Cape as well as for community action engagement interventions is also mooted. To address supply drivers, the policy proposes considering the possibility of a provincially determined framework that would set maximum limits for trading hours in line with the alcohol-related harms reduction

approach, with provision for exceptions based on set criteria. Reducing the availability of alcohol by regulating the density of outlets and regulating trading days and hours and evaluating available studies or initiating a study to determine effective and cost-efficient disruption mechanisms that could be implemented to increase the real cost of taking legally produced alcohol into the illegal market is put forward. Lobbying national government to increase the price of alcohol through increasing excise tax and/or introducing minimum unit pricing, tighten definitions and regulations of ales and beer, incentivise the reduction of the ethanol content and implement a tracking system of liquor products are proposed.

Chapter 2: Unlicensed liquor outlets and the illicit liquor trade identifies the concern of a lack of regulation leading to increased harm and the loss of tax and licence revenue that can be used to mitigate harms. The policy proposes taking steps to bring responsible unlicensed liquor outlets into the regulated space in a sustainable and responsible manner, identifying mechanisms and criteria that will enable the rezoning of outlets for liquor sales in appropriate residential areas and prioritising upstream interventions targeting suppliers to the unlicensed liquor industry and the illicit liquor trade. Awareness of alternative economic opportunities should be provided to currently unlicensed outlet owners. Legislation must provide for the efficient and effective disruption of the liquor supply to unlicensed outlets and liquor enforcement units are to be capacitated and strengthened through increased resources and an integrated liquor enforcement approach should be developed, among other proposals.

Chapter 3: Enforcement recognises both regulatory compliance and criminal enforcement as integral parts of a comprehensive approach to reduce alcohol-related harms. It proposes that all spheres of government and relevant departments should contribute to the clamp-down and that information from community based-organisations and structures as well as the enforcement opportunities from municipal zoning schemes should be leveraged. Implementing innovative strategies such as the “last drinks survey” and promoting the involvement of communities themselves through interactive opportunities is suggested. Lobbying for well-prepared police dockets, increasing the number of trained liquor law enforcement officers, establishing one overarching liquor enforcement centre for operational coherence, legislating for sentencing in line with the seriousness of the harms and mobile testing for breath and/or blood by an approved, legally admissible device are among the further interventions put forward.

Chapter 4: Alcohol and the Road Environment acknowledges the trend that there is a consistent high prevalence of alcohol in road traffic fatalities and supports the Safe Systems approach favoured by the WHO and UN. Placing liquor licensing restrictions in areas with a high prevalence of alcohol-related road trauma, considering imposing restrictions on the sale of alcohol on premises that are on national or provincial roads and lobbying national government to implement a graduated alcohol limit for drivers with a zero tolerance for young or novice drivers, the introduction of alcohol Interlocks and strengthening random breath testing are among the interventions mooted.

Chapter 5: Health and social services advocates a whole-of-society approach in the provision of services with a focus on the individual in the context of their families and communities. Intervention proposals include providing equitably distributed emergency medical services for alcohol-related conditions, strengthen prevention, early intervention, detoxification, treatment and aftercare evidence-based interventions, providing programmes for screening, provision of information and

brief motivational interventions and providing interventions at antenatal clinics. Establishing early screening and referral services at schools and other institutions of learning and establishing an effective referral system to services provided by the DoH, DSD, other departments and NPOs are among other interventions put forward.

Chapter 6: Community-based action aims to build on the existing strengths and resources of the community and facilitate partnership and capacity building throughout the process. The community-based model for substance abuse treatment and rehabilitation should be expanded. The capacity of municipalities should be strengthened and institutionalised through the establishment of LDACs and the PSAF, together with LDACs will coordinate integrated community programmes. The successful aspects of the AHR community-based action projects in three areas, namely in Khayelitsha, in Gugulethu and Nyanga and in Paarl East, will be progressively rolled out to other areas is another among the interventions presented.

Chapter 7: Education and awareness supports a whole-of-society, multi-sectoral approach to education and awareness because knowledge is valuable in mobilising support for strategies to reduce harms and provide awareness of effective interventions available to the public. Proposals include prioritising the PSAF and LDACs as platforms for integration, referral pathways and reciprocal communication, continuing and strengthening the WCED education and awareness interventions and leveraging the after-school space for education and awareness targeted at youth. Promoting and strengthening education and awareness programmes to stakeholders, improving the reach and ease of access to education and awareness material, expanding and strategically directing addiction care education courses and the continuation of education programmes on FASD are also included in the proposals.

Chapter 8: Information, data collection, monitoring and evaluation highlights the need for an efficient and co-ordinated collection, management, analysis system and sharing of alcohol-related information and data given the complexity and transversal nature of alcohol-related harms. The WCG will lobby national government for a transversal structure (national, provincial and local government) to collect information and data and to undertake monitoring and evaluation related to alcohol. The WCG will also explore the feasibility of implementing a purpose-built monitoring-and-surveillance system. The system will aim to provide ongoing relevant information about alcohol – on both the alcohol economy and alcohol-related harms, inform planning and implementation of interventions to reduce harm and monitor and evaluate the implementation of interventions.

Chapter 9: Institutional arrangements recognises the critical role played by institutions in supporting and implementing the Western Cape Alcohol-Related Harms Reduction Policy. The policy suggests the selection of an efficient and effective institutional structure form from four proposed models (current, hybrid, commission and in-house). Generally, it also recommends shifting the administrative burden and cost of liquor licence applications to the applicant, qualification requirements for the on site manager and updating licence categories. Fee structures based on actual processing cost and renewal fees based on volume category to provide additional resources to address alcohol-related harms proportionally are proposed.

In the *conclusion* the policy provides an overview of the various sections and highlights a number of the proposals in the chapter that pertain to the issue areas.

List of Acronyms

ADR	Alternative dispute resolution
BAC	Blood alcohol concentration
BrAC	breath alcohol concentration
CoCT	City of Cape Town
CPF	Community police forum
DALYS	Disability-adjusted life years
DLO	Designated liquor officers
DoH	Western Cape Department of Health
DoCS	Western Cape Department of Community Safety
DSD	Western Cape Department of Social Development
DUI	Driving under the influence
FASD	Foetal Alcohol Spectrum Disorder
FPS	Forensic Pathology Services
HSRC	Human Sciences Research Council
LDAC	Local drug action committee
LLT	Liquor Licensing Tribunal
LUPA	Western Cape Land Use Planning Act, 2014 (Act 3 of 2014)
MOD	Mass participation, Opportunity and access and Development and growth
NDMP	National Drug Master Plan
NPA	National Prosecuting Authority
NPO	Non-profit organisations
PNP	Policing needs and priorities
PSAF	Provincial Substance Abuse Forum
PSP	Provincial Strategic Plan 2014 – 2019
RTD	Ready-to-drink
SACENDU	South African Community Epidemiology Network on Drug Uses

SAMRC	South African Medical Research Council
SAPS	South African Police Services
SPLUMA	Spatial Planning and Land Use Management Act, 2013 (Act 16 of 2013)
UK	United Kingdom
US	United States of America
UNODC	United Nations Office on Drugs and Crime
WCED	Western Cape Education Department
WCG	Western Cape Government
WCLA	Western Cape Liquor Authority
WHO	World Health Organisation

Note regarding terminology:

The terms alcohol and liquor are both used in this document. Alcohol is preferred by researchers while liquor is preferred by legislators. In order to be regarded as liquor the product must contain a percentage of alcohol, also referred to as ethyl alcohol.

“Alcohol”, for the purposes of this policy document, has the same meaning as “liquor”.

Introduction

During 2015 the Western Cape Provincial Cabinet agreed that an Alcohol-Related Harms Reduction Policy should be developed to guide the Western Cape Government's approach to the regulation of alcohol.

A diverse public sector working group was established to drive the process of developing the draft Alcohol-Related Harms Reduction Green Paper. The working group comprised of representatives from relevant provincial departments, local government, South African Police Services, Western Cape Liquor Authority, South African Medical Research Council and academia. External stakeholder groups were met and contributed to the process.

The development was collaborative and focused on alcohol-related harms reduction in the Western Cape context. Based on their expertise and in consultation with their departments, stakeholder groups provided evidence-based input on their focus areas. The rationale was firstly, that relevant stakeholder departments hold the expertise and knowledge, and secondly, that the process would facilitate endorsement from the relevant Departments that will be responsible for implementing the proposals in their focus areas.

Public participation has begun and will continue throughout the comment process to elicit widespread comments from communities most fundamentally affected by widespread harms, and not only from those who regularly respond to requests for policy comment.

The policy begins by providing a brief *background* section that considers the emphasis and shortcoming of the current legislative framework.

The *problem statement* section sets out the nature of the problem and provides the basis of the policy. It first discusses the context of alcohol-related harms in South Africa. It then focuses on the Western Cape specifically, arguing that due to the alcohol-related risks and harms to individuals and communities there is a need for an alcohol-related harms reduction approach in the province.

The *principles, approach and policy context* section sets out the principles by which the policy was guided, the approach that was undertaken in developing the policy and the policy context in which it is embedded.

The *purpose and goals* section of the policy is followed by the *Chapter 1 – 9*, which provides the target policy areas and proposed interventions.

The policy concludes with an outline of the policy areas and proposed interventions.

Background

The current legal framework in respect of alcohol regulation in the Western Cape comprises legislation from the national, provincial and local spheres of government.

Currently alcohol legislation largely relates to regulating the activities of licensing and enforcement of the production, distribution and sale of alcohol. The focus of the applicable alcohol legislation is that of regulation and compliance of, among other aspects, the registration of manufacturers and distributors of liquor¹, the production and composition for sale of certain liquor products², the granting of licences to retailers to sell³ or the setting of trading times in respect of licensed premises.⁴ The general focus of the legislation does not adequately take into consideration the impact of alcohol-related harms on society and address the consequences.

The Western Cape Government (WCG) has in the past attempted to address the harmful use of alcohol in many ways - for example, by more vigorously shutting down unlicensed liquor outlets, increasing breath testing of drivers, undertaking trials to screen and intervene in cases of persons coming to trauma units with alcohol-related injuries. Legislation and regulation, policy development, informational, motivational and social-mobilization TV materials, alcohol policy development, perception of alcohol regulatory authorities in the media, and the design of specific surveillance systems have also been undertaken.

Efforts however have been largely unsuccessful, and problem drinking and its associated negative consequences remain a substantial health, social and economic burden to the province⁵. As for substance abuse treatment, the focus has shifted to making more treatment slots available to drug users, with the result that the number of treatment slots available to persons with an alcohol problem in the province has steadily declined. These reveal mostly failures or missed opportunities to limit alcohol-related harms.

¹ Section 11 of the National Liquor Act, 2003 (Act 59 of 2003).

² Liquor Products Act, 1989 (Act 60 OF 1989).

³ Section 33(1)(a) of the Western Cape Liquor Act, 2008 (Act 4 of 2008).

⁴ City of Cape Town: *Control of undertakings that sell liquor to the public*, 2013.

⁵ Myers, JE (2015) *Rapid review of the problem of alcohol harm reduction in the Western Cape province* (available on request) at 10 and 11.

Problem Statement

Context of alcohol-related harms reduction

Alcohol-related harms are destroying lives, tearing apart the social fabric and hampering socio-economic development - but there is a lack of integrated, sustained support for effective interventions to reduce alcohol-related harms.

The World Health Organisation (WHO) ranks South Africa as the country with the highest per capita alcohol consumption in Africa, which refers to the total consumption divided by the entire population.⁶ The average consumption of pure alcohol *per drinker*, which excludes abstainers in the population, is estimated at 27.1 l, per year; this places South African *drinkers* in as the fourth highest position on the continent and at the upper end of global consumption.⁷

A review in the medical journal, *The Lancet*,⁸ point outs that:

*“Ecologically there is a very close link between a country’s total alcohol per head consumption and its prevalence of alcohol-related harm and alcohol dependence, implying that when alcohol consumption increases so does alcohol-related harm and the proportion of people with alcohol dependence and vice versa”.*⁹

Evidence supports the notion that profits in the alcohol industry are dependent on excessive drinking. Information shows that in developed countries such as the US, UK, Canada and Australia 80% of alcohol is consumed in excess of current government guidelines, and 50% is consumed during binge drinking.¹⁰ At least half of alcohol consumption, and accompanying profits, is therefore dependent on risky drinkers.

Figures point to a similar trend in South Africa, with many of those who do drink alcohol doing so in risky patterns. A 2014 study of almost 2000 adult drinkers in Tshwane (Gauteng) conducted by the SAMRC,¹¹ for example, found that roughly 66% drank six or more drinks on a typical drinking occasion and that 86% of the alcohol is consumed by heavy drinkers. The percentage of people who abstain in South Africa is high, as reflected in the WHO report showing an estimated abstention rate of 59,4%¹², compared to only 33,6% of Europeans¹³ and 31,1% of the US population.¹⁴ Brazil, a

⁶ WHO. (2014) *Global status report on alcohol and health* at 289-290.

⁷ *Ibid.* at 297 – note that this statistic is differentiated from the above notes figure, which pertains to consumption per capita, as this statistic pertains to consumption per drinkers only.

⁸ Anderson, P, Chrisholm, D and Fuhr, DC. (2009) *Effectiveness and cost-effectiveness of policies and programmes to reduce the harm caused by alcohol* The Lancet Vol 373 2234-2246.

⁹ *Ibid.* at 2236.

¹⁰ Baumberg, B. (2009) *How will alcohol sales in the UK be affected if drinkers follow government guidelines?* Alcohol and Alcoholism, 44(5):523-528.

¹¹ Prof. C Parry, personal communication 4 June 2016.

¹² Note 6 at 128.

¹³ *Ibid.* at 32.

country comparable to South Africa because of similar socio-economic circumstances, has an abstention rate of 42,3% – approximately 17% lower than that of South Africa. What this means is that South Africans consumes almost 80% more alcohol per drinker. It indicates that South Africa's alcohol consumption is less widespread among the population, and that those who do consume alcohol display more risky patterns of drinking.¹⁵

WHO indicates that 40,6% of South Africans are current drinkers¹⁶ and approximately a quarter of South African drinkers drink in heavy, episodic ways, commonly referred to as binge drinking. On average, South African male drinkers each consume 32,8 l of pure alcohol per year – over 50% more than the world average of 21,2 l.¹⁷ South African female drinkers each consume 16 litres of pure alcohol per year on average, which is approximately 80% above the world average of 8,9 l.¹⁸ Approximately 5,6% of South African alcohol users suffered from alcohol use disorders, including dependence and harmful use, according to twelve-month prevalence estimates.¹⁹

Further, the alcohol industry is looking to increase alcohol consumption. While most of the developed world has stable alcohol consumption, the developing world is increasing its consumption. As the SABMiller Executive Chairman explained, "If you talk about the immediate runway for growth, I don't think there's anything that beats Africa."²⁰

The volume of consumption and drinking patterns are therefore critical issues that need to be addressed to reduce alcohol-related harms. A concern that is slightly less prevalent is the quality of alcohol consumed. At issue are not only homebrewed beer and spirit concoctions, but also industrially produced products, including cheap wine²¹ and sugar fermented beverages.

The reality of the harmful use of alcohol is that it impacts the lives of individuals, destroys families and burdens societies as reflected below.

Alcohol is legal but is the most widely abused drug in South Africa. In 2013 alcohol was identified as the third leading risk factor for death and disability in South Africa, following unsafe sex and a high body mass index (obesity).²² This confirms the earlier research from 2000 that found that alcohol was the third leading risk factor for death and disability in South Africa, following only unsafe sex

¹⁴ *Ibid.* at 170.

¹⁵ *Ibid.* at 143.

¹⁶ Current drinkers are those who had an alcoholic drink in the last 12 months.

¹⁷ WHO. (2015) Alcohol factsheet accessed 3 November 2015.

<http://www.who.int/mediacentre/factsheets/fs349/en/> and *ibid.* at 128.

¹⁸ WHO alcohol factsheet accessed 3 November 2015 <http://www.who.int/mediacentre/factsheets/fs349/en/> and note 1 at 128.

¹⁹ *Ibid.* at 128.

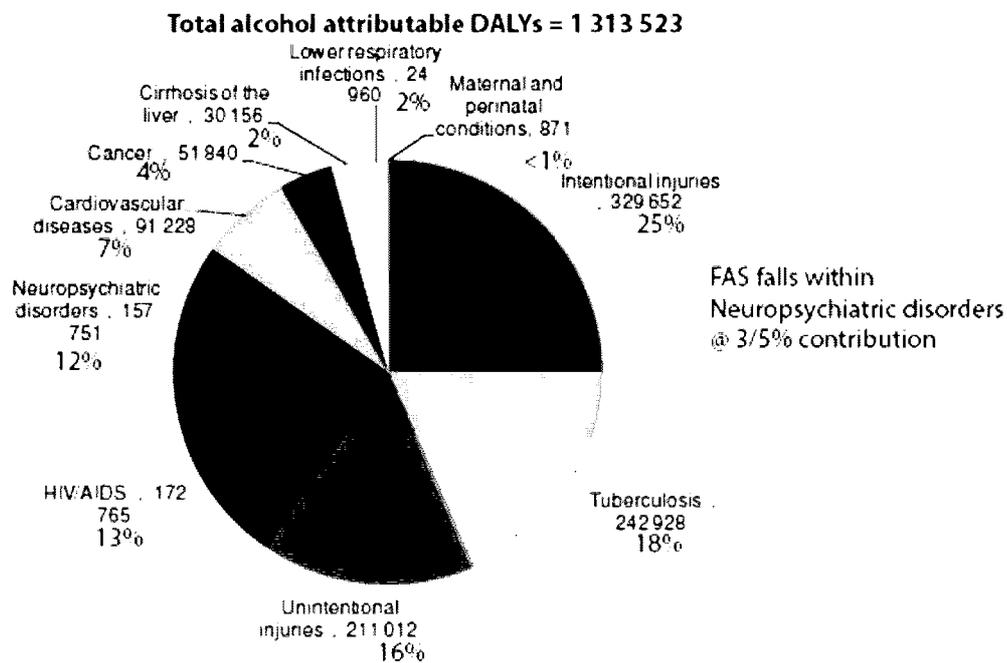
²⁰ Thomas N. *The Beer Giants are Toasting the Rise of Africa*. London: The Telegraph; 2012. Available at: <http://www.telegraph.co.uk/finance/newsbysector/retailandconsumer/9307598/The-beer-giants-are-toasting-the-rise-of-Africa.html> (Archived by <http://www.webcitation.org/6F7OExXXF> on 14 March 2013).

²¹ London, L., Mazok, C., Adam, H., Parry, C. *If the alcohol doesn't get you, then the toxins will: The health impacts of bulk wine provision in the Western Cape province of South Africa*. Poster presented at the American Public Health Association Conference, Boston, November 2006.

²² Global Burden of Disease Study 2013 Collaborators. (2015) *Global, regional and national comparative risk assessment of 79 behavioural, environmental/occupational and metabolic risks or clusters of risks in 188 countries 1990-2013: a systematic analysis for the GBD 2013*. *The Lancet*, 386, 2287-2323. [http://dx.doi.org/10.1016/S0140-6736\(15\)00128-2](http://dx.doi.org/10.1016/S0140-6736(15)00128-2)

(and the associated sexually transmitted infections) and interpersonal violence.²³ The latter two are, however, themselves influenced by alcohol consumption.²⁴ According to a 2013 report released by the WHO’s Regional Office for Africa, of all DALYS (disability-adjusted life years) lost due to alcohol from dying early or living with an alcohol-related disability in South Africa in the period 2004–2006, 41,2% can be attributed to intentional and unintentional injuries; 33,6% due to infectious diseases such as HIV and TB; 13,1% due to non-communicable diseases such as cancer, liver cirrhosis and cardiovascular diseases; 12,0% due to neuropsychiatric disorders; and 0,1% due to maternal and perinatal conditions.²⁵ (See figure: Estimated breakdown by BOD components of alcohol-attributable DALYs, South Africa, 2004)

Estimated breakdown by BOD components of alcohol-attributable DALYs, South Africa, 2004²⁶



Based on the magnitude of harms the drug causes both to drinkers and those affected by drinking, a group of experts determined that, in the UK, alcohol ranks as the most harmful of a selection of 20

²³ Matzopoulos, R, Truen, S, Bowman, B and Corrigan, J. (2014) *The cost of harmful alcohol use in South Africa* South African Medical Journal Vol 104, no 2, 127-132 at 128 based on 2000 data from Schneider, M., Norman, R., Parry, C.D.H., Plüddemann, A., & Bradshaw, D. (2007). *Estimating the burden of disease attributable to alcohol in South Africa in 2000*. South African Medical Journal, 97, 664-672.

²⁴ *Ibid.* at 128.

²⁵ WHO Regional Office for Africa. (2013). *Alcohol consumption and harm in the African region status report*. Brazzaville, DRC: Author. p. 95.

²⁶ Department of Trade and Industry. (2011) *Baseline study of the liquor industry including the National Liquor Act 2003*.

distortion of the brain chemistry.³² A study found that patterns of heavy episodic drinking increases the risk for some diseases and for all injury outcomes.³³

The report *A profile of fatal injuries in South Africa*³⁴, which analysed data from the National Injury Mortality Surveillance System 2008, indicated that 54% (5,701 out of 10,613) of injury related deaths in South Africa involved persons with positive blood alcohol concentrations (BACs) levels.³⁵ The average BAC for those who tested positive was 0.18 (\pm 0.10g/100ml), at least double the current legal limit of 0.05g per 100ml for driving. Levels of BAC were high for violent fatalities (61%), transport related deaths (56%) and suicide (41%).³⁶

While mortuary studies only indicate the linkage between fatalities and alcohol, studies of patients presenting at emergency treatment centres have also demonstrated a link between violence and alcohol. A study of patients presenting to trauma units in Cape Town, Durban and Port Elizabeth found that more than half of patients presenting for injuries caused by violence tested positive for alcohol use.³⁷ The Western Cape Injury Morbidity Surveillance System in sentinel emergency centres shows that about a third of those surveyed presented a probable alcohol use, while nearly half of patients with injuries from interpersonal violence showed probable alcohol use.³⁸ A statistics SA study found that both victim and perpetrator were reported to have been under the influence of alcohol or drugs in 72.1% of sexual violence incidents taking place outdoors and 23.3% of incidents taking place at home, with the victim being under the influence during 63.9% of the incidents in the street.³⁹

The UN has recognised road fatalities as a major public health and development problem. In the Sustainable Development Goals adopted in 2015 by UN member states, a specific stand-alone target in the Health Goal to reduce road traffic fatalities by 50% was adopted⁴⁰.

Goal 3: Ensure healthy lives and promote well-being for all at all ages

3.6. By 2020, halve the number of global deaths and injuries from road traffic accidents

³² Panza F, Capurso C, D'Introno A, et al. (2008) *Vascular risk factors, alcohol intake, and cognitive decline* *Journal of Nutrition Health Aging* Vol 12 No 6: 376–81 accessed via https://en.wikipedia.org/wiki/Long-term_effects_of_alcohol_consumption.

³³ Rehm J, Baliunas D, Borges GL, Graham K, Irving H, Kehoe T, Parry CD, Patra J, Popova S, Poznyak V, Roerecke M, Room R, Samokhvalov AV, Taylor B (2010) *The relation between different dimensions of alcohol consumption and burden of disease: an overview* *Addiction* Vol 105, no 5, 817–843.

³⁴ SAMRC-UNISA (2009) *A Profile of Fatal Injuries in South Africa*.

³⁵ *Ibid.* at 12.

³⁶ *Ibid.* at 12.

³⁷ Plüddemann, A., Parry, C., Donson, H., Sukhai, A. (2004) *Alcohol use and trauma in Cape Town and Port Elizabeth, South Africa: 1999-2000. Inj Control Saf Promotion*. 2004, 11(4), pp. 265-7. Cited in Corrigan, J., and Matzopoulos, R. (2012/2013) *Violence, Alcohol Misuse and mental Health: Gaps in the health system's response, SAHR 2012/12*, pp 103-114, at p. 106.

³⁸ Naledi, T. (2016) *Concept note for teachable Moments intervention in Emergency Centres in the Western Cape to reduce harmful alcohol and substance use*. Western Cape Department of Health.

³⁹ Statistics South Africa. (2016). *Crime statistics series Volume III: Exploration of selected contact crimes in South Africa, 2011-2014/15, Report 03-04-01*, p. 18.

⁴⁰ United Nations Sustainable Development Goals, <http://www.un.org/sustainabledevelopment/health/> (accessed on 15 June 2016).

Approximately 17 000 people are killed on SA roads every year, of which approximately 3000 are children.⁴¹ A further 68 300 people are seriously injured. SAMRC figures show 50% of drivers and over 60% of pedestrians killed were over the legal BAC for driving. It is estimated that if drivers were not driving under the influence of alcohol, 24% of SA driver deaths and non-fatal injuries would be prevented.⁴² Previously, the total estimated annual vehicular-related damage cost of alcohol-involved crashes in SA is R7.9 billion in terms of 2009 estimates.⁴³ More recently, the Road Management Traffic Corporation acting CEO Collins Letsoalo estimated that South Africa's alcohol related crashes had an economic cost of R180 billion per annum in 2010.⁴⁴

The tangible financial cost of harmful alcohol use is estimated to be R37.9 billion, or 1.6% of the 2009 GDP. The total estimated tangible and intangible (**Figure: Tangible and Intangible cost table below**) cost attributable to harmful alcohol use was estimated to be between R245-280 billion, representing 10-12% of 2009 GDP.⁴⁵ In contrast to the costs to the South African economy, the National Treasury⁴⁶ estimates that the economic contribution of the alcoholic beverages sector for the year 2009/10 was R73 billion, or 2.9% of GDP.⁴⁷ The estimates point to a net cost to the economy of approximately 7-10% of GDP, or R165-236 billion.

Tangible and Intangible cost table⁴⁸:

Category	Estimate (R million)	
	Low	High
Tangible costs		
Healthcare	9 330	
Other healthcare costs	2 333	
Treatment research and prevention	18	
Social and welfare costs	397	
Crime response	9 680	
Crime consequence – transfers	4 500	
Crime anticipation	3 750	
Road traffic accidents - damage to motor vehicles	7 912	
Total tangible costs	37 920	
Intangible costs		
Premature mortality and morbidity - reduction in earnings	8 245	9 769
Premature mortality and morbidity - VSL	183 527	216 450
Absenteeism	141	448
Non-financial welfare costs	16 100	
Total intangible costs	208 013	242 767
Insufficient data to estimate cost		
Hangovers and drunkenness at work	Uncertain	
Unemployment and early retirement	Uncertain	
Other labour costs	Uncertain	
Miscellaneous other social and welfare costs	Uncertain	

⁴¹ Medical Research Council (2012) *Injury Mortality Survey 2012* (2009 data).

⁴² Peer N, Matzopoulos R, Myers JE. (2009) *The Number of Motor Vehicle Crash Deaths Attributable to Alcohol-impaired Driving and its Cost to the Economy Between 2002 and 2006 in South Africa*. CapeTown: University of Cape Town.

⁴³ Note 23 at 130.

⁴⁴ Business day live, (2013) <http://www.bdlive.co.za/economy/2013/01/11/road-accidents-rob-sa-of-10th-of-gdp> accessed on 18 August 2014.

⁴⁵ Note 23 at 130.

⁴⁶ Truen S, Ramkolowan Y, Corrigan J, Matzopoulos R. *Baseline study of the liquor industry Including the impact of the National Liquor Act 59 of 2003*. Pretoria, South Africa, 2011 and in National Treasury, South Africa. (2014) *A Review of the Taxation of Alcoholic Beverages in South Africa*.

⁴⁷ *Ibid.* at 6.

⁴⁸ Note 23 at 130.

The need for an alcohol-related harms reduction approach in the Western Cape

The Western Cape is habitually worse than other provinces when it comes to alcohol-related harm statistics. Additionally, alcohol risk contributes significantly to 4 of the 5 major components of the Western Cape Burden of Disease pattern.⁴⁹

The most recent South African Community Epidemiology Network on Drug Use's (SACENDU) update reveals that alcohol is a dominant substance of abuse in the Western Cape.⁵⁰ Results show that 21% of all patients accessing drug-rehabilitative treatment had alcohol as the primary drug of abuse.⁵¹ The fourth South African National Prevalence, Incidence and Behaviour Survey, published by the Human Sciences Research Council (HSRC) in 2012, found that among persons 15 years and older, rates of frequent binge drinking (five or more drinks per occasion for men and four or more for women, at least monthly) were highest in the Free State and Western Cape (at 16%).⁵²

In 2010/11 the WCG, in partnership with the United Nations Office on Drugs and Crime (UNODC) Southern Africa, tasked the Alcohol and Drug Abuse Research Unit at the South African Medical Research Council (SAMRC) with conducting a survey to determine the regional prevalence of drug and alcohol use, risk behaviours and mental health problems among school learners in grades 8 to 10. The *Survey on substance use, risk behaviour and mental health among grade 8 to 10 Learners in Western Cape Provincial Schools, 2012*⁵³ sampled 20227 learners.⁵⁴ The survey found that the most frequently reported substance used was alcohol with 66% of learners reporting use.⁵⁵ In comparison, cannabis use was reported by 23,6% of learners⁵⁶ and less than 6,1% of the learners reported taking hard drugs.⁵⁷ Between a fifth and a quarter (22,3%) reported binge drinking in the two weeks prior to the study and 10% being drunk on a weekly basis.⁵⁸ This study, however, did not compare drinking habits among young people in the Western Cape with other provinces. Another SAMRC study, the Youth Risk Behaviour Survey (YRBS), found that binge drinking in this province among learners in grades 8 to 11 was 35,2%, substantially higher than the national average of 25,1% and more than any of the other provinces.⁵⁹

⁴⁹ Myers, JE (2015) *Rapid Review of the Problem of Alcohol Harm Reduction in the Western Cape Province* (available on request) at 10 and 11.

⁵⁰ South African Community Epidemiology Network on Drug Use. (2015) Update November 2015 at 1.

⁵¹ *Ibid.* at 1.

⁵² Simbayi, personal communication, 03 June 2016.

⁵³ Western Cape Government, Social Development Department. (2012) *Survey on Substance Use, Risk Behaviour and Mental Health among Grade 8 - 10 Learners in Western Cape*. South African Medical Research Council.

⁵⁴ *Ibid.* at 1.

⁵⁵ *Ibid.* at 2.

⁵⁶ *Ibid.* at 3.

⁵⁷ *Ibid.* at 4.

⁵⁸ *Ibid.* at 3.

⁵⁹ Reddy SP, James S, Sewpaul R, Sifunda S, Ellahebokus A, Kambaran NS, Omardien RG. *Umfhente Uhlaba Usamila – The 3RD South African National Youth Risk Behaviour Survey 2011*. Cape Town: South African Medical Research Council, 2013, 126-127.

The prevalence of Foetal Alcohol Spectrum Disorder (FASD) recorded in the Western Cape is among the highest, with levels as high as 18% to 26% among grade 1 learners in certain high-risk communities.⁶⁰

The WCG has identified harm caused by alcohol use as a priority issue for the Province, and the Western Cape Provincial Cabinet has selected the reduction of alcohol-related harm to be one of its “game changers”.⁶¹ The focus is to make a significant impact on an intractable problem that is destroying lives, tearing apart the social fabric and hampering socio-economic development by providing effective interventions to reduce alcohol-related harm.

The current approach to the regulation and distribution of alcohol is founded on maximising the contribution of the liquor industry to the local economy.⁶² This important and valuable economic benefit must be measured against the economic, social and health costs associated with the end use of the products and must take into consideration those paying the costs of alcohol-related harms.⁶³

International studies reflect that social harms dominate individual harms⁶⁴ (as shown in the **Social harms dominate individual harms histogram** in the *Context of alcohol-related harms* chapter above), which means that even people who abstain can suffer alcohol-related harms. The broader set of externalised social costs imposed on society as a result of the excessive personal consumption of alcohol represent instances of market failure, which is a central justification for government intervention and action.⁶⁵

Alcohol is a single modifiable risk factor responsible for a substantial contribution to societal harms. Consequently, targeted approaches could pay high social and economic dividends in terms of harm reduction.

Alcohol risk contributes to the burden of disease in both lesser and more developed settings and are substantial in all the major components. Therefore, while it may be necessary to target high risk groups with particular interventions, a targeted population-orientated approach should also be pursued for the Western Cape because harms are socially pervasive.

An international study found that policies that regulate the alcohol environment are “effective in reducing alcohol-related harm”.⁶⁶ Within environmental solutions, WHO recommends three “best

⁶⁰ May, P.A. de Vries, M., Marais, A-S., Buckley, D., Kalberg, W.O., Adnams, C.M., Hasken, J.M., Robinson, L.K., Manning, M.A., Jones, K.L., Hoyme, D., Seedat, S., Parry, C.D.H., Hoyme, H.E. (2016). *The continuum of fetal alcohol spectrum disorders in four rural communities in South Africa: Prevalence and characteristics*. Drug & Alcohol Dependence, 159, 207-218.

⁶¹ Western Cape Government, Provincial Strategic Plan 2014-2019 at 2 and 13.

⁶² Note 23 at 132.

⁶³ Note 23 at 132.

⁶⁴ Note 27.

⁶⁵ Note 8 at 2240.

⁶⁶ Note 8 at 2443.

buys”: regulating marketing, reducing physical availability, and increasing prices.⁶⁷ As Matzopoulos *et al.* point out, “regulatory and policy interventions have the potential to substantially curtail the costs of harmful alcohol use, and in doing so make a direct contribution to the well-being of the average citizen, and to the economy”.^{68 69}

From responsible consumption, to responsible production, distribution and consumption

Upstream (supply side) interventions should be prioritised because they “typically have considerable gearing with multiple downstream (demand side) effects which amplify effectiveness, they do not rely on human behaviour to avoid harm to self or society, and are relatively easy to implement and typically cost-effective”.⁷⁰

The WCG regulates alcohol, but alcohol-related harm in the province is an ongoing challenge that has been tackled without significant impact. Alcohol continues to be a legal product that is frequently abused and that causes substantial harm. A revised policy focus will shape the content of the regulatory framework within which the Western Cape will operate in respect of alcohol. In order to reflect this revised policy focus, it will become necessary for provincial legislation to accordingly reflect policy changes aimed at reducing alcohol-related harms. The Western Cape Liquor Act, 2008, will have to be amended in order to reflect the policy changes legislatively.

It is with this in mind that we begin our process for a new policy to regulate alcohol with a focus on alcohol-related harms reduction. We do this so that the rights of individuals, families and communities are protected and all our people are able to make the most of their opportunities.

⁶⁷ WHO. (2011). *From Burden to “Best Buys”: Reducing the Economic Impact of Non-Communicable Diseases in Low- and Middle-Income Countries*. Available at: http://www.who.int/nmh/publications/best_buys_summary.pdf.

⁶⁸ Note 23 at 132.

⁶⁹ Freiden, T. (2010). *A Framework for Public Health Action: The Health Impact Pyramid*. *American Journal of Public Health*, 100(4): 590–595.

⁷⁰ Note 49 at 9.

Principles, approach and policy context

This policy is guided by the principles of an open opportunity society for all, where the rights of those who are adversely affected by alcohol-related harms are protected through transparent processes and the rule of law. The policy aims to provide individuals and communities, irrespective of their circumstances, opportunities to develop their own capabilities as well as to access opportunities to address the scourge of alcohol-related harm. Public participation has begun and will continue throughout the comment process to elicit widespread comments from communities most fundamentally affected by widespread harms, and not only from those who regularly respond to requests for policy comment.

An international and domestic evidence-based and whole-of-society approach, guided by the WHO's *Global strategy to reduce the harmful use of alcohol*,⁷¹ was undertaken. Developing and implementing integrated governance systems was also emphasised.

The WHO ten recommended target areas for policy and intervention at a national level are:

1. Leadership, awareness and commitment
2. Health services' response
3. Community action
4. Drink-driving policies and countermeasures
5. Availability of alcohol
6. Marketing of alcoholic beverages
7. Pricing policies
8. Reducing the negative consequences of drinking and alcohol intoxication
9. Reducing the public health impact of illicit alcohol and informally produced alcohol
10. Monitoring and surveillance.

A cooperative governance approach was also emphasised, with the acknowledgement that the reduction of harms requires integrated action, collaborative research, seamless enforcement and community engagement. A rights-based approach was taken, with the policy seeking to respect, protect and promote a number of constitutional rights⁷², including the right to equality, human dignity, life and health care. Children's rights and the right to access to information required for the protection of the above-mentioned rights are also addressed in the policy.

The policy is embedded within a context of a variety of significant instruments. Internationally, the policy seeks to contribute to the attainment of the Sustainable Development Goals,⁷³ because

⁷¹ WHO. (2010) *Global strategy to reduce the harmful use of alcohol*. WHO Press, WHO.

⁷² Constitution of the Republic of South Africa, 1996.

⁷³ United Nations, Sustainable Development Goals. <http://www.un.org/sustainabledevelopment/sustainable-development-goals/> accessed on 24 March 2016.

alcohol-related harm is an obstacle to the achievement of the goals.⁷⁴ Nationally, fundamental rights entrenched in the Constitution of the Republic of South Africa, as discussed above, provide essential direction and impetus. Provincially, the WCG has identified harm caused by alcohol use as a priority issue for the Province in its Provincial Strategic Plan 2014 – 2019 (PSP).⁷⁵ Reducing the most prevalent harm caused by alcohol abuse, namely intentional and unintentional injuries, was selected as one of the priority “game changers”, emphasising the importance of the issue in the Western Cape.⁷⁶

It is acknowledged that the causes of alcohol abuse and misuse are varied and span from limited access to economic opportunities to issues of social disconnect. The PSP, through its many multi-faceted goals, seeks to address systemic challenges related to these issues. It is against this backdrop that this policy is developed.

Purpose and goals of the policy

The purpose of the policy is to target specific alcohol-related harms issues and ancillary matters, with the goal of contributing to the reduction of alcohol-related harms in the Western Cape, while the PSP addresses the broader contributing systemic challenges.

⁷⁴ IOGT International, Obstacle to development. <http://iogt.org/the-issues/advocacy/obstacle-to-development/> accessed on 24 March 2016.

⁷⁵ Western Cape Government, *Provincial Strategic Plan 2014-2019*

⁷⁶ *Ibid.* at 2 and 13.

Chapter 1: Pricing and the economy

The importance of the alcohol industry is acknowledged, particularly in the Western Cape. The alcohol sector makes a considerable contribution to South Africa's economy with the latest independent costing study estimating that the manufacturing and retail of alcohol contributed R93,2 billion to the economy in 2009, or 3,9 per cent of GDP.⁷⁷

In terms of absolute alcohol consumed, beer accounts for 45%, wine 16%, spirits 15%, "backyard concoctions" 12%, ready to drink (RTDs) 6% and traditional beer 4%, with illicit wine and spirits accounting for the remaining 2% of alcohol consumed.⁷⁸

In the Western Cape the wine and spirit industries are inextricably linked with agriculture and are important contributors to the provincial economy and job creation. The contribution is reflected in provincial consumption patterns: wine accounts for a significantly higher proportion of alcohol consumed in the Western Cape than any other province. Although domestic wine consumption fell from 1998 to 2009, production has continued to increase to meet increasing demand overall, driven by the export market. The export market accounted for 55% of wine production in 2009 compared to just 24% in 1998.⁷⁹

The policy seeks to be applied in an economic context that does not unreasonably negatively impact on the existing contribution to the GDP or limit prospective employment opportunities (particularly unskilled and semi-skilled) in the alcohol sector. It does not aim to apply limitations to opportunities within the export market or apply unnecessary red tape that will impact on private-sector investment. Exports of premium wines and brandy are fully supported.

However, as discussed in the problem statement section of this policy, the economic contribution of the liquor industry is dwarfed by the costs of alcohol consumption, which was estimated at between R245-280 billion in 2009 (10 – 12% of GDP).⁸⁰ Social harms of death and disability related to violence, transport and suicide, along with other harms, were also discussed leading to the conclusion that a revised policy focus aimed at reducing alcohol-related harms is necessary in the Western Cape.

Who benefits and who pays the costs?

As previously discussed, evidence supports the notion that the alcohol industry profits are dependent on excessive drinking. The result is that binge drinking accounts for a considerable share of alcohol industry profits, especially at the lower end of the market, where profit is derived from volumes rather than premium brands.

The overwhelming benefit in the alcohol sector accrues to major players: large manufacturers, distributors, retailers and their shareholders. SABMiller, even before the take-over by AB InBev, to

⁷⁷ Truen S, Ramkolowan Y, Corrigan J, Matzopoulos R. (2011) *Baseline study of the liquor industry Including the impact of the National Liquor Act 59 of 2003*. Pretoria, South Africa.

⁷⁸ *Ibid.*

⁷⁹ SAWIS (2010) cited in Truen S, Ramkolowan Y, Corrigan J, Matzopoulos R. (2011) *Baseline study of the liquor industry including the impact of the national liquor act 59 of 2003*. Pretoria, South Africa.

⁸⁰ Note 23 at 127–32.

form the world's largest beer company, had a net income of US\$3,65 billion, approximately R40,15 billion⁸¹, in 2014 and was a multi-national with its primary listing on the London Stock Exchange rather than in South Africa.⁸² Distell, the country's major wine and spirits producer, had a net income of R1,5 billion in 2014.⁸³

At the lower end of the market, alcohol is retailed as a survivalist activity with very low profit margins. In rural areas, farmworkers are among the country's lowest paid workers.⁸⁴ The latest wage determination puts the figure at R2 778,83 per month. Not only do farmworkers earn very little, but they also suffer the harms of poor rural communities in the Western Cape, which have high rates of alcohol-related harms including FASDs.

Despite the profits of the liquor industry, the public sector experiences a net loss, spending more to address harms than it raises from tax and excise. The net cost to the economy was approximately 7% to 10% of the GDP. The bulk of the harm costs arising from alcohol consumption are borne by the public.⁸⁵ The public sector effectively subsidises the liquor industry in SA.

The challenge for government is to develop mechanisms to disincentivise local consumption, especially in respect of the cheaper products and more harmful drinking patterns and to recover through tax, excise, licensing and levies, a greater contribution from the industry to address the burden it places on state-funded health and social welfare systems.

Demand

The WCG proposes the following interventions:

Lobby for a national ban on alcohol advertising that is visible to any persons under the age of 18 and for restrictions on sports advertising and promotion that links alcohol to aspirational achievement.

Demand is influenced by advertising, marketing and promotion. Alcohol advertising does this by encouraging young viewers to create identities as drinkers and cultivate brand allegiance.⁸⁶ The youth are particularly vulnerable to the effects of advertising, and there is evidence that one-third to two-thirds of youth's exposure to alcohol advertising is in excess of adult exposure.⁸⁷ Systematic reviews of longitudinal studies found that alcohol advertising

⁸¹ The exchange rate of 11 Rand to one US Dollar was used for the estimation in accordance with reserve bank figures <https://www.resbank.co.za/webindicators/ExchangeRateDetail.aspx?DataItem=EXCX135D>.

⁸² "Preliminary Results 2014" SABMiller. http://www.sabmiller.com/docs/default-source/investor-documents/results/financial-year-2014-full-year-results-22-may-2014/newsrelease_hf_220514.pdf?sfvrsn=4 Accessed 21 March 2015.

⁸³ Financial times, <http://markets.ft.com/research/Markets/Tearsheets/Financials?s=DST:JNB>.

⁸⁴ Charman, A., Petersen, L., Hartnack, A. & Clark, A. 2009. *A rapid assessment of the potential socioeconomic impact of the Western Cape Liquor Act*. Sustainable Livelihood Consultants.

⁸⁵ Note 23 at 127–32.

⁸⁶ McClure A. C., Stoolmiller M., Tanski S. E., Engels R. C., Sargent J. D. Alcohol marketing receptivity, marketing specific cognitions, and underage binge drinking. *Alcohol Clin Exp Res* 2013; 37: E404–13.

⁸⁷ De Bruijn A, van den Wildenberg E, van den Broeck A. *Commercial promotion of drinking in Europe*. 2012. http://www.amphoraproject.net/w2box/data/AMPHORA%20Reports/Ammie_repport_2012.pdf.

and promotion are linked to under-age consumption,⁸⁸ specifically increasing the likelihood that adolescents will start to use alcohol and to drink more if they are already using alcohol.⁸⁹ Further, young people's exposure to alcohol advertising raises the likelihood of experiencing alcohol-related harms in the subsequent 3 years.⁹⁰

With the growth of social-media platforms, there is a move of youth usage from formal to social-media platforms,⁹¹ which has been accompanied by an upsurge in the alcohol industry's use of social networking, interactive websites, and branded screensavers, among others.⁹² This has resulted in countries incorporating social-media bans in advertising regulations. Finland, for example, banned interactive alcohol advertisements on social media.⁹³ Russia banned alcohol advertisements on the internet.⁹⁴

Restrictions on sports advertising and promotion are recommended. Sporting events sponsored by the alcohol industry are associated with higher levels of consumption among sport spectators.⁹⁵ The use of sports stars in alcohol advertising leads to young people associating drinking with sporting success.⁹⁶

Reducing television and radio time slots has a limited impact on restricting youth exposure, as the option is still available for alcohol advertisers to maximise their available exposure.⁹⁷ An overall restriction of televised alcohol advertising to protect young people is preferable,⁹⁸ as total advertising bans have been shown to have the potential to decrease youth alcohol consumption⁹⁹ and prevent youth deaths.¹⁰⁰

⁸⁸ Smith LA and Foxcroft DR. (2009). The effect of alcohol advertising, marketing and portrayal on drinking behaviour in young people: systematic review of prospective cohort studies. *BioMedCentral* 9(51). Available at: <http://bmcpubhealth.biomedcentral.com/articles/10.1186/1471-2458-9-51>.

⁸⁹ Anderson P, De Bruijn A, Angus K, Gordon R, Hastings G. *Special issue: The message and the media: Impact of alcohol advertising and media exposure on adolescent alcohol use: A systematic review of longitudinal studies.* *Alcohol* 2009; 44: 229–43.

⁹⁰ Grenard J. L., Dent C. W., Stacy A. W. *Exposure to alcohol advertisements and teenage alcohol-related problems.* *Pediatrics* 2013; 131: e369–79.

⁹¹ Nielson (2016). Total Audience Report: Q1. Available at: <http://www.nielsen.com/us/en/insights/reports/2016/the-total-audience-report-q1-2016.html>.

⁹² Casswell, S. (2012). *Current status of alcohol marketing policy-an urgent challenge for global governance.* *Addiction*, 107(3): 478-485.

⁹³ <http://eucam.info/2014/02/27/finland-bans-alcohol-branded-social-media-communication-in-2015/>.

⁹⁴ BBC. (2012) *Russia slaps ban on alcohol advertising in media.* Available at: <http://www.bbc.com/news/world-europe-18960770>.

⁹⁵ Note 87 210-3.

⁹⁶ De Bruijn A, van den Wildenberg E, van den Broeck A. *Commercial promotion of drinking in Europe.* 2012. http://www.eucam.info/content/bestanden/ammie-eu-rapport_final.pdf.

⁹⁷ Ross C., de Bruijn A., Jernigan D. *Time watersheds and youth alcohol advertising exposure: cautionary tales from the U.S. and the Netherlands.* *J Public Aff*; in press; 2013, DOI: 10.1002/pa.1452.

⁹⁸ De Bruijn A, van den Wildenberg E, van den Broeck A. *Commercial promotion of drinking in Europe.* 2012. http://www.eucam.info/content/bestanden/ammie-eu-rapport_final.pdf.

⁹⁹ Saffer H., Dave D. *Alcohol advertising and alcohol consumption by adolescents.* *Health Econ* 2006; 15: 617–37.

¹⁰⁰ Hollingworth W., Ebel B. E., McCarty C. A., Garrison M. M., Christakis D. A., Rivara F. P. *Prevention of deaths from harmful drinking in the United States: the potential effects of tax increases and advertising bans on young drinkers.* *J Stud Alcohol* 2006; 67: 300–8.

Examples, for illustrative purposes, of advertising that would not be visible to persons under the age of 18 would include adult venues such as night clubs and casinos.

The analogous ban on tobacco industry advertising showed negligible impact on the media and marketing sector.

The alcohol industry often suggests self-regulation as an alternative to advertising policies. However, these codes can become weakened over time,¹⁰¹ and audits show that the industry frequently does not conform to self-imposed standards. For example, audits from the US and Europe found advertisements consistently placed where youth were more likely to view them than adults.^{102 103} Further, social media and sponsorship are often excluded from these codes.¹⁰⁴ For these reasons, this approach is not recommended.

The WCG would support the National Department of Health to stringently regulate alcohol advertising.

On the provincial level, the WCG should prohibit advertising, marketing and promotion of alcohol products and companies at all public facilities and events organised by the WCG in the event that a total ban is not achieved.

Alcohol industries may provide sponsorships and receive any applicable BBBEE points for their corporate social investment, however their products or companies may not advertised, marketed and promoted at any public facilities or events organised by the WCG.

Consideration would be given to variations for public facilities and events directly related to tourism and the promotion of exporting locally made alcohol products.

Support the application of (national) levies on marketing and promotional spending to cover alcohol-related harms counter messaging in the event that a total ban is not achieved.

Above-the-line advertising expenditure, according to ACNielsen's Adex, on alcoholic beverages in South Africa has increased dramatically over the past five years, from R834,6 million in 2007 to R1,8 billion in 2012.¹⁰⁵ There is considerably less money and effort expended on counter-messaging to challenge the beliefs and norms created by alcohol industry advertising.¹⁰⁶ The industry should contribute to this counter-messaging, however not produce the content.

¹⁰¹ Babor T. F., Xuan Z., Damon D. *Changes in the selfregulation guidelines of US Beer Code reduce the number of content violations reported in TV advertisements.* J Public Aff 2010; 10: 6–18.

¹⁰² Center on Alcohol Marketing and Youth. *Youth Exposure to Alcohol Advertising on Television, 2001–2009.* Baltimore, MD: Center on Alcohol Marketing and Youth, 2010.

¹⁰³ De Bruijn A, van den Wildenberg E, van den Broeck A. *Commercial promotion of drinking in Europe.* 2012. http://www.amphoraproject.net/w2box/data/AMPHORA%20Reports/Ammie_repport_2012.pdf

¹⁰⁴ Casswell, S. (2012). *Current status of alcohol marketing policy-an urgent challenge for global governance.* Addiction, 107(3): 478-485.

¹⁰⁵ van Walbeek, C and Daly, M. (2014). *Alcohol Advertising in South Africa: A Trend and Comparative Analysis.* WHO, Available at: <http://tobaccoecon.org/wp-content/uploads/2014/03/alcohol-advertising-in-south-africa-a-trend-and-comparative-analysis.pdf>.

¹⁰⁶ Alcohol Justice. (2014) *Why Colleges and Communities Should Refuse Alcohol Industry Funding* at 1 provides figures from Century Council that estimates alcohol products advertising spending between 13 to 27 times more on than on funding educational campaigns.

A ban on advertising is, however, the preferred option. It is more effective and cost-efficient and does not rely on individual-level behavioural change.

Budget for alcohol-related harms interventions at all public health and social service facilities in the Western Cape as well as for community action engagement interventions.

Ensure brief interventions for drinkers who have experienced a traumatic alcohol-related event are available at all public health and social service facilities in the Western Cape. (This point is further addressed under the *Integrated health and social services* chapter).

Supply

In South Africa low pricing, volume-based trade practices and a large poorly regulated and poorly enforced retail trade are important supply-side drivers of consumption and harmful drinking patterns.

For example, it is estimated that as much as 70% to 80% of SAB products are consumed in the informal and unlicensed market.¹⁰⁷ Also damaging are sugar-fermented beverages that provide the cheapest source of alcohol and are widely distributed in the Western and Eastern Cape. The manufacturing of sugar fermented beverages is currently poorly regulated because they are sold as “ales” due to the effectively broad definition of ale in the Liquor Products Act, 1989 (Act 60 of 1989). The problem is currently the subject of an Amendment Bill being introduced in the National Assembly. The Act currently has no definition for beer, but it is understood that the Amendment Bill, once enacted, will also rectify this issue.

The WCG proposes the following policy interventions:

Consider the possibility of a provincially determined framework that would set maximum limits for trading hours in line with the alcohol-related harms reduction approach of reducing consumption. Provision for exceptions would allow for flexibility based on set criteria.

At present trading hours and days vary across the province, with some trading times being excessive and leading to increased availability. As previously discussed, reducing the availability of alcohol is a WHO “best buy” to reduce alcohol-related harms, because decreasing alcohol trading hours is among the most effective and cost-effective alcohol-related harms prevention strategies.¹⁰⁸

The purpose of this proposal is to provide for considered and uniform trading hours that avoid the unintended consequences of excessive trading hours contrary to a harms reduction approach. The proposal may provide for variations, such as different trading hours

¹⁰⁷ Webster et al (2008), *Competition Commission 2007* cited in Truen S, Ramkolowan Y, Corrigan J, Matzopoulos R. 2011. *Baseline study of the liquor industry including the impact of the National Liquor Act 59 of 2003*. Pretoria, South Africa

¹⁰⁸ Anderson, P, Chrisolm, D and Fuhr, DC (2009) *Effectiveness and cost-effectiveness of policies and programmes to reduce the harm caused by alcohol*. The Lancet Vol 373 2234-2246.

and days in residential areas versus in business nodes or for tourism purposes (e.g. wine farms). These exceptions would be included to allow for flexibility based on the set criteria.

Reduce the availability of alcohol by regulating density of outlets (zoning requirements and population density) and regulating trading days and hours.

The WCG should reduce the trading hours for on and off-consumption outlets, and limit the density of outlets in any particular area taking into account zoning requirements and the population size and density.

The proposal would provide for variations based on residential areas versus in business nodes or for tourism purposes. These exceptions would be included to allow for flexibility based on the set criteria.

Higher alcohol outlet density has repeatedly been associated with increased harms,^{109 110} including intimate partner violence¹¹¹ and murder.¹¹²

Recommendations for a harm-based norm, where statistically determined harm is used to evaluate whether licenses are provided or renewed, is discussed under the Institutional Arrangements chapter.

Cutting hours and days of trade reduces the consumption of alcohol and leads to reduced alcohol-related harm. A systematic review found that increasing trading by two hours increases harms, so a two hour reduction is anticipated to reduce harms.¹¹³ A study in Diadema in Brazil, for example, found that a new law mandating on-premises consumption alcohol outlets to close at 11 pm had the effect of reducing murders by 106 per year, or 30 per 100 000 population (approximately 9 per month). Prior to the new law, most bars traded 24 hours a day. Diadema is an industrial city with a population of 360 000 located near to São Paulo which, like parts of Cape Town, has poor socio-economic conditions and high levels of interpersonal violence.¹¹⁴

Less rigorously controlled studies in Australia and in South Africa have also shown positive effects resulting from cutting back on hours of alcohol sales. For example, in Tennant Creek in

¹⁰⁹ Grubestic, T. H. & Pridemore, W. A. (2011). *Alcohol Outlets and Clusters of Violence*. *International Journal of Health Geographics*, 10:30. Available at: <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3098133/pdf/1476-072X-10-30.pdf>.

¹¹⁰ Giesbrecht, N., Huguet, N., Ogden, L., Kaplan, M.S., McFarland, B.H., Caetano, R., Conner, K.R., & Nolte, K.B. 2015. *Acute alcohol use among suicide decedents in 14 US states: impacts of off-premise and on-premise alcohol outlet density*. *Addiction*, 110, (2) 300-307.

¹¹¹ Cunradi, C.B., Mair, C., & Todd, M. (2014) *Alcohol Outlet Density, Drinking Contexts and Intimate Partner Violence A Review of Environmental Risk Factors*. *Journal of drug education*, 44, (1-2) 19-33.

¹¹² Parker R. N., Williams K. R., McCaffree K. J., Acensio, E. K., Browne, A., Strom, K. J., and Barrick, K. (2011) *Alcohol Availability and Youth Homicide in the 91 Largest US Cities, 1984-2006*. *Drug and Alcohol Review*, 30(5):505-14.

¹¹³ Hahn RA, Kuzara JL, Elder R, Brewer R, Chattopadhyay S, Fielding J, Naimi TS, Toomey T, Middleton JC, Lawrence B. (2010) "Effectiveness of Policies Restricting Hours of Alcohol Sales in Preventing Excessive Alcohol." *Consumption and Related Harms Task Force on Community Preventive Services*.

¹¹⁴ Duailibi S, Ponicki W, Grube J, Pinsky I, Laranjeira R, Raw M. The effect of restricting opening hours on alcohol-related violence. *American journal of public health*. 2007;97(12):2276-80. When the mayor was changed the gains were subsequently lost with an easing of the approach, showing the importance of a sustained approach.

the Australian outback, an aboriginal community group successfully mounted a campaign to close off-premise consumption outlets on the days that pay checks arrived and to limit bars on Thursdays and Fridays to opening only after 12:00. Off-premise consumption sales were limited to between 12:00 and 21:00 on other days. Alcohol-related admissions dropped by 34% and admissions to a women's shelter dropped by almost half.¹¹⁵

While the following example relates to shebeens, the evidence supports the point that reducing trading hours leads to a reduction in alcohol-related harms. In Siyahlala, an informal settlement of around 1 300 dwellings in the Brown's Farm area of Nyanga, a suburb of Cape Town with the highest murder rates in South Africa in 2006/7, a broad-based community crime-prevention initiative was implemented between May 2006 and June 2007. Over this time, crime figures plummeted in Siyahlala from between 5 and 8 murders a month to nil and between 30 and 38 assault cases a month to between 10 and 17. One of the interventions involved getting shebeens to close by 21:00. The drop in violent crimes correlated closely with the enactment of these early closures, and this was backed up by the views of shebeen owners.¹¹⁶

Reducing the amount of time business owners sell alcohol would mitigate the harms that their surrounding communities are shouldering. Reducing alcohol-related harms is also in the business community's interest, because up to 72% of alcohol-related costs are incurred from diminished workplace productivity.¹¹⁷

There should also be strict penalties for selling liquor for off consumption from a premise licensed to sell on consumption, with possible suspension of a license as a consequence.

Lobby national government to increase the price of alcohol through increasing excise tax and/or introducing minimum unit pricing.

Alcohol pricing policies are one of the most effective alcohol prevention strategies. This is widely supported by research, including cross-cultural studies.¹¹⁸ For this reason the WHO and the US National Academy of Medicine (previously the Institute of Medicine) recommend alcohol price strategies to combat alcohol-related harms.^{119 120}

Currently alcohol products in South Africa are more affordable than in most low- and middle-income countries in the context of household income.¹²¹ A South African study of

¹¹⁵ Babor, T. et al. (2010) *Alcohol: No ordinary commodity research and public policy* (2nd ed). New York: Oxford University Press.

¹¹⁶ Griggs, R.A. (2007) *An evaluation of nine pilot sites to propose a South African Model of Community Prosecution*, page 27, 28,101, 113.

¹¹⁷ Bouchery, E.E., Harwood, H.J., Sacks, J.J., Simon, C.J., & Brewer, R.D. (2011) *Economic costs of excessive alcohol consumption in the U.S., 2006. American Journal of Preventive Medicine*, 41(5):516-524.

¹¹⁸ Babor, T. et al. (2010). *Alcohol: No ordinary commodity research and public policy* (2nd ed). New York: Oxford University Press.

¹¹⁹ Chaloupka, F. J., Grossman, M., & Saffer, H. (2002). *The effects of price on alcohol consumption and alcohol-related problems*. Retrieved from: <http://pubs.niaaa.nih.gov.ezproxy.welch.jhmi.edu/publications/arh26-1/22-34.htm>.

¹²⁰ IOM. (2004). Reducing underage drinking: A collective responsibility. Retrieved from: http://www.nap.edu.ezproxy.welch.jhmi.edu/catalog.php?record_id=10729.

¹²¹ Van Walbeek C, Blecher M. *The economics of alcohol use, misuse and policy in South Africa*. Cape Town, 2014.

price elasticity for alcohol concludes that a policy targeting the price of alcohol would have significant effects in curbing alcohol demand and that effects are likely to be greater for poorer households and young people, who are more responsive to price changes, than for richer ones.¹²²

The two main strategies to regulate prices are

1. Tax and excise and
2. Minimum unit pricing

Both policies must be considered at the national level.

According to Prof. Corné van Walbeek from UCT's School of Economics, it can be demonstrated from econometric data that changes in alcohol excise taxes translate into changes in alcohol consumption in South Africa, and that the beer industry in South Africa makes it easier for poor South Africans to access relatively cheaper beer through differentially pricing different sizes of alcohol containers (750 ml containers of alcohol are substantially cheaper than 340 ml containers of alcohol per volume).¹²³

Excise taxes: In South Africa excise taxes are the preferred mechanism to curtail alcohol consumption. It has been shown that an increase in tax is passed on to consumers by an increase in the retail price. In addition, an excise tax increase would generate additional revenue. Most excise taxes are derived from beer sales (59%), compared to wine (27%) and spirits (14%). Sorghum beer is taxed at very low rates. A 10% increase in the alcohol price is expected to decrease consumption of beer by 4%, low-price wine by 11%, medium-price wine by 8% and spirits by 8%.¹²⁴

Minimum unit pricing (MUP): MUP at the point of retail is considered the most targeted way to tackle the affordability of cheap, strong alcohol consumed by heavy drinkers without penalising moderate drinkers. It also averts the possibility of alcohol being sold below cost, given away or subsidised.

In both cases, taxing and MUP, a key aspect is for it to be applied volumetrically according to the volume of ethanol /alcohol in the beverage (absolute alcohol) rather than the volume of the alcoholic beverage.

¹²² *Ibid.*

¹²³ Russell, C. & van Walbeek, C. *An analysis of beer tax pass-through in South Africa*. Presentation at the Cape Town 6-monthly meeting of the South African Community Epidemiology Network on Drug Use (SACENDU) project, SAMRC Parow, 26/4/16]. See also Russell, C., & van Walbeek, C. (2016). *How does a change in the excise tax on beer impact beer retail prices in South Africa*. South African Journal of Economics. Doi: 10.1111/saje.12123.

¹²⁴ Van Walbeek C, Blecher M. *The economics of alcohol use, misuse and policy in South Africa*. Cape Town, 2014.

Lobby national government to incentivise the reduction of the ethanol content in alcohol beverages.

A recent study has suggested the approach of reducing the ethanol content in alcoholic beverages to reduce the intake per drinker. Experiments showed that drinkers did not discern different strengths of beers and will not necessarily drink greater quantities. The decrease is expected to lead to lower alcohol-related harms.¹²⁵

The study discussed a reduction of beer to 4% and comparative experiences in Brazil supports the decrease.

Lobby national government to tighten definitions and regulations of ales and beer.

A revised tax regimen needs to go hand-in-hand with the amendment of regulations pertaining to the manufacture of alcoholic beverages and in particular the definition of products that should fall within the scope of the Liquor Products Act (ales, beer, fruit-fermented and other sugar-fermented beverages). This would ensure that higher tax rates are directed at products that are cheaper to manufacture - in particular sugar-fermented alcohols that use cheaper ingredients and that do not require extensive maturation as in the case of wine.

Evaluate available studies or initiate a study to determine effective and cost-efficient disruption mechanisms that could be implemented to increase the real cost of taking legally produced alcohol into the illegal market.

The proposal will require considering disruption mechanisms of distribution networks that supply informal outlets and that benefit from volume-based trading discounts. The aim is to ensure a fully regulated, accountable and responsible alcohol supply chain. These interventions should include mechanisms that will reduce the sale of discounted wholesale liquor to consumers.

Lobby national government to implement a tracking system of liquor products.

The issue to address is the practice of licensed distributors and outlets selling to unlicensed outlets and unlicensed distributors who then supply unlicensed outlets.

The purpose of the proposal is to track liquor products from the point of production to the point of consumption to see where a legal product becomes illegally distributed and for guilty persons to be identified.

Tracking mechanisms in Kenya, Turkey, Brazil and Morocco are proving effective in tracking the product to point of consumption, to establish unregulated sales and consumption, and also in raising significant revenue for the fiscus.

¹²⁵Rehm, J., Lachenmeier, D.W., Llopis, E.J., Imtiaz, S., Anderson, P. *Evidence of reducing ethanol content in beverages to reduce harmful use of alcohol*. The Lancet Gastroenterology & Hepatology, 1(1), 78 - 83 (2016).

Lobby for increasing enforcement of under-age drinking regulations

The majority (61%) of under-age adolescent drinkers in the 2014 Tshwane study reported never showing their ID to obtain alcohol.¹²⁶ In order to partly address the issue of the high level of harmful use of alcohol referred to earlier (see Background) it is recommended that more resources be expended on prosecuting liquor outlets that continually flout regulations regarding the sale of alcohol to persons who are under the legal age. Harnessing the support of the community (see Chapter 7) will be essential in this process.

¹²⁶ Unpublished analysis using International Alcohol Control Study data. 7/11/2016

Chapter 2: Unlicensed liquor outlets and the illicit liquor trade

The number of licensed liquor outlets in the Western Cape in December 2015 was 9 296, comprising 8 888 liquor licenses issued by the Western Cape Liquor Authority (WCLA)¹²⁷ and 408 issued by the National Liquor Authority.¹²⁸

In a 2015 survey, the number of unlicensed liquor outlets in 2015 was determined as 3 483, the equivalent of 37% of the licensed outlets.¹²⁹

A number of concerns emanate from the unlicensed and illicit liquor sector, such as a lack of regulation leading to increased harm and the loss of tax and licence revenue that can be used to mitigate harms.

The WCG proposes the following policy interventions:

Take steps to bring responsible unlicensed liquor outlets into the regulated space in a sustainable and responsible manner to facilitate compliance with minimum requirements.

The liquor industry is regarded as an important industry for economic development, the tourism industry and job creation in the Western Cape. Unlicensed liquor outlets, however, provide disproportionate risk due to a lack of regulation. They are not incentivised to obtain a licence and comply with requirements relating to the prohibition of sales to under-age drinkers, product regulation, the separation of on-and-off consumption, trading days and hours, and other regulations that would reduce harm.

Liquor is also a tax creator for the national government, and 'sin taxes' account for a substantial amount of the national revenue.¹³⁰ Unlicensed outlets are effectively tax evaders, and the government needs to bring them into the regulated system to obtain tax revenue to be used for the benefit of society.

Recommendations for a harm-based norm, where statistically determined harm is used to evaluate whether licenses are provided or renewed, is proposed to ensure a sustainable and responsible absorption of unlicensed outlets into the regulated space.¹³¹

The regulated space must be attractive for both traders and their customers. Incentives for becoming a licensed outlet should be clearly identified and communicated to current illegal

¹²⁷ WCLA, Register of Licenses accessed December 2015.

¹²⁸ National Liquor Authority, database accessed in 2015. https://www.thedti.gov.za/business_regulation/nla_register.jsp.

¹²⁹ SAPS information from South African Police Services Designated Liquor Officers, Sector Commanders, Neighbourhood Watches and Street Committees survey in respect of each policing area per police stations, 2015.

¹³⁰ National Treasury website, http://www.treasury.gov.za/comm_media/press/monthly/1608/Table%201.pdf, accessed on 22 August 2014. The data found that liquor products contributed R20 823m:

Beer	R11 999 m
Sorghum	R 4 m
Wine + fermented	R3 129 m
Spirits	R5 700 m

¹³¹ Discussed under the *Institutional arrangements* chapter.

outlets as well as the consequences of not becoming licensed. The application process for liquor licences must be simplified and streamlined.¹³² The aim of the Western Cape Liquor Act, 2008,¹³³ must be to promote and support the responsible sale and consumption of liquor. Likewise, the municipal by-laws, liquor regulations and liquor licence conditions must be aligned to prevent alcohol abuse within the scope of the licensed environment.

Identify mechanisms and criteria that will enable the rezoning of outlets for liquor sales in appropriate residential areas.

The importance of this is to ensure that there is a clear basis for rezoning that takes into account factors such as location, suitability, public input of affected neighbours, development potential, which can be used to ensure it is not an approach that encroaches on neighbours' rights.

The proposal includes identifying the policy changes required to support this approach and ensuring collaboration and clarification of competencies between municipalities and the WCLA in licensing outlets in residential areas.

Prioritise upstream interventions targeting suppliers to the unlicensed liquor industry and the illicit liquor trade.

A key strategy to combat the unlicensed liquor industry and the illicit liquor trade is to cut off the supply at the source. Obtaining information from community structures and enforcement officials of the licensed traders supplying the liquor, targeting enforcement operations on these licensed traders and lobbying for the prioritisation of the prosecution of them is recommended as a focus area.

Place scientific studies and evidence before the justice system to argue for the prioritisation of liquor law transgressions and to be considered in the sentencing process for tougher sanctions.

Unlicensed liquor outlets that cannot be brought into the regulated space and those who do not comply must face the consequences of the justice system, be prosecuted and closed.

As discussed in the *Problem Statement* section, alcohol's mind-altering effects are drivers of various and extensive harms, including violence^{134 135 136} and criminal activities¹³⁷ such as robbery, murder¹³⁸ and assault. The courts need to take cognisance of this and to that effect

¹³² See chapter on *Institutional arrangements*.

¹³³ Western Cape Liquor Act, 2008 (Act 4 of 2008).

¹³⁴ Darke, S. (2010). *The Toxicology of Homicide Offenders and Victims: A review*. *Drug and Alcohol Review*, 29(2):202-215.

¹³⁵ Foran, H.M. & O'Leary, K.D., *Alcohol and intimate partner violence: A meta-analytic review*, *Clinical Psychology Review*, Volume 28, Issue 7, October 2008, Pages 1222-1234.

¹³⁶ Hughes, K., Anderson, Z., Morleo, M., & Bellis, M.A. (2008) *Alcohol, nightlife and violence: the relative contributions of drinking before and during nights out to negative health and criminal justice outcomes*, Volume 103, Issue 1, pages 60–65.

¹³⁷ Graham, K.; West, P. (2001). *Alcohol and crime: Examining the link*. In Heather, N., Peters, T., & Stockwell, T. (Eds), *International handbook of alcohol dependence and problems*, Wiley. (pp. 439-470).

¹³⁸ Kuhns, J. B., Exum, M. L., Clodfelter, T. A., & Bottia, M. C. (2014). *The Prevalence of Alcohol-Involved Homicide Offending: A Meta-Analytic Review*. *Homicide Studies*, 18(3):251-270.

prosecutors need to be assisted with scientific studies and evidence to be placed before the courts.

The sentences imposed should indicate the seriousness of the harm and possible sanctions must include community service.

Consistent prosecution and heavier sentences will also act as an incentive to become licensed.

Awareness of alternative economic opportunities should be provided to currently unlicensed outlet owners who cannot be accommodated within the applicable zoning scheme.

A clear strategy benefitting and empowering individuals regarding economic alternatives must be developed and shared with the affected parties.¹³⁹

Legislation must provide for the efficient and effective disruption by South African Police Services (SAPS), liquor inspectors and municipal peace officers of the of the liquor supply to unlicensed outlets.

As discussed under the Pricing and Economy chapter, an evaluation of studies or an initiation of a study to determine effective and cost-efficient disruption mechanisms that could be implemented to increase the real cost of taking legally produced alcohol into the illegal market is proposed. Legislation should then provide the power and authority to the appropriate role-players, such as law enforcement officers, to undertake the efficient and effective disruption of the liquor supply.

Liquor enforcement units to be capacitated and strengthened through increased resources and an integrated liquor enforcement approach should be developed.

The enforcement agencies must allocate more resources and prioritise unlicensed or illegal trade in liquor. An integrated approach to liquor enforcement would be required possibly by the establishment of a permanent provincial multi-disciplined and inter-governmental task team.

¹³⁹ Refer to the *Community-based action* chapter.

Chapter 3: Enforcement

Enforcement is an integral part of a comprehensive approach to reduce alcohol-related harms.¹⁴⁰

The role of enforcement is far reaching. It includes both regulatory compliance, which ensures liquor licence holders and applicants comply with the empowering legislation, and criminal enforcement, which is geared towards the enforcement of the penal provisions of the applicable legislation.

Enforcement can serve as an effective mechanism to assist in addressing the issue of unlicensed liquor outlets. There remain opportunities, however, to increase the efficiency and effectiveness of enforcement to serve society.

Addressing fragmented legislation, strengthening unity to harness available resources strategically, simplifying the process to prove alcohol-related offences while increasing the sanctions, and providing greater powers and numbers of liquor law enforcement officials are areas of opportunity to increase the efficiency and effectiveness of enforcement.

The WCG proposes the following policy interventions:

Reducing unlicensed liquor outlets and focusing on problematic outlets

Change in legislation to enable some of the unlicensed outlets to be licensed and therefore regulated.

The proposals for this intervention are discussed under the *Unlicensed liquor outlets and the illicit liquor trade* chapter. They do not constitute a closed list however, and changes may be needed to the criteria to obtain a valid liquor license.

It is estimated that there are about 3 483 unlicensed and therefore unregulated liquor outlets in the Western Cape. Notwithstanding the aim to reduce unlicensed outlets in the province, it is acknowledged that because of the legacy of the past unlicensed outlets have mushroomed, mainly in informal settlements and poorer communities.

The aim must be to bring sustainable, currently unlicensed liquor outlets into the regulated space, on condition that they comply with the minimum requirements. It is not desirable and it must not be seen as an effort to have more liquor outlets. The purpose is to reduce the number of illegal outlets but retain an appropriate number of licensed, and therefore regulated, outlets. The appropriate number would be based on the recommendations for a harm-based norm, where statistically determined harm is used to evaluate whether licenses are provided or renewed, to ensure a sustainable and responsible absorption into the regulated space.

All spheres of government and relevant departments should contribute to the clamp-down on unlicensed outlets and the supply of liquor to these unlicensed liquor outlets. Information from community based-organisations and structures as well as the enforcement opportunities from

¹⁴⁰ Jones-Webb, R., Nelson, T., McKee, P., & Toomey, T. 2014. *An implementation model to increase the effectiveness of alcohol control policies*. American Journal of Health Promotion, 28, (5) 328-335.

municipal zoning schemes, the Western Cape Land Use Planning Act, 2015 (Act 3 of 2015)(LUPA), and the Spatial Planning and Land Use Management Act, 2013 (Act 16 of 2013)(SPLUMA), should be leveraged to aid the law-enforcement agencies.

All spheres of government and relevant departments must apply zero tolerance and a harsh sanction approach to offences like the supply of liquor to unlicensed outlets and the unlicensed retail trade in liquor.

Neighbourhood watch structures, which the Province is capacitating through increased resources and training, are well-placed to provide information on illegal outlets and the sale and distribution of alcohol at the local level.

Active support for civic organisations with regard to the compilation of well-drafted submissions on objections against unlicensed outlets that are problematic should be provided through local structures.

Communities can also raise their concerns regarding harmful drinking and problematic liquor outlets at policing needs and priorities (PNP) meetings. Role-players will be able to develop strategies to reduce these harms at a local level and feed into the safety plans disseminated to the SAPS at Provincial and cluster level, as well as to municipalities and community police forums (CPFs).

CPFs can also play a role in informing the police and law enforcement of problematic liquor outlets and comment on the licensing application process.

LUPA and SPLUMA should be used in prosecutions to ensure that non-compliant outlets in residential areas are closed by an order of court.

Implementing innovative strategies to reduce harms from problematic outlets.

The “last drinks survey” has been quite usefully applied in New Zealand and elsewhere. It involves routinely trying to identify where persons involved in violent acts (both perpetrators and victims), persons involved in motor-vehicle crashes (drivers, pedestrians etc.) and/or persons found to be intoxicated at roadblocks had their last drink. The information is routinely analysed and used to proactively focus attention on outlets contributing significantly to harm.

Promote the involvement of communities themselves through interactive opportunities such as hotlines.

Community members are those most affected by alcohol-related harms and are aware of the issues and role-players. Communication opportunities for them to provide information and tip-offs are essential. Hotlines would encompass communication channels such as telephonic, email, SMS and others.

Refer to the *Community-based action* chapter for further proposals.

Lobby for well-prepared police dockets for the prosecution of liquor-related matters by providing evidence of the link between crime and alcohol – and provide evidence, where appropriate, to support the prosecutions process.

As discussed in the *Problem statement* chapter, alcohol is a driver of various and extensive harms. It is therefore important that every action against illegal or non-compliant outlets is effective.

Successful prosecution requires that police dockets must be well prepared and that prosecutors are well informed and prepared for the matters. The availability and preparation of witnesses is also important.

Appropriate evidence needs to be led in court matters to ensure the sanction is appropriately harsh. As proposed under the *Unlicensed liquor outlets and the illicit liquor trade* chapter, scientific studies and evidence should be placed before the judges and magistrates. Evidence should be led by the prosecutor, and the possibility of an expert to be identified and made available to testify in court, for sentencing of liquor-related offences with regard to the strong correlation between crime and alcohol, as well as the harms caused by alcohol.

Addressing fragmented liquor legislation and strengthening unity to harness available resources

Increase the number of trained liquor law enforcement officers in each sphere of government to operate in a co-ordinated manner, and with extended law enforcement powers.

A small number of officials – 321 designated liquor officers (DLO), eight WCLA liquor inspectors and eight liquor law enforcement officials in the City of Cape Town – regulate approximately 8 888 licensed and 3 483 unlicensed liquor outlets.

Due to the fragmented nature of the legislation across governmental spheres, the powers of these officials are similarly fragmented. The different reporting structures also give rise to units not working in a co-ordinated manner. Currently initiatives to standardise the reporting structures are underway.

Investing in more trained, empowered and capable liquor law enforcement officials should result in returns in the form of reduced expenditure.

The possibility of increasing licensing revenue to employ and train additional liquor law enforcement officers, as discussed further under the *Institutional arrangements* chapter, should be explored.

All enforcement officials must be trained in all aspects of liquor legislation, liquor control and liquor enforcement. A guide needs to be developed and should be available to prosecutors and other state officials.

Training all enforcement officials in all aspects of liquor legislation will provide the technical knowledge to take advantage of the transfer of enforcement powers as discussed above.

Lobby provincial SAPS to report on numbers, cases and convictions of alcohol-related offences.

The number of alcohol-related offences, cases and convictions would provide up-to-date information of the problem in a particular area and an indication of the repercussions. The report should also discuss the reasons for the non-prosecutions and convictions so that any hurdles can be addressed.

Delegations, agency agreements and memorandums of co-operation and designations between the spheres of government and departments to transfer enforcement powers to all public service peace officers.

A number of laws spanning over all spheres of government are concerned with alcohol-related compliance.

Zoning and building regulations, for example, are local government competencies¹⁴¹ provided for in by-laws best known to municipal officials. The WCLA liquor inspectors and SAPS members are not always familiar with municipal by-laws. The interpretation of liquor licence conditions and requirements would be best known to the WCLA liquor inspectors. National requirements in respect of liquor products and labelling would be best known to the administering officers of the national Department of Agriculture, Forestry and Fisheries.

The delegations, agency agreements and memorandums of co-operation and designations between the spheres of government and departments to transfer enforcement powers to all public-service peace officers, coupled with training as discussed above, will increase capacity and the ability to enforce laws operating across the alcohol related compliance space.

Establish one overarching liquor enforcement centre for operational coherence, either within SAPS or the WCLA.

As discussed, enforcement is complicated because of a number of laws spanning over all spheres of government operating in the alcohol-related compliance space.

The actual number of persons responsible for liquor law enforcement in the Western Cape is significantly and inappropriately low, and these limited resources must be used in a manner to achieve maximum results.

An integrated approach to liquor enforcement, through an overarching liquor enforcement centre for operational coherence, is recommended for the co-ordination of enforcement information, to serve as reference point for all units and to supply expert advice on liquor enforcement matters.

The hours of work of enforcement officials must be brought in line with operational requirements.

The times and areas where enforcement officials are deployed should be determined by the patterns of crime and other negative impacts of liquor on society. Strategies and the hours of work of enforcement officials must be brought in line with these operational requirements.

¹⁴¹ Schedules 4 and 5 of the Constitution of the Republic of South Africa, 1996.

The requirements of obtaining a liquor licence should be amended to ensure that licence holders, and the managers, who will be on site must have undergone training and passed a test on the Western Cape Liquor Act and on the rights and obligations of license holders.

Licence holders must comply with a number of laws spanning over all spheres of government. It is therefore essential that licence holders, and those managing the undertaking on behalf of licence holders, are aware of the applicable laws and obligations.

The licence holder or the relevant manager(s), who must be natural persons, must be on site at all times when the outlet is open for business. The proposal is meant to address the issue of persons in the position of managers obtaining the training and found to be competent in understanding the outlets obligations not being present during day-to-day trading to ensure compliance.

The test should be in all three official languages of the Western Cape and administered by the WCLA.

Consideration should also be given to requiring staff, especially those directly working with sales at the licensed premises, to undergo competency training.

Liquor consultants should establish a mandatory association that will regulate the conduct of these consultants.

Liquor licence holders regularly rely on liquor consultants when they make applications to the WCLA. The conduct of these liquor consultants requires regulation to ensure a minimum standard of professionalism.

The consultants should establish a mandatory association that will ensure their members meet a minimum professional standard for membership and the WCLA should refrain from dealing with persons professing to act as consultants if they are not affiliated to this association.

Simplifying the process to prove alcohol-related offences while increasing the sanctions

Legislation must provide for sentencing in line with the seriousness of the harms associated with alcohol to society and barriers to prosecution must be tackled.

Proposed increases in spot fines for liquor-related offences (such as selling to unlicensed outlets, allowing under-age persons in a restricted area of a business selling liquor for consumption on the premises, selling to intoxicated persons and irresponsible trade in liquor), are often minimal. The direct relation between alcohol and crime should be brought to the attention of the provincial magistrates' forum for consideration in increasing penalties and sanctions.

All barriers to the prosecution of liquor-related offences must be identified, explored and understood, and a strategy needs to be developed to address each of these barriers.

Mobile testing for breath and/or blood by an approved, legally admissible device by a suitably qualified provincial official must be used at roadblocks in the Western Cape.

One of the reasons for cases of “driving under the influence of liquor” being withdrawn is the backlog in analysing blood alcohol samples at the Forensic Chemistry Laboratory of the National Department of Health.¹⁴²

It is proposed that mobile testing for breath and/or blood by an approved, legally admissible device operated by a suitably qualified provincial official, be used in the Western Cape at roadblocks. Having everything on site at the roadblock will save time, lessen the risk of tampering and prevent matters from being withdrawn by the courts due to outstanding reports from the laboratory.

Increase the use of breathalyser testing.

The use of breathalyser tests as part of admissible prosecutorial evidence has recently been approved by the National Prosecuting Authority (NPA) and can be used as a method of data collection, evidence gathering and a tool to prevent the misuse of alcohol holistically.

Lobby for the Chief Magistrate for each district to identify one court in the district to deal with all liquor related matters.

Alcohol-related matters are specialised and can be extremely technical. A court in each magisterial district, identified by the Chief Magistrate, should deal with, among other matters, all liquor-related cases. Magistrates in such courts will be able to take judicial notice of trends in their courts as far as sentencing is concerned.

Diversion or alternative dispute resolution (ADR) as a sanction negotiated by prosecutors should be implemented for lower-level alcohol transgressions such as being drunk and drinking in public.

Courts are backlogged with a variety of serious matters. Individuals detained for being drunk and/or drinking in public have the potential to cause serious harm to others or themselves, despite their transgression being perceived as a petty transgression. As discussed in the *Problem statement*, it was found in the Western Cape in 2010 that 61% of pedestrians killed on the road, who were tested, were found to have alcohol present.¹⁴³

It is proposed that diversion or ADR, such as community service or treatment in a rehabilitation centre, be considered in cases of being drunk or drinking in public. Prosecutors can negotiate these sanctions, and these matters need not go before a magistrate.

¹⁴² News 24, *Forensic backlogs reduced, but still too high*:

<http://www.news24.com/SouthAfrica/News/forensic-backlogs-reduced-but-still-too-high-20160406>, accessed on 7 April 2016.

¹⁴³ Provincial Injury Mortality Surveillance System: *Injury Mortality Report 2010*. (2013) Provincial Government of the Western Cape Burden of Disease Project.

Rigorous use of compliance notices¹⁴⁴ by empowered enforcement officers to address poor compliance with the law.

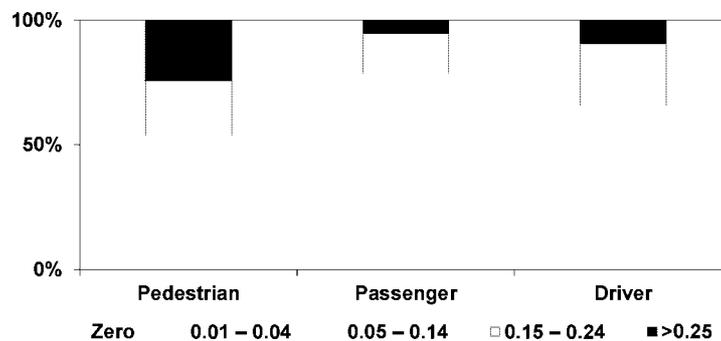
The purpose of this proposal is to facilitate a more compliance-orientated environment. The annual report of the WCG must provide statistics regarding the number and type of compliance notices issued and any further steps taken. An example of steps taken may include requiring further responsible beverage training.

¹⁴⁴ Western Cape Liquor Act, 2008, Chapter 11.

Chapter 4: Alcohol and the Road Environment

Numerous reports and studies on fatalities on Western Cape roads, and particularly Cape Town roads, illustrate the trend that there is a consistent high prevalence of alcohol in road traffic fatalities. Forensic Pathology Services (FPS) data¹⁴⁵ indicate, for example, that alcohol is present in approximately 50% of crash victims, with concentrations of alcohol present in a significant number of pedestrians, passengers and drivers. Pedestrians, who make up approximately 43% of road traffic injury fatalities in the Western Cape,¹⁴⁶ have the highest prevalence of markedly high concentrations of alcohol (**Figure: Fatalities by road user category and by BAC**).

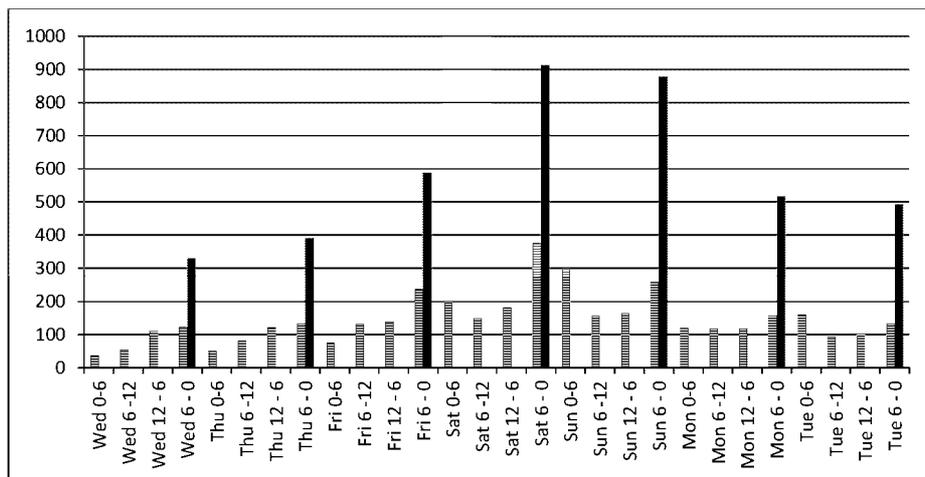
Fatalities by road user category and by BAC level (n=2432). Road user category and by BAC level (n=2432).



Source: National injury mortality survey system, 2005

Road fatalities for both pedestrians and motorists show significant spikes during late nights and early mornings associated with weekend alcohol consumption. (**Figure: Fatalities by day of week, day parts, day total.**) This trend is exacerbated on payday weekends.

Fatalities by day of week, day parts, day total. N=4014



¹⁴⁵ Forensic Pathology Services (2014) *Report on Road Traffic Fatalities*.

¹⁴⁶ *Ibid.*

Source: FPS, road traffic fatality reports prepared for the Department of Transport and Public Works 2012-2014

A substantial reduction in alcohol-related harms in the road environment would result in a significant reduction in the overall cost burden associated with road trauma. The National Department of Transport figures for 2012 estimate R306 billion in costs to the state and loss of earnings.¹⁴⁷ Based on FPS data for the Western Cape, the approximate cost to the Western Cape economy for the same year can be estimated at R21,7 billion. These costs do not include secondary economic impacts such as the inflation of insurance costs or loss of productivity caused by congestion resulting from crashes.

It is therefore imperative that all avenues be explored to reduce alcohol-related road traffic injuries. The WHO¹⁴⁸ and the United Nations favour the Safe Systems approach that identifies a number of pillars to achieve effects in road safety. The approach is supported by this policy.

The WCG proposes the following policy interventions:

Place liquor licensing restrictions in areas with high prevalence of alcohol-related road trauma.

Current and proposed legislation tends to place restrictions on the awarding of licenses for the sale of *alcohol*, based on proximity to certain institutions such as schools or places of worship. Implementing restrictions with a direct bearing on alcohol-related road trauma may help reduce these injuries.

The introduction of road safety related liquor licensing criteria should be considered, such as:

1. A relationship between liquor licensing, trading hours and lighting can be introduced. Trading hours can then be restricted where premises lighting and infrastructure is poor, and licences and renewals can be denied if inadequate lighting is provided outside venues. The aim of these conditions should be to encourage liquor traders to take responsibility for the safety of their clients exiting their venues.
2. Consideration of steps and actions where traders can make up for more dangerous aspects of their business - such as a location in a dark, unlit area with a high prevalence of road deaths - by applying off-sets. For example, a trader whose licence cannot be renewed due to a high prevalence of alcohol-linked road deaths in the vicinity could be compensated by providing proof of a contract with an approved public transport

¹⁴⁷ Minister Dikobe Ben Martins. (2013) *Transport Minister Dikobe Ben Martins saddened by road accident and wishes the injured a speedy recovery*. Available from: <http://www.gov.za/transport-minister-dikobe-ben-martins-saddened-road-accident-and-wishes-injured-speedy-recovery>. [Accessed: 4th December 2015].

¹⁴⁸ WHO. (2014) UN Road Safety Collaboration Meeting Road Safety Management Project Group Meeting Minutes. Available from: http://www.who.int/roadsafety/events/2014/Appendix_5.pdf. [Accessed: 11 December 2015].

operator who is responsible for safely transporting patrons from the surrounding area home at the expense of the patrons.

Consider imposing restrictions on the sale of alcohol on premises that are on national or provincial roads (e.g. at petrol stations).¹⁴⁹

In Brazil an experiment in banning the purchase and sale of alcohol on state highways was somewhat effective in reducing alcohol-related traffic injuries.

Consider lobbying national government to implement a graduated alcohol limit for drivers.

Currently South Africa generally follows an *all-or-nothing* approach to alcohol use by motorists. There is a set legal limit for blood and breath alcohol content. The legislation enacting this is most commonly used to prosecute offenders. Other jurisdictions, notably certain Brazilian provinces and the Federal Republic of Germany have taken a more nuanced approach, with some success.¹⁵⁰ First, these countries have introduced non-criminal alcohol limits in addition to the already existent criminal limits.

In Brazilian provinces where the *Lei Seca* has been implemented: drivers who are screened with a positive BrAC below or equal to 0,06 BAC or lower are detained, must pay a spot fine, and cannot remove their own vehicle from the scene. Germany has non-criminal offences for DUIs under 0,1 BAC until a third offence is committed. Heavy fines and driver's licence suspensions accompany the first two offences, but there is no criminal record.

These systems have been credited with being effective in discouraging drinking and driving, while not over-burdening legal systems with cases where the offender has posed a very low risk to society in comparison with an offender who has exceeded the criminal limit.

The considerations for this limit could include non-criminal sanctions for offenders under 0,1 g, 0,06 g, or the current limit of 0,05 g per 100 ml of blood but over 0,02 g. Individuals screened within the non-criminal limits can be given an option to follow administrative or criminal routes. Evidence of the rationale for these limits is that drivers with a BAC of 0,02 to 0,05 have a three times greater risk of being in a lethal car accident than persons with a BAC of zero. The risk increases by more than six times with a BAC of 0,05 to 0,08, and by 11 times with a BAC of 0,08 to 0,10.¹⁵¹

It is recommended that licence suspensions should be favoured over fines because they are perceived as less open to corruption and do not discriminate on income level. An alternative sanction of community work should also be considered.

¹⁴⁹ Room, R., Carlini-Cotrim, B., Gureje, O., Jernigan, D., Mäkelä, K., Marshall, M., Medina-Mora, M.E., Monteiro, M., Parry, C.D.H., Partanen, J., Riley, L., & Saxena, S. (2002) *Alcohol and Developing Societies: A Public Health Perspective*. Helsinki: Finnish Foundation of Alcohol Studies in collaboration with the WHO.

¹⁵⁰ Stewart, K and Sweedler, B. (2018) *Worldwide Trends in Impaired Driving: Past Experience and Future Progress, Safety and Policy Analysis* International LLC. According to this paper, Germany experienced a 65% reduction in alcohol-related traffic fatalities between 1995 and 2005, against an overall drop in road crash fatalities of 43%.

¹⁵¹ Killoran, A., Canning, U., Doyle, N., & Sheppard, L. (2010) *Review of effectiveness of laws limiting blood alcohol concentration levels to reduce alcohol-related road injuries and deaths*. London: Centre for Public Health Excellence NICE.

Consider the introduction in the Western Cape and/or promotion within the national framework of a licensing system with a zero tolerance for young or novice drivers.

The proposal is to consider a policy whereby no driver under the age of 21 or persons within 3 years of getting their first licence should be allowed to consume any alcohol and then drive. In other words, the drink-and-drive limit would be set between 0,00 g and 0,02 g per 100 ml of blood for this category of drivers.

The rationale is that one would thereby separate the two events: learning to drink and learning to drive. Young drivers under the influence of alcohol have a higher crash risk than would be expected by the additive effects of BAC and age, possibly because they lack crash avoidance skills or because youth who drink engage in riskier behaviours.¹⁵² Young, inexperienced drivers with a BAC of 0,05g per 100 ml have nearly twice the risk of older, more experienced drivers at similar BACs.¹⁵³

Consider the introduction of legislation to place alcohol-related limits for pedestrians on certain classes of road between certain hours.

Pedestrians under the influence of alcohol often exhibit risky behaviour, like crossing streets dangerously,¹⁵⁴ and sustain more severe injuries.¹⁵⁵ Law enforcement has limited tools to remove pedestrians who are posing a danger to themselves and others by walking on or near roads while under the influence. In most instances, officers cannot arrest the person for public drunkenness unless they are visibly intoxicated or commit other offences. While it is not feasible or justifiable to legislate an offence covering all pedestrians who may have consumed alcohol, consideration should be given to legislating BAC and BrAC limits for pedestrians on certain classes of roads at certain times.

The proposal is that consideration be given to the introduction of legislation, for example as municipal by-laws, that make it illegal for pedestrians with a BAC or BrAC over 0,15 BAC to walk on or adjacent to certain higher order roads between designated hours where alcohol-related pedestrian crashes are prevalent or there is significant potential risk, unless pedestrians infrastructure has specifically been provided and the pedestrian is making use of that infrastructure.

Researchers concluded that breathalyser testing of pedestrians was the only potentially effective policy option to counter alcohol-related pedestrian crashes.¹⁵⁶ Legislation would need to empower law enforcement officers to be able to, at a minimum, obtain passive alcohol screening results from pedestrians suspected of being under the influence.

¹⁵² Peck, RC., Gebers, MA., Voas, RB., & Romano, E. (2009). *The relationship between blood alcohol concentration (BAC), age, and crash risk*. Journal of Safety Research, 39(3): 311-319.

¹⁵³ Peden M et al., eds. (2014) *World report on road traffic injury prevention*. Geneva, WHO.

¹⁵⁴ Oxley, J. Lenné, M. & Corben, B. (2006). *The effect of alcohol impairment on road-crossing behaviour*. Traffic Psychology and Behavior, 9(4):258-268.

¹⁵⁵ Dultz LA, Frangos S, Foltin G, et al. *Alcohol use by pedestrians who are struck by motor vehicles: how drinking influences behaviors, medical management, and outcomes*. J Trauma. 2011;71:1252–1257.

¹⁵⁶ Hutchinson TP. (2010). *Countermeasures to the problem of accidents to intoxicated pedestrians*. Journal of Forensic and Legal Medicine, 17(3):115-119.

Legislation could also be designed to target specific hotspots, or to cover specific classes of roads.

The introduction of alcohol Interlocks¹⁵⁷ be considered for certain categories of road users and vehicles – as well as for sentencing in convictions of driving under the influence.

Alcohol interlocks can be used to effectively prevent or discourage driving under the influence,¹⁵⁸ specifically in instances where drivers may have already consumed alcohol and are not able to make a responsible decision about their course of action.

It is recommended that alcohol interlocks are considered for all public transport vehicles, including scholar transport vehicles and school buses, all government and government agency vehicles¹⁵⁹ and goods vehicles over a certain weight.

It is proposed that the Magistrates' Forum and the NPA be encouraged to consider the introduction of alcohol interlocks as potential measures to be used both in diversion programmes and as part of sentencing in convictions of driving under the influence or with a breath or blood alcohol level higher than the legally permissible level. At a minimum, it is suggested that an alcohol interlock should be mandatory in cases where the NPA opts to permit a diversion arrangement, or a magistrate or judge delivers a sentence that does not include a licence suspension because of consideration for the offender's work circumstances.

Alcohol interlocks have the benefit of permitting the offender to continue to drive to work and other places while providing assurances that they are not driving under the influence.

The cost of the installation should be to the account of the offender. The courts would have the discretion to offset this cost by a reduction in the fine levied. It is of far greater importance to road safety to implement measures to prevent reoffending than to punish the offender financially. Attempts to tamper with the interlock would trigger more sanctions.

Supporting and strengthening random breath testing.

Random breath testing is among the most effective drink driving interventions¹⁶⁰¹⁶¹ and can reduce fatal traffic crashes by 20%.¹⁶² A Random Breath Testing programme has been designed for alcohol-related harms reduction in the province, which should be supported and strengthened.

¹⁵⁷ An alcohol interlock is a device that requires the driver to provide a breath sample that has less than a specific BrAC to start the vehicle.

¹⁵⁸ Marques, PR (2010). Ignition interlocks: Review of the evidence. *Blutalkohol*, 47(5): 318-327.

¹⁵⁹ Excluding emergency response vehicles, such as ambulances, law enforcement vehicles, combat and combat support vehicles of the SANDF.

¹⁶⁰ Morrison DS, Petticrew M, Thomson H. What are the most effective ways of improving population health through transport interventions? Evidence from systematic reviews. *J Epid Comm Health* 2003;57:327-333.

¹⁶¹ Erke A, Goldenbelt C, Vaa T. The effects of drink-driving checkpoints on crashes—A meta-analysis. *Accid Ana Prev* 2009;41:914.

¹⁶² Shults RA, Elder RW, Sleet DA, Nichols JL, Alao MO, Carande-Kulis VG, Zaza S, Sosin DM, Thompson RS, Task Force on Community Preventive Services. Reviews of evidence regarding interventions to reduce alcohol-impaired driving. *American journal of preventive medicine*. 2001 Nov 30;21(4):66-88.

Integrate law enforcement and road safety awareness action.

Legislation cannot make a significant impact without the public being made aware of it and it being enforced. It is thus important that the public is educated about the consequences of alcohol and road user behaviours – and that it is widely publicised when law enforcement action is taken.

In line with WHO recommendations, budgets to be identified and allocated to law enforcement and mass communication efforts to change road-user behaviour.

A random breath testing programme of the kind designed for alcohol-related harms reduction in the province is an example of a suitable intervention of this nature.

Blood samples should be obtained from all those involved in road crashes as soon as possible within the restrictions of the duty of care to seriously injured persons.

Emergency rooms and intensive care units are focussed on the immediate requirements of patient care. In the case of individuals who have injured themselves in the commission of serious road traffic offences, law enforcement is often not able to obtain usable blood or breath alcohol samples because the patient is protected during treatment for injuries. The absence of a BAC record for an injured party can mean that a potentially important part of the evidence cannot be collected, which this proposal attempts to address.

Lobby for alcohol-related harms awareness material to be included in the content for licence testing.

The purpose for alcohol-related harms awareness material to be included is so that new drivers can take preventative measures from causing harms.

Develop interventions for first-time DUI offenders.

The proposal is to develop and standardise compulsory alcohol safety intervention weekend programmes for persons convicted of driving under the influence of alcohol for the first time.¹⁶³

¹⁶³ Parry, C.D.H., Morojele, N., & Jernigan, D. (2008). *Creating a Sober South Africa*. In S. Pennington (Ed.) *Action for a Safe South Africa* (pp. 68-75). Paarl: SA Good News.

Chapter 5: Health and social services

Health and social services play a critical role in providing prevention, treatment and rehabilitation services to individuals with conditions that are associated with alcohol misuse and abuse.

The whole-of-society approach, in line with the Prevention of and Treatment for Substance Abuse Act, 2008 (Act 70 of 2008),¹⁶⁴ along with supply side interventions discussed in this policy, is advocated in the provision of services with a focus on the individual in the context of their families and communities. It is through continuous engagement with communities, youth peer education programmes, parenting skills programmes, psycho-education for families that government empowers communities to recognise early warning signs of alcohol abuse.¹⁶⁵

The WCG proposes the following policy interventions:

The following interventions as recommended by the WHO¹⁶⁶ and in line with the Prevention of and Treatment for Substance Abuse Act, 2008, and the regulations to that Act will be implemented within health and social services. Where such services currently do not exist, they will be progressively realised, starting with areas of greatest burden and need. The intervention proposals may require new or reprioritised budgets.

*Provide equitably distributed emergency medical services for alcohol-related conditions, including detoxification services such as behavioural and pharmacological therapies, to improve access to treatment services.*¹⁶⁷

The Department of Health (DoH) and the Department of Social Development (DSD) provide treatment and rehabilitation services. The DSD and its funded non-profit organisations (NPOs) render services across the Western Cape. Facilities are divided into prevention, early intervention, treatment, aftercare and reintegration. The facilities are, however, inequitably distributed, resulting in poor access for rural and semi-urban communities in particular. Providing equitably distributed emergency medical services for alcohol-related conditions, including detoxification services, is therefore an important step to advance harms reduction. These services will be most effective when a post-emergency program focuses on individuals and families at risk.

*The DSD, in collaboration with the DoH and other stakeholders, will strengthen prevention, early intervention, detoxification, treatment and aftercare evidence-based interventions.*¹⁶⁸

The purpose of this intervention is to ensure that the minimum norms and standards are adhered to for inpatient community-based organisations and half-way houses.

¹⁶⁴ Prevention of and Treatment for Substance Abuse Act, 2008 (Act 70 of 2008).

¹⁶⁵ Section 9(1).

¹⁶⁶ Chapters 4, 6 and 7 and note 50 at 12.

¹⁶⁷ Note 50 at 12.

¹⁶⁸ Note 50 at 12.

Provide programmes for screening, provision of information, brief motivational interventions¹⁶⁹ and appropriate treatment services for hazardous and harmful drinking in primary health care settings, including antenatal clinics, and in emergency units.¹⁷⁰

Brief interventions in healthcare settings is a highly effective alcohol consumption reduction strategy.¹⁷¹ WHO recommends targeting educational interventions according to alcohol consumption patterns, as indicated by screening results. WHO recommends providing light/moderate and moderate/heavy drinkers with simple advice outlining alcohol-related risks. Additionally, WHO recommends healthcare providers provide normative feedback, advice on drinking limits and goals, and offer encouragement to moderate/heavy drinkers.¹⁷²

Therefore, primary health-care facilities and other health facilities that are widely distributed in the province and serve the vast majority of the population in the province present an ideal opportunity for screening for alcohol misuse and early referral to treatment and rehabilitation services provided by both the DoH and DSD. The opportunity is, however, often missed because there are no standardised screening protocols.

Local research has been undertaken in the Western Cape that can inform efforts to screen and intervene in such settings.¹⁷³

However, there are barriers to this effective strategy that must be circumvented. Currently emergency centres are not equipped or staffed to provide the services proposed and will have to be capacitated over time. Meta-analyses also show practitioner frustration with managing alcohol use disorders, perceived time constraints can impede implementation¹⁷⁴, and a systematic review found adequate financial/managerial support and training are critical to successful implementation. While the cost of this approach is moderate, there is

¹⁶⁹ Spirito, A (PhD), Monti, PM (PhD), Barnett, NP (PhD), Colby, SM (PhD), Sindelar, H (PhD), Rohsenow, DJ (PhD), Lewander, W (MD), Myers, M (PhD). (2004) *A randomized clinical trial of a brief motivational intervention for alcohol-positive adolescents treated in an emergency department* The Journal of Paediatrics, Vol 145, no 3, 396–402.

¹⁷⁰ Note 71 at 12.

¹⁷¹ Babor, T. et al. (2010). *Alcohol: No ordinary commodity research and public policy* (2nd ed). New York: Oxford University Press.

¹⁷² WHO. (2001) Brief Intervention for Hazardous and Harmful Drinking. Retrieved from: http://whqlibdoc.who.int/hq/2001/who_msd_msb_01.6b.pdf.

¹⁷³ Sorsdahl, K, Myers, B, Ward, C., Matzopoulos, R, Mtukushe, B, Nicol, A, Stein, D. *Screening and brief interventions for substance use in emergency departments in the Western Cape Province of South Africa: views of health care professionals*. 2013 Jul. International Journal of Injury Control and Safety Promotion. DOI: 10.1080/17457300.2013. 811267; Sorsdahl, K., Stein, D.J., Corrigan, J., Cuijpers, P., Smits, N., Naledi, T., Myers, B. (2015). *The efficacy of a blended motivational interviewing and problem solving therapy intervention to reduce substance use among patients presenting for emergency services in South Africa: A randomized controlled trial*. Substance Abuse Treatment, Prevention and Policy, 2015. DOI: 10.1186/s13011-015-0042-1.

¹⁷⁴ Anderson P., Laurant M., Kaner E., Wensing M., & Grol R. (2003). Engaging general practitioners in the management of hazardous and harmful alcohol consumption: results of a meta-analysis. *Journal of Studies on Alcohol*, 65(2):191-9.

the potential for an unanticipated benefit that providers become more skilled at working with alcohol abusing populations.¹⁷⁵

Provide interventions at antenatal clinics to reduce the likelihood of alcohol-exposed pregnancies.

The following measures recommended: (i) education of women of child-bearing age who are not on birth control of the risks alcohol consumption poses to foetal development (through life-skills education in schools and broader education campaigns), (ii) encouraging earlier uptake of antenatal services for pregnant women and expecting fathers, and ongoing screening of alcohol use for women attending antenatal clinics, and (iii) active case management of mothers who are at higher risk of an alcohol-exposed pregnancy who attend antenatal clinics. The latter has been found to help women at risk to either stop drinking or cut down on drinking during pregnancy, leading to a reduced risk of Foetal Alcohol Spectrum Disorder (FASD).¹⁷⁶

Strengthen the to-be-developed early screening and referral services at schools and other institutions of learning, targeting high-risk areas in the province.¹⁷⁷ Specialised services for treatment and brief interventions for youth to be expanded and included at child- and youth-care centres and appropriate health facilities.

Youth who begin drinking before age 15 are five times more likely to develop an alcohol use disorder than those who wait until age 21.¹⁷⁸ Youth who start drinking when they are younger than 14 have 5 times greater odds of suffering an alcohol-related injury, 6.3 times greater odds of ever being in a traffic crash, and 6 times greater odds of ever being in a fight as compared to youth who wait until age 21 to start drinking.¹⁷⁹

The *Survey on substance use, risk behaviour and mental health among grade 8-10 learners in schools in the Western Cape, 2011* found that the most frequently reported substance used was alcohol, with 66% of learners reporting use¹⁸⁰ and approximately 25% reported binge-drinking in the two weeks prior to the study.¹⁸¹ Youth are a key demographic group to focus on to address the challenges of alcohol-related harms.

¹⁷⁵ Johnson M., Jackson R., Guillaume L., Meier P., & Goyder E. (2011). Barriers and facilitators to implementing screening and brief intervention for alcohol misuse: a systematic review of qualitative evidence. *Journal of Public Health*, 33(3):412-21.

¹⁷⁶ De Vries, M.M., Joubert, B., Cloete, M., Roux, S., Baca, B.A., Hasken, J.M., Barnard, R., Buckley, D., Kalberg, W.O., Snell, C.L., Marais, A-S., Seedat, S., Parry, C.D.H., May, P.A. (2015). Indicated Prevention of Foetal Alcohol Spectrum Disorders in South Africa: Effectiveness of Case Management.

¹⁷⁷ Note 71 at 12.

¹⁷⁸ U.S. Department of Health and Human Services. The Surgeon General's Call to Action to Prevent and Reduce Underage Drinking: A Guide to Action for Educators. U.S. Department of Health and Human Services, Office of the Surgeon General, 2007. Available at: <http://www.surgeongeneral.gov/library/calls/underage-drinking-educator-guide.pdf>

¹⁷⁹ Hingson RW, Edwards EM, Heeren T, & Rosenbloom D. (2009). Age of Drinking Onset and Injuries, Motor Vehicle Crashes, and Physical Fights After Drinking and When Not Drinking. *Alcoholism: Clinical & Experimental Research*, 33(5): 783-790. Available at: <http://www.ncbi.nlm.nih.gov/pubmed/19298330>.

¹⁸⁰ Note 53 at 1.

¹⁸¹ Note 38 at 1.

*Establish an effective referral system to services provided by the DoH, DSD, other departments and NPOs to provide long-term treatment, prevention and diversion activities.*¹⁸²

The DoH has one dedicated detoxification unit in Cape Town and the DSD has two public treatment centres. The City of Cape Town (CoCT) has six treatment sites. A close working relationship exists between the detoxification unit and various inpatient and community-based treatment facilities. Primary health care workers and social workers however cannot always refer people for detoxification at a treatment facility or a day hospital because of a poor referral system and lack of resources. Establishing an effective risk stratification and referral system to services provided by the DoH, DSD, other departments and NPOs is a priority.

*Outpatient care for clients on treatment and rehabilitation services, as well as active outreach into communities, to be strengthened to improve treatment outcomes.*¹⁸³

Active involvement of families, faith-based organisations and NPOs would be required.

*Improve effective coordination and integration between the DoH and DSD of services for alcohol-use disorders and co-morbid conditions, including drug-use disorders, depression, attempted suicide, HIV/AIDS and tuberculosis.*¹⁸⁴

The DSD, through the Provincial Substance Abuse Forum (PSAF) and the local drug action committees (LDACs),¹⁸⁵ will coordinate an integrated transversal approach to determine gaps and co-ordinate the development of integrated, cost-effective and evidence-based programmes.

*Institutionalise and maintain an integrated surveillance system in the DSD and DoH for alcohol-attributable morbidity and mortality and feed the information into a provincial monitoring and surveillance system.*¹⁸⁶

¹⁸² Note 50 at 12.

¹⁸³ Ouimette, P C, Moos, R H, and Finney, J W. (1998) *Influence of outpatient treatment and 12-step group involvement on one-year substance abuse treatment outcomes*, Journal of Studies on Alcohol, Vol 59, no 5, 513–522.

¹⁸⁴ Note 50 at 12 and 31.

¹⁸⁵ Established in terms of the Prevention of and Treatment for Substance Abuse Act (Act No. 70 of 2008) and in line with The National Drug Master Plan (2013-2017), approved by the Provincial Cabinet on 26 June 2013.

¹⁸⁶ Note 50 at 12.

Chapter 6: Community-based action

Community-based initiatives recognise the specific and unique needs of communities. These strategies should aim to build on the existing strengths and resources of the community and facilitate partnership and capacity building throughout the process.

Community-based action requires a long-term commitment with communities. A number of different stakeholders may be involved, including government, civil society and the private sector.

Substance abuse has a range of effects on an individual's physical, emotional, social and cognitive health and well-being.¹⁸⁷ These effects have an impact on their environment, such as on their family, community and workplace. Treatment should therefore not only focus on the individual, but also on their environment through community-based action.

The WCG proposes the following policy interventions:

The community-based model for substance abuse treatment and rehabilitation should be expanded.

The model has been adopted by the National Department of Social Development and the WCG. It is more cost effective and allows clients to access services within their community – saving on unnecessary expenses, time and difficulty of seeking treatment outside of their environment. The model is also in line with WHO recommendations because the services include community care and support for affected individuals and their families and¹⁸⁸ creates awareness of the facts relating to alcohol abuse and alcohol-related harms.¹⁸⁹

The capacity of municipalities should be strengthened and institutionalised through the establishment of LDACs – with accountability mechanisms based on intergovernmental relations lobbied for to ensure the establishment of effective LDACs.

The LDACs, as a multi-stakeholder forum, are a vehicle that would “encourage and coordinate concerted community action by supporting and promoting the development of municipal policies to reduce harmful use of alcohol ... enhance partnerships and networks of community institutions and nongovernmental organisations”¹⁹⁰ as recommended by the WHO.

The PSAF, together with LDACs will coordinate integrated community programmes.

LDACs will identify the community needs and service delivery gaps, as well as develop a referral pathway linking the needs of the community with available service providers. The coordination of integrated community programmes will be pursued through the efficient use of facilities and infrastructure, including primary health care centres and other public facilities. Fostering multidisciplinary-team approaches (made up of social workers,

¹⁸⁷ Bezuidenhout, F.J. 2008. *A reader on selected social issues*. 4th Edition. Pretoria: Van Schaik Publishers. Page 138.

¹⁸⁸ Note 50 at 12.

¹⁸⁹ Note 50 at 13.

¹⁹⁰ Note 50 at 13.

professional nurses, mental health practitioners, community structures and service users), establishing support groups, as well as ensuring professional and lay support in the community environment will be important steps in the coordination of integrated community programmes. Enhancing the capacity of communities to respond to their own needs through community mobilization, strength-based approaches and empowerment programmes, along with supporting the strategic establishment of recreational, cultural and sports activities to divert young people at risk, will receive attention. Supporting early-childhood-development programmes will be supported with the relevant referral of services for mothers with substance-abuse problems.

Provide further support for the the Western Cape at Risk Families programme..

Support for this proposal comes from positive findings that have been noted for the universal Strengthening Families Programme for 10- to 14-year-olds, including longer-term follow-ups.¹⁹¹

LDACs will coordinate the availability of timely information of good quality about the effectiveness of community-based interventions and provide it to the PSAF for wide dissemination.

The information will be used for best practice awareness for action, integrated planning of interventions and building of capacity at community level for implementation.

The DSD, in collaboration with LDACs, will maintain an integrated and easily accessible Western Cape Substance Abuse Resource Directory, available in hard copies and online, to inform the public where they can access effective community-based and inpatient services.

The WHO recommends providing information on effective community-based interventions,¹⁹² and this cross-community sharing could spark additional interventions. Other countries have acted on this recommendation, including Slovenia, which created the website “Mobilizing society for more responsible attitudes towards alcohol” (<http://www.infomosa.si/>) to share best practices.

Leverage neighbourhood watch structures to assist with gathering and dissemination of information.

Neighbourhood watches, which the Province is capacitating through increased resources and training, should play a pivotal role in providing information on illegal outlets to disrupt illegal alcohol distribution and selling at a local level. They are also ideally placed to disseminate information to the community.

Increasing community input in the management of conflicts arising as a result of social disruption associated with liquor outlets.

The benefit of this approach has been demonstrated in the regional city of Geelong, Australia. The Local Industry Accord, designed to promote a range of harm minimisation

¹⁹¹ Kumpfer, Karol L.; Whiteside, Henry O.; Greene, Jeanie Ahearn; Allen, Keely Cofrin, *Effectiveness outcomes of four age versions of the Strengthening Families Program in statewide field sites*. Group Dynamics: Theory, Research, and Practice, Vol 14(3), Sep 2010, 211-229. <http://dx.doi.org/10.1037/a0020602>.

¹⁹² Note 50 at 13.

strategies aimed at reducing alcohol-related violence and crime, brought together the police, local licensed-premises operators, Liquor Licensing Commission representatives and other relevant agencies and individuals.¹⁹³

To achieve the objectives of the accord, the following practices were strongly discouraged: free and heavily discounted drinks, unsatisfactory standards of crowd controllers not checking the identity of patrons leading to underage persons entering licenced premises, and all-age events with the availability of large volumes of alcohol.

Over time a number of additional strategies were implemented to combat alcohol-related problems. These included requiring all crowd controllers to be licensed and display identification to this effect when working; improving the training of bar staff, security personnel and new licensees; offering all licensed-premises operators a mechanism of referral for dealing with young persons who present false or altered identification to gain entry into licensed premises; establishing alternative, alcohol-free entertainment (e.g. discos) in a supervised venue for young people; allocating eight hotels or nightclubs to one police sergeant who would assist licensees with problems they might have and to work with them in dealing with incidents occurring in or around their premises; and having the local authority enact a by-law prohibiting persons from having open containers of alcohol in public places. Breaches of the latter attract a \$100 spot fine and are actively enforced by local council officers and police.

Since the adoption of the accord in 1991, crime and violence associated with intoxication is reported to have decreased significantly. The focus is on proactive engagement with outlets prior to the occurrence of problems.

The successful aspects of the AHR community-based action projects in three areas, namely in Khayelitsha, in Gugulethu and Nyanga and in Paarl East, will be progressively rolled out to other areas.

The project to reduce alcohol-related harm is a game changer in the Western Cape.

The project aims to create socially active and safer neighbourhoods. It will do so through building social cohesion and strong community networks to partner in managing and implementing the project.

The project consists of three levers:

Lever 1: Enforcement: Reduce access to alcohol.

Lever 2: Recreational and economic: Enhance quality and participation in recreational alternatives and to facilitate access of outlet owners to alternative economic activities.

Lever 3: Health and social services: Create awareness of and access to health and social-support services to those who have alcohol-related problems.

¹⁹³ Turning Point (1998) *An Evaluation of the Geelong Local Industry Accord*. Victoria: Alcohol and Drug Centre Inc. – see also Geelong Regional Liquor Licensing Accord: Draft

The PNP meetings will be used as an opportunity to develop policing strategies to reduce alcohol-related harms.

In the Western Cape, the PNPs are determined annually through a public consultation process facilitated by the Western Cape Department of Community Safety (DoCS) and hosted by the Western Cape Minister for Community Safety. Key stakeholders are invited from the safety and security environment that are believed to represent the broader population and who have influence over the allocation or deployment of resources.¹⁹⁴

Members of the community are able to raise their safety concerns about harmful drinking and problematic liquor outlets at PNP meetings. Role-players will be able to develop strategies to reduce these harms at the local level and feed into the safety plans disseminated to the SAPS at Provincial and cluster level, as well as to municipalities and CPFs. The PNP workshops will in the upcoming financial years monitor the implementation of the community safety plans and review their implementation.

The PNP workshops are also an opportunity for community safety structures such as neighbourhood watches to provide information and discuss strategies to disrupt illegal alcohol distribution and selling. The strategies would be based on shared insights and evidence from what has worked elsewhere, including, for example, the AHR community based action project game changer discussed earlier.

CPFes are established in terms of section 18(1) of the South African Police Service Act, 1995.¹⁹⁵ CPFes play a role in establishing and maintaining a partnership, communication and cooperation between the police and the community in fulfilling the safety needs of the community. They must also promote joint problem identification and problem solving by the police and the community. CPFes are to play a role in informing the police and law enforcement structures of problematic liquor outlets and CPF comments should be mandatory in the licensing application process.

¹⁹⁴ Such as mayors, municipal managers, ward councillors, SAPs station and cluster commanders, CPF and cluster chairpersons, community safety forums, neighbourhood watch chairpersons, security service providers, businesses owners, NGO's, faith-based organisations, government departments, and the media.

¹⁹⁵ South African Police Service Act, 1995 (Act 68 of 1995).

Chapter 7: Education and awareness

Education and awareness are important to understand alcohol-use risks. Knowledge is valuable in mobilising support for strategies to reduce harms and provide awareness of effective interventions available to the public.¹⁹⁶

We support a whole-of-society, multi-sectoral approach to education and awareness, integrated appropriately, with the aim of educating the public and stakeholders about the negative consequences of harmful alcohol use and its associated risks, mobilising support for strategies to reduce harms and supporting effective alcohol interventions to deal with these harms.¹⁹⁷

The WCG proposes the following policy interventions:

Prioritise the PSAF and LDACs as platforms for integration, referral pathways and reciprocal communication.

The PSAF is the forum established in terms of section 57 of the Prevention of and Treatment of Substance Abuse Act, 2008 (Act 70 of 2008), by an MEC in order to give effect to the National Drug Master Plan (NDMP).¹⁹⁸ The PSAF's proposed role with regard to education and awareness, compatible with a core function to 'strengthen member organisations to carry out functions related directly or indirectly to addressing the problem of substance abuse',¹⁹⁹ is to receive and disseminate relevant information with regard to education and awareness. For example, where information is received about problems or threats that may affect other LDAC geographic areas or interventions and strategies that are successful, relevant information could be disseminated to all LDAC areas so that they may make use of the shared knowledge and experiences.

According to the NDMP 2013-2017 each province has to establish LDACs to ensure and implement integrated services for substance abuse. LDACs comprise members from local government, various provincial departments [including the DSD, DOH and Western Cape Education Department (WCED)], and representatives from the South African Police Services (SAPS) and Correctional Services. LDACs also includes broader stakeholders such as representatives from non-profit organisations and the legal, professional, business, research, and traditional authority sectors. The feasibility of including representation from other

¹⁹⁶ The WHO supports this position in its *Global Strategy to reduce the harmful use of alcohol* (note 71) at section 18 The WHO calls for a solid base of awareness and "ensuring broad access to information and effective education and public awareness programmes among all levels of society about the full range of alcohol-related harm experienced in the country and the need for, and existence of, effective preventive measures".

¹⁹⁷ The WHO's position is that "education about alcohol needs to go beyond providing information about the risks of harmful use of alcohol to promoting the availability of effective interventions and mobilizing public opinion and support for effective alcohol policies". This position is reiterated echoed by Anderson et al. (note 8) (2009), who found that information and education type programmes do not reduce alcohol-related harm and rather recommend them as means to highlight awareness of the harms and to prepare for the introduction of interventions and policy changes.

¹⁹⁸ Prevention of and Treatment of Substance Abuse, 2008 (Act 70 of 2008).

¹⁹⁹ Section 58(a).

appropriate structures, such as the CPFs and others mentioned below, should be investigated and supported.

LDACs will be used as a vehicle to coordinate education and raise awareness about alcohol risk within communities. They will design locally orientated referral pathways of services, in order to generate awareness of services within the communities they serve, as part of their action plan. They will also be a platform where the public can reciprocally raise awareness of their concerns and issues, through their local representatives, so that interventions can be tailored to meet community needs.

The integrated nature of the platform will also allow for resource sharing and networking for integration opportunities, as well as communication between stakeholders to avoid duplication of awareness campaigns.

Continuing and strengthening the WCED education and awareness interventions

The substance abuse material that has been mainstreamed into the Life Orientation Skills teaching material for grades R to 12 should be continued.

An example of an evidence-based intervention for children in primary school that can be mainstreamed is the Good Behaviour Game. It is an approach to the management of classroom behaviours that rewards children for displaying appropriate on-task behaviours during instructional times. The class is divided into two teams and a point is given to a team for any inappropriate behaviour displayed by one of its members. The team with the fewest number of points at the Game's conclusion each day wins a group reward. If both teams keep their points below a pre-set level, then both teams share in the reward. There is some evidence that the Good Behaviour Game prevents later substance abuse, with a strong cost-benefit ratio.²⁰⁰

The WCED Safe Schools unit focuses on the training of principals, safety officers and an additional educator to capacitate the educators for early detection of alcohol experimentation and abuse. A closer collaboration between the WCED and DSD on the identification of learners with high-risk behaviour due to alcohol abuse through educator training or information sharing should be promoted.

The WCED Safe Schools call centre²⁰¹ is used to identify trends and assess how best to assist schools by referring them to relevant community-based organisations or the local DSD office for further intervention. The viability of the representation on LDACs of safety officers, the Safe Schools unit and call centre agents should be investigated and their representation supported so that information and access to community interventions can be promoted in their training and referrals.

Education and awareness must promote access by schools to evidence-based substance abuse programmes, such as those provided by DSD child- and youth-care centres and DoH

²⁰⁰ Nolan, J.D., Houlihan, D., Wanzek, M., Jenson, W.R. (2014). *The Good Behaviour Game: A classroom-behaviour intervention effective across cultures*. *School Psychology International*, 35, 191-205.

²⁰¹ <https://www.westerncape.gov.za/service/safe-schools-programme>; Safe Schools Call Centre: 0800 45 46 47.

programmes. Opportunities for the WCED, DoH and DSD to work in partnership, including where the DSD and DoH could assist in education and awareness presentations and providing tools and literature for schools, should be supported. The LDACs are a valuable platform to facilitate this resource sharing and networking for integration opportunities.

Norms and standards should be developed for school-based prevention programmes.

Research conducted in Cape Town a number of years ago found several shortcomings with substance abuse prevention programmes targeting young people. For example, over 60% used shock tactics as a means of preventing initiation of substance use, a large percentage of the main prevention programmes were once-off sessions with less than 60% conducting follow-up sessions and respondents displayed a poor understanding of evaluation. One of the key recommendations coming out of the study was that an effective regulatory regime in the form of minimum norms and standards for primary prevention activities should be developed.²⁰²

In other words, norms and standards should be developed and strong consideration should be given to the accreditation of primary prevention programmes aimed at young people. Capacitating is essential to providing the programmes. Accreditation and capacitation, it is argued, would stress the importance of values clarification, resistance-skills training, would be age-appropriate and linked to broader initiatives involving parents, teachers and the broader community.²⁰³

Leveraging the after-school space for education and awareness targeted at youth

The WCG uses its after-school programme to engage learners in extra-mural activities and minimise the risk of youth engaging in alcohol-related risk-taking behaviour. Incorporating education and awareness sessions into the after-school space should be promoted. Representation from the different after-school centres on their community's LDACs should be supported.

Lobby for education and awareness at the post-school education level

Post-school education institutions are a national government competence, comprising universities, TVET colleges and, more recently, community colleges. We will lobby national government and post-school education institutions, and where appropriate partner with the institutions in the province, for education and awareness programmes linked to effective interventions.

The use of radio stations for awareness messaging and facilitating the organisation of interested students to provide education and awareness campaigns will be explored.

²⁰² Harker, N., Myers, B., & Parry, C. (2008). *Audit of prevention programmes targeting substance abuse among young people in the greater Cape Town metropole: Technical report*. Parow: SAMRC.

²⁰³ Parry, C.D.H. & Bennetts, A.L. (1998). *Alcohol policy and public health in South Africa*. Cape Town: Oxford University Press.

Mainstreaming education and awareness in all WCG departments

The WCG employs many people. Providing civil servants with education and awareness training and information has the potential to expand the reach significantly as it may be transmitted to their friends, family and community.

Education and awareness opportunities in day-to-day service provision must be leveraged. A number of departments, such as Health, Transport, Education and Community Safety are in a good position to disseminate information and implement education and awareness campaigns.

Promote and strengthen education and awareness programmes to stakeholders

The WCLA, in partnership with SAPS, provides education and awareness campaigns that educate liquor licence holders and prospective holders, and/or their managers, and while group training is also scheduled with industry and their employees on request. Awareness sessions regarding the irresponsible use of and trade in liquor, as well as the Liquor Act, are also held with communities and schools by using industrial theatre, as well as group or classroom discussions. During these sessions they distribute booklets, pamphlets and DVDs. Local media are invited to the event to broaden awareness. An easy-to-read booklet should be periodically updated that presents and references all applicable laws so that ignorance of the law does not increase risk of harms and so that communities can play their oversight role.

The WCLA also provides education and awareness to schools that includes industrial theatre, booklets, pamphlets, door-to-door visits, posters and newspapers.

The WCLA sits on the PSAF and reports directly to the forum. The forum may assist the WCLA in partnering with the LDACs when the former has their roadshows. The feasibility of WCLA representation on LDACs, possibly through the use of conference calling technology, should be investigated and supported to avoid duplication and to tailor education and awareness to community needs.

A requirement of obtaining a liquor licence should be amended to ensure that the managers and licence holders who will be on site must undergo the training sessions and competency tests. The requirement is discussed as a proposal under the *Enforcement* chapter. The proposal is meant to address the issue of persons in the position of managers obtaining the training and found to be competent in understanding the outlets obligations not being present during day-to-day trading to ensure compliance.

Improve the reach and ease of access to education and awareness material

Information on alcohol abuse and treatment facilities are available on the WCG website in the Western Cape *Substance Abuse Service Directory*²⁰⁴ and should be continually updated.

²⁰⁴ <https://www.westerncape.gov.za/dept/social-development/services/956/38612>

The *WC Substance Abuse Resource Directory* is also produced in a booklet form and is updated every six months. It is a user friendly booklet that is region specific. It lists all the local DSD offices and the inpatient and community based facilities that offer services for people with alcohol abuse problems.

Different strategies to improve the reach and ease of access to education and awareness material should be pursued. Leveraging potential government sites and structures (such as LDACs, MOD centres, schools, libraries) for distribution to expand access to valuable resources, such as the *Substance Abuse Resource Directory* and WCLA material, should be made a priority. Innovative new forms of communication, such as on social media and the use of mobile applications should be pursued to extend the reach of education and awareness and facilitate engagement and learning.

Greater resources should also be obtained to expand these campaigns. All funding should be received by an independent authority linked to the PSAF and content should be independent. The alcohol industry, as part of their social responsibility, could be approached to provide funding. However, in order to maintain credibility and integrity of the information, any funding should not be ring-fenced to particular issues and branding of alcohol companies should not form part of the campaigns and associated materials.

Expand and strategically direct addiction care education courses

The WCG funds two courses at tertiary level in order to capacitate persons on addiction care. A *Postgraduate Diploma in Addiction Care* is offered at two Western Cape universities and covers a wide range of topics, including why people become addicted, approaches and evidence-based interventions for substance-use disorders, assessment of individuals with substance-use disorders, addictions in special populations, dealing with families with addictions, legal and ethical issues pertaining to addictions, case management and service monitoring. A community-based programme offered at a university's community engagement unit is intended to build awareness about substance abuse and its impact. It elaborates on how drug-induced changes affect the brain, behaviours and emotions of the individual and the impact this has on the family and community. The programme enhances the knowledge and skills of community workers to address the problem of substance abuse in communities.

Expanding and strategically directing bursaries to key role-players such as health professionals, social workers and community members to facilitate the process of standardising professional and management best practices in addition to monitoring services closely should be progressively rolled out.

The continuation of education programmes on FASD

The WCG will focus on the continuation of education programmes on FASD in collaboration with specific strategic partners specialising in the field, with the aim of expanding the programme. Current initiatives include screening participants and providing psychosocial therapy and life-skills training. While many farmers support the initiative and provide access

to their farms and to farmworkers, partnerships must be developed with those farmers not providing the required access to these services. Where there is an issue with cheap alcohol being delivered directly to their farms, engagement with farmers is required to persuade them to limit such access.

Chapter 8: Information, data collection, monitoring and evaluation

Given the complexity and transversal nature of alcohol-related harms, the efficient and co-ordinated collection, management, analysis and sharing of alcohol-related information and data is critical for the necessary monitoring and evaluation of harm-benefit trends and the impact of interventions.

Interventions have a greater likelihood of being effective if they are informed by credible and accurate evidence provided by ongoing economic, social and health research into the effects of alcohol. Similarly, credible and accurate evidence is needed on the impact of legislation on the liquor industry in terms of economic growth and job creation.

Anderson *et al.* point out that the best combination of interventions at different spending limits will depend on the “relative cost and cost-effectiveness of individual intervention components”.²⁰⁵ However the understanding of cost and cost-effectiveness requires monitoring and evaluating comprehensive and up to date information and data of a good quality.

Recognising the multi-sectoral impact of alcohol-related harms, improved coordination and information sharing is essential between the different spheres and entities of government, as well as a whole-of-society approach that includes industry, civil society and communities.

National lobbying

Understanding that many of the interventions required for reducing alcohol harms are located in the national sphere of government, the WCG will lobby for the following:

A transversal structure (national, provincial and local government) to collect information and data and to undertake monitoring and evaluation related to alcohol.

The structure should:

1. Coordinate systematic data collection on alcohol-related indicators across sectors on a national level;
2. Be empowered to collect information, monitor and report on the alcohol economy, including the production, distribution, and retail sales (including outlet density, volume and pricing) and consumption. It must also be empowered to collect alcohol-related harms data, including mortality, morbidity, damage to property, crime and violence data from available sources in the different provinces. Economic benefits, such as contributions to job creation and the fiscus, of alcohol and economic costs of the harms should be included in data collection to provide a balanced assessment of impact.
3. Coordinate and/or provide support to provinces and municipalities to conduct robust research to identify the key drivers of alcohol-harm in order to establish contextually appropriate responses for change over time.
4. Design and provide support to provinces and municipalities to implement multi-sectoral interventions.

²⁰⁵ Note 8 at 2242.

5. Recommend policy refinement, strategies and legislative amendments to all spheres of government.

An expert forum of officials from all three spheres of government and researchers is established to make recommendations to a national liquor policy forum to strengthen data collection and management.

A national strategy, grounded on baseline data, to set target indicators for harm reduction. The strategy must include the mandatory provision of information from the liquor industry.

Provincial interventions

The Province has not been able to put in place adequate monitoring-and-surveillance mechanisms, contemplated in the WHO strategy area 10²⁰⁶ to keep track of relevant data to evaluate alcohol-related harms and interventions.

The WCG will explore the feasibility of implementing the following:

A purpose-built monitoring-and-surveillance system

The system will aim to:

1. *Provide ongoing relevant information about alcohol – on both the alcohol economy and alcohol-related harms.*
 2. *Inform planning and implementation of interventions to reduce harm.*
 3. *Monitor and evaluate the implementation of interventions.*
- a) The system should be coordinated by a designated transversal structure, such as the PSAF, or a lead agency, and be supported by the provincial monitoring-and-evaluation structures.
 - b) The system should collect, collate, monitor and report on detailed information and data on:
 - i. The provincial alcohol economy, including the production, distribution, retail sales (including outlet density, volume and pricing) and consumption as well as the provincial alcohol-related harms data, including mortality, morbidity, damage to property, crime and violence data from available sources in the province. (Refer to **Annexure 1: Selected detailed indicators and data requirements on consumption and harm** that should be considered.)²⁰⁷ The indicators would be collected according to useful categories for analysis, including geography and demographics in the province. The purpose would be to monitor and evaluate the presence and directions of the trends relating to alcohol-related harms and the subsequent interventions.

²⁰⁶ Note 71 at 18.

²⁰⁷ From C Parry, and stems largely from WHO *Management of Substance Abuse*. (2010). *Report on the meeting on indicators for monitoring alcohol, drugs and other psychoactive substance use, substance-attributable harm and societal response*, Valencia, Spain, 19-21 October 2009. Geneva: WHO.

- ii. Provincial economic benefits, such as contributions to job creation and the fiscus, of alcohol and economic costs of the harms will be included in the data collection to provide a balanced assessment of financial implications.
 - iii. The GPS co-ordinates of licensed outlets, obtained through an amended licence application form, and unlicensed premises, through alternative channels such as community reporting, would also be collected.
 - iv. Information from local, liquor and SAPS authorities with regard to licenses, transgressions and actions. It would include information on both current licensees and new applicants, details of incidents, compliance notices and hearings, persons disqualified from holding a licence and education and training initiatives. (See **Annexure 2 Information from local, liquor and SAPS authorities with regard to licences, transgressions and actions** for a selection of proposed data requirements that should be considered.)
- c) The system would be a crucial component of the national transversal structure recommended as discussed above, feeding provincial information into the national structure. It would set up indicators and develop evaluation mechanisms that would take into account reporting formats of the national transversal structure as well as international reporting formats.
- d) The system envisioned is not a stand-alone that duplicates data collection and collation. Rather, it is coordination and analysis orientated. Importantly, to avoid duplication, the system would exploit existing data sources and sources that are being developed, which could then be fed into a monitoring and evaluation structure - such as the BizIntelligence system being developed.

A variety of data and information-collecting channels will be tapped into, including:

- i. Available government and government entity sources in the Province, including the Province's monitoring and evaluation units as well as data collection structures of departments and their entities;
- ii. Household and community surveys;
- iii. Partnering with and utilising information from universities, think tanks and service providers, such as Statistics SA, HSRC, SAMRC and CSIR²⁰⁸.
- iv. Civil society information and data;
- v. Legislative empowerment to collect information from various sources, including the alcohol industry and private facilities that may hold relevant information (e.g. private medical facilities), will be introduced in keeping with the whole-of-society approach;

²⁰⁸ There are existing surveillance systems run by the SAMRC that should be tapped into: such as the South African Demographic and Health Survey (SADHS) which provides information on the quantity and frequency of drinking and a measure of problem drinking as well as drinking during pregnancy), the South African Community Epidemiology Network on Drug Use (SACENDU) which assesses drug treatment demand related to alcohol and other drug use; the Youth Risk Behaviour Survey (YRBS) which assesses drinking habits of persons in grades 8-11 and some alcohol-related negative consequences, and the National Non-Natural Mortality Surveillance System (NNMSS) which among other things assesses alcohol-involvement in non-natural deaths. Provincial (or sub-provincial) data are available for some of these systems.

- vi. Existing community structures and representatives, such as the PNP sessions, LDACS and Councillors, will be leveraged to both provide and receive pertinent community information, including on problematic liquor outlets, pricing and enforcement targeting.
- e) Gaps in information could then be filled by leveraging partnerships to utilise information or commission studies from universities, think tanks and service providers to further understand the economic benefits and social harms of alcohol, and facilitate the planning and implementation of effective interventions.
- f) An intersectoral working group will be established to set up the system and draw on the various agencies producing and using the data.
- g) The structure or agency must be capacitated with funding – including possible funding from the alcohol industry as part of their corporate social responsibility or through levies on the industry. While the alcohol industry may contribute by providing funding for the research and subsequent initiatives, there should be an arm’s-length relationship with the alcohol industry for research to maintain credibility. All funding should be received by the designated structure or lead agency, and should not be ring-fenced.
- h) The key criteria for research should be usefulness and cost-effectiveness and that it should be independently undertaken, supervised and peer reviewed.

Chapter 9: Institutional arrangements

Institutional arrangements play a critical role in supporting and implementing the Western Cape Alcohol-Related Harms Reduction Policy. These arrangements incorporate the policies, systems and processes that organisations use to legislate, plan and manage their activities efficiently and objectively to effectively reach their goals and coordinate with other role-players.

The approach to institutional arrangements should focus on co-operation across spheres of government and relevant departments and supporting effective measures that give due regard to alcohol-related harms reduction.

The WCG proposes the following interventions:

Institutional structure form

Selection of an efficient and effective institutional structure form from the proposed options.

The WCLA, comprising a governing board and a Tribunal, was established as an independent juristic person in terms of the Western Cape Liquor Act, 2008. An Appeals Tribunal was established as an independent structure. The current Act provides for the following in this regard:

1. A **Governing Board** to manage the business of the WCLA, with an established administration. The administration is responsible for the administration of liquor license applications, support functions and the enforcement of the Act.²⁰⁹
2. A **Liquor Licensing Tribunal (LLT)** is responsible for the independent adjudication of all applications. The LLT also presides over contraventions of the Western Cape Liquor Act, 2008, as reported and investigated by the liquor inspectors.²¹⁰ The rationale for establishing an independent tribunal is based on ensuring non-discriminatory treatment of all players. The LLT therefore has an arm's-length relationship with the liquor industry, political authorities and other interested parties. The Tribunal is empowered to act against transgressors in the liquor industry.²¹¹ The sanctions imposed by the LLT for non-compliance with licence conditions enable enforcement.
3. An **Appeals Tribunal**, comprising an independent person, to afford aggrieved parties the right to appeal and review decisions.

On 12 February 2016, the Premier transferred the administration of the WCLA and the powers and functions in terms of the Western Cape Liquor Act, 2008, and regulations made thereunder from the Western Cape Department of Economic Development and Tourism to the DoCS with effect from 1 April 2016.²¹²

²⁰⁹ Sections 3 to 14 of the Western Cape Liquor Act, 2008.

²¹⁰ Sections 16 to 24 of the Western Cape Liquor Act, 2008.

²¹¹ Section 20(1)(d) and (e) of the Western Cape Liquor Act, 2008.

²¹² See Proclamation 3/2016 published in *Provincial Gazette* 7564 of 12 February 2016.

The Western Cape Liquor Act, 2008, provides a clear distinction between legislative, judicial and administrative powers in line with administrative law.²¹³ The LLT, as a regulator, must be able to make decisions in terms of empowering legislation without fear or favour. It is however acknowledged that empowering legislation must be adhered to and that absolute independence of the WCLA is neither possible nor desirable. Independent regulators are expected to be subject to government policy, oversight and a system of checks and balances.²¹⁴ The government cannot abdicate its policy-making mandate, and a regulator cannot set and implement its own policy agenda. The regulating body must be an impartial and transparent enforcer, free of transitory political influences, by taking decisions in line with the empowering legislation of the regulator.²¹⁵

The following considerations must be taken into account when considering and selecting the option for the structural form:

1. Good governance and integrated service delivery are embedded through partnerships and spatial alignment.
2. Limited available public resources are used prudently, in light of the multitude of demands on public funds.
3. Objectivity, accountability, effectiveness, efficiency and accessibility, where discretion is exercised cautiously and the rights of individuals are weighed against the interests of society more broadly.

The following are structural form options proposed for consideration:

Option 1: Current model

The current structure that includes a Governing Board to manage the WCLA and that oversees operations and the LLT.

The current structure was established in four years ago, when the first Governing Board was appointed with effect from 11 March 2012, and it could be argued that it has not been given sufficient time to prove itself.

The disadvantage of this model is that it does not provide sufficiently for integration of policy, partnerships and organisational alignment. The model entails duplication of administration structures such as those relating to human resources, financial administration, IT services and office accommodation. It is not the most efficient allocation of scarce provincial resources. Direct accountability to government is also not strong.

Option 2: Hybrid model

The hybrid model entails housing core administrative, secretariat and enforcement services in the DoCS while maintaining an independent Liquor Licensing Tribunal and an independent Appeal Tribunal to adjudicate on matters in terms of empowering legislation.

²¹³ Devenish G.E., Govender K. & Hulme D.H. (2001) Administrative Law and Justice in South Africa, Butterworths, Durban, p 19.

²¹⁴ Trias Politica principle or Separation of Powers principle.

²¹⁵ Promotion of Administrative Justice Act, 2000 (Act 2 of 2000).

Receiving and processing liquor licence applications, enforcing liquor laws and conditions for licences and other related tasks would be performed by the Department.

The option offers a number of positive elements.

- Duplication is prevented, so that there will be a better allocation of scarce resources. Reporting lines would be shortened between the responsible Head of Department and the administration. Direct action would be served through integrating service delivery and having all employees under one public service.
- The option aligns with the recommendations of the *Presidential guide for the reformation of South Africa's state owned enterprises*, the findings of the Presidential Review Commission on State Owned Enterprises,²¹⁶ the 2015 budget speech by Minister Nhlanhla Nene²¹⁷ and the 24 February 2016 budget speech by Minister Pravin Gordhan²¹⁸ - all of which advocate fewer public entities. Minister Gordhan recommended "reduced transfers for operating budgets of public entities".²¹⁹
- The approach, due to economies of scale, would increase efficiency and reduce costs.

The hybrid option above is the preferred model based on the positive elements as discussed.

Option 3: Commission model

The commission model allocates the responsibility of investigation, control and evaluation to a commission and provides for the establishment of an appeal authority.

Although this model has, through the Competition Commission, served the regulation of competition well to date it would appear to require separate support structures as it would undertake its own investigations. The model also places considerable power in the hands of one individual with no clear separation between the judicial and the administrative functions. Risks of concentrated power in one individual is the exclusion of differing opinions and provides a single target for external powers to attempt to influence.

Option 4: In-house model

The model used by the Western Cape Department of Health for licensing private hospitals was proposed. The model requires the Head of Department to be directly involved in the issuing of authorisations, such as liquor licenses.

The advantage of the model is that it allows changes in government policy to be applied immediately and the highest ranking official to apply their mind to an application. The disadvantage is that the model does not enable an arm's length relationship with vested

²¹⁶ Established in 2011.

²¹⁷ National Treasury website, 2015 budget speech by Minister Nhlanhla Nene, <http://www.treasury.gov.za/documents/national%20budget/2015/speech/speech.pdf>.

²¹⁸ National Treasury website, 2016 budget speech by Minister Pravin Gordhan, <http://www.treasury.gov.za/documents/national%20budget/2016/speech/speech.pdf>.

²¹⁹ *Ibid.* at 14.

lobby interests. Due to the volume of applications, this option would also not be practical, because it is argued that delegations would take away from the strength of the model.

General matters

The administrative burden and cost of liquor licence applications should be shifted from SAPS, municipalities and the WCLA to the applicant.

It is proposed that the application procedure be amended to include the following:

1. An application is made to the WCLA for a unique reference number.
2. Once a reference number has been obtained, it must be used in all communication regarding the liquor licence application.
3. The applicant is required to bring the application to the attention of SAPS, the municipality, neighbours to the premises, community-based organisations operating in the area, community police forum and any other interested parties – the obligation includes the payment of required advertisements. The comments of these stakeholders are to be submitted to the WCLA directly.
4. The applicant is required to apply for a police clearance certificate which must be supplied to the WCLA directly by SAPS.
5. Once all the external comments are in the possession of the WCLA, the applicant may submit their application, with replies to the comments if any, to the WCLA.

A requirement of obtaining a liquor licence should be amended to ensure that licence holders, and the managers, who will be on site must have undergone training and passed a test on the Western Cape Liquor Act and on the rights and obligations of licence holders.

This proposal is discussed under the *Enforcement* chapter. The proposal is meant to determine competency while addressing the issue of persons obtaining the training and found to be competent but not present during day-to-day trading to ensure compliance.

The applicant must obtain prior approval from the municipality, in consultation with the WCLA, that the activity can be carried out on the premises pertaining to the application.

The suitability of premises regarding town planning, land use management, building regulations, safety, traffic impact and similar aspects should be established. Collaboration and the clarification of competencies between municipalities and the WCLA is required regarding these and other functions in licensing premises as liquor outlets.

Where the alcohol-related harms, statistically determined for the area, are higher than the harm-based norm, no new liquor licenses should be approved in that municipal ward.

The purpose is to ensure sustainable and responsible licensing allocations. An example would be a 10 per 100 000 alcohol-related mortality ratio.

No new liquor licences should be approved in a municipal ward where the number of liquor outlets has reached a cut-off point to be determined according to the norm.

A relationship between liquor licensing, trading hours, lighting and pedestrian infrastructure to be introduced.

This proposal is discussed under the *Alcohol and the road environment* chapter.

Fee structure based on actual processing cost and renewal fees based on volume category to provide additional resources to address alcohol-related harms proportionally.

Liquor licencing is one of very few areas in which the provincial government can generate income to contribute to society and off-set alcohol-related harm risks.

The actual, all-inclusive cost for processing applications should determine the application and issuing fees in respect of applications. The purpose is to ensure that applicants, and not the state, carry the cost of applications.

It is proposed that a volume-related renewal fee, separated into three categories, is introduced. The three categories would distinguish between small, medium and large outlets, based on criteria that relate to the volume sold. The large outlets would pay higher fees and the small outlets lower fees. This distributes the financial responsibility proportionally among liquor outlets based on the volume of alcohol introduced by the licence holder into society.

The proposal further aims to alleviate some of the cost burden to society by providing additional resources, such as employing and training more liquor enforcement officials, which will add to job creation capacitating local structures (e.g. neighbourhood watches) or transferring conditional grants to other departments that provide related services to address alcohol-related harms.

Ensuring that licensing legislation keeps up to date with developments relating to technology, marketing and commercial development.

It is proposed that the current categories of licences be amended to provide for the following categories:

1. Micro-manufacturing with off-consumption.
2. Micro-manufacturing with on- and off-consumption.

These two categories are currently described as a single type, namely micro-manufacturing with off-consumption or on- and off-consumption, which leads to confusion. It is recommended that the two categories are separated to simplify regulation and compliance, as well as provide clarity for application purposes.

3. On-consumption for restaurants.

4. On-consumption for night clubs, bars and other.

Current legislation combines all on-consumption licenses and there is no clear separation between categories for on-consumption undertakings where persons under the age of 18 are allowed and those where they are not allowed. The intention is to differentiate between the different types of premises to simplify regulation and compliance.
5. Off-consumption.

Consideration will be given to the phasing out of grocer liquor licenses over 5 years where there is an off consumption liquor outlet within 50 meters from that grocers store. A phasing is being undertaken by the Eastern Cape Provincial Government. The Constitutional Court found that the provisions were not unconstitutional.²²⁰ An option to convert the right to sell liquor on different premises than that of the grocery business will still be available.
6. Off-consumption for electronic sales.

A new category is proposed. In these instances liquor is not kept on the premises where the sales take place. The sales are not specific to a geographical area and the conditions differ from the licences for on-consumption and off-consumption. Electronic sales are obtaining a larger portion of the market, and legislation and licensing requirements must be developed for this type of liquor business.
7. Both on- and off-consumption licence.

The category is the same as the current licence but the intention is to remove the “exceptional circumstances” requirement.
8. Market licence.

A new category is proposed. Markets are becoming more popular and legislation and regulation should align itself to this reality. This category of licence will, within parameters, allow on- and off-consumption and the premises need not be permanent structures.
9. Event licence.

In line with the Western Cape Liquor Amendment Act, 2015 (Act 3 of 2015), it allows for condonation of late submission, the application and approval for multiple events ahead of time and events that take place at different premises would also fall under this category.
10. Short-term licenses.

Previously “temporary licence”. The purpose is to allow for liquor licence holders to temporarily use the licence on other premises.

²²⁰Shoprite Checkers (Pty) Limited v Member of the Executive Council for Economic Development, Environmental Affairs and Tourism, Eastern Cape and Others (2015) at <http://www.saflii.org/cgi-bin/disp.pl?file=za/cases/ZACC/2015/23.html&query=shoprite>

Conclusion

The policy began by providing a brief *background* section. It considered the emphasis of the current legislative framework and the shortcoming that the general focus does not adequately consider the impact of alcohol-related harms on society and address the consequences.

The *problem statement* section set out the nature of the problem and provided the basis of the policy. It discussed the context of alcohol-related harms in South Africa and noted high consumption and risky drinking patterns in South Africa. It also highlighted the alcohol-related harms of death and disability, brain impairment on youth and links to increased violence, transport related deaths and suicide. The financial cost of alcohol to South Africa's economy was estimated as a net loss of approximately 7-10% of GDP. The *problem statement* then focused on the Western Cape specifically and argued that there is a need for an alcohol-related harms reduction approach.

The *principles, approach and policy context* section affirmed that the policy was guided by the principles of an open opportunity society for all. An international and domestic evidence-based and whole-of-society approach, along with a cooperative governance and a rights based approach, were undertaken in developing the policy. The international, national and provincial policy context in which this policy is embedded was also highlighted.

The *purpose and goals* section provided the policy purpose to target specific alcohol-related harms issues and ancillary matters, with the goal of contributing to the reduction of alcohol-related harms in the Western Cape.

Chapters 1 to 9 provided the target policy areas and proposed interventions.

Chapter 1: Pricing and the Economy, acknowledged the importance of the alcohol industry, particularly in the Western Cape. The economic contribution is however dwarfed by the costs of alcohol-related harms necessitating a revised policy focus aimed at reducing alcohol-related harms. In addressing demand drivers the policy proposed lobbying for a national ban on alcohol advertising that is visible to any persons under the age of 18. On the provincial level, in the event that a total ban is not achieved, the WCG should prohibit advertising, marketing and promotion of alcohol products and companies at all public facilities and events organised by the WCG. A budget for alcohol-related harms interventions at all public health and social service facilities in the Western Cape as well as for community action engagement interventions was also mooted. To address supply drivers, the policy proposed considering the possibility of a provincially determined framework that would set maximum limits for trading hours in line with the alcohol-related harms reduction approach, with provision for exceptions based on set criteria. Reducing the availability of alcohol by regulating the density of outlets and regulating trading days and hours and evaluating available studies or initiating a study to determine effective and cost-efficient disruption mechanisms that could be implemented to increase the real cost of taking legally produced alcohol into the illegal market were also put forward. Lobbying national government to increase the price of alcohol through increasing excise tax and/or introducing minimum unit pricing, tighten definitions and regulations of ales and beer, incentivise the reduction of the ethanol content and implement a tracking system of liquor products were other interventions proposed.

Chapter 2: Unlicensed liquor outlets and the illicit liquor trade identified the concern of a lack of regulation leading to increased harm and the loss of tax and licence revenue that can be used to mitigate harms. The policy proposed taking steps to bring responsible unlicensed liquor outlets into the regulated space in a sustainable and responsible manner, identifying mechanisms and criteria that will enable the rezoning of outlets for liquor sales in appropriate residential areas and prioritising upstream interventions targeting suppliers to the unlicensed liquor industry and the illicit liquor trade. Awareness of alternative economic opportunities should be provided to currently unlicensed outlet owners. Legislation must provide for the efficient and effective disruption of the liquor supply to unlicensed outlets and liquor enforcement units are to be capacitated and strengthened through increased resources and an integrated liquor enforcement approach should be developed, among other proposals.

Chapter 3: Enforcement recognised both regulatory compliance and criminal enforcement as integral parts of a comprehensive approach to reduce alcohol-related harms. It proposed that all spheres of government and relevant departments should contribute to the clamp-down and that information from community based-organisations and structures as well as the enforcement opportunities from municipal zoning schemes should be leveraged. Implementing innovative strategies such as the “last drinks survey” and promoting the involvement of communities themselves through interactive opportunities was suggested. Lobbying for well-prepared police dockets, increasing the number of trained liquor law enforcement officers, establishing one overarching liquor enforcement centre for operational coherence, legislating for sentencing in line with the seriousness of the harms and mobile testing for breath and/or blood by an approved, legally admissible device were among the further interventions put forward.

Chapter 4: Alcohol and the Road Environment acknowledged the trend that there is a consistent high prevalence of alcohol in road traffic fatalities and supports the Safe Systems approach favoured by the WHO and UN. Placing liquor licensing restrictions in areas with a high prevalence of alcohol-related road trauma, considering imposing restrictions on the sale of alcohol on premises that are on national or provincial roads and lobbying national government to implement a graduated alcohol limit for drivers with a zero tolerance for young or novice drivers, the introduction of alcohol Interlocks and strengthening random breath testing were among the interventions mooted.

Chapter 5: Health and social services advocated a whole-of-society approach in the provision of services with a focus on the individual in the context of their families and communities. Intervention proposals included providing equitably distributed emergency medical services for alcohol-related conditions, strengthen prevention, early intervention, detoxification, treatment and aftercare evidence-based interventions, providing programmes for screening, provision of information, brief motivational interventions and providing interventions at antenatal clinics. Establishing early screening and referral services at schools and other institutions of learning and establishing an effective referral system to services provided by the DoH, DSD, other departments and NPOs were among other interventions put forward.

Chapter 6: Community-based action aimed to build on the existing strengths and resources of the community and facilitate partnership and capacity building throughout the process. The community-based model for substance abuse treatment and rehabilitation should be expanded. The capacity of municipalities should be strengthened and institutionalised through the establishment of LDACs and

the PSAF, together with LDACs will coordinate integrated community programmes. The successful aspects of the AHR community-based action projects in three areas, namely in Khayelitsha, in Gugulethu and Nyanga and in Paarl East, will be progressively rolled out to other areas as another among the interventions presented.

Chapter 7: Education and awareness supported a whole-of-society, multi-sectoral approach to education and awareness because knowledge is valuable in mobilising support for strategies to reduce harms and provide awareness of effective interventions available to the public. Proposals included prioritising the PSAF and LDACs as platforms for integration, referral pathways and reciprocal communication, continuing and strengthening the WCED education and awareness interventions and leveraging the after-school space for education and awareness targeted at youth. Promoting and strengthening education and awareness programmes to stakeholders, improving the reach and ease of access to education and awareness material, expanding and strategically directing addiction care education courses and the continuation of education programmes on FASD were also included in the proposals.

Chapter 8: Information, data collection, monitoring and evaluation highlighted the need for an efficient and co-ordinated collection, management, analysis system and sharing of alcohol-related information and data given the complexity and transversal nature of alcohol-related harms. The WCG will lobby national government for a transversal structure (national, provincial and local government) to collect information and data and to undertake monitoring and evaluation related to alcohol. The WCG will also explore the feasibility of implementing a purpose-built monitoring-and-surveillance system. The system will aim to provide ongoing relevant information about alcohol – on both the alcohol economy and alcohol-related harms, inform planning and implementation of interventions to reduce harm and monitor and evaluate the implementation of interventions.

Chapter 9: Institutional arrangements recognised the critical role played by institutions in supporting and implementing the Western Cape Alcohol-Related Harms Reduction Policy. The policy suggested the selection of an efficient and effective institutional structure form from four proposed models (current, hybrid, commission and in-house). Generally, it also recommended shifting the administrative burden and cost of liquor licence applications to the applicant, qualification requirements for the on site manager and updating licence categories. Fee structures based on actual processing cost and renewal fees based on volume category to provide additional resources to address alcohol-related harms proportionally were proposed.

This is a policy paper to guide legislative changes and provide relevant interventions to reduce alcohol-related harms in the Western Cape. It seeks to change behaviour in relation to alcohol – by producers, distributors, retailers and also consumers. A multi-pronged approach as recommended by WHO is being proposed to be implemented. Adequate resources should be provided and regular reporting is required for the various interventions at the relevant stages of progression. Reflective processes should be built into the project planning of the interventions so that lessons can be learnt from monitoring and evaluation of the implementation. Budget however should be allocated to alleviate the scourge of alcohol-related harms.

Crucial priority areas to tackle alcohol-related harms must be to amend relevant legislation, enhance community support and harness cooperative governance resources and efficiencies.

Once public comments have been considered on the draft Alcohol-Related Harms Reduction Green Paper the White Paper will be published. The White Paper will inform amendments to liquor legislation and proposals would be operationalised by relevant departments. Stakeholders will be encouraged to implement programmes for the reduction of alcohol harms.

As discussed the WCG regulates alcohol, but alcohol-related harm in the province is an ongoing challenge that has been tackled without significant impact. The Alcohol-Related Harms Reduction Green Paper endeavours to shift the status quo by taking into consideration the impact of alcohol-related harms on society and address the consequences. This policy targets specific alcohol-related harms issues and ancillary matters, with the goal of contributing to the reduction of alcohol-related harms in the Western Cape.

The WCG does so to protect the rights of individuals, families and communities so that they are able to make the most of their opportunities.

Bibliography

Alcohol Justice. (2014) *Why Colleges and Communities Should Refuse Alcohol Industry Funding*.

Anderson, P, Chrisholm, D and Fuhr, DC (2009) *Effectiveness and cost-effectiveness of policies and programmes to reduce the harm caused by alcohol* The Lancet Vol 373 2234-2246.

Anderson P, De Bruijn A, Angus K, Gordon R, Hastings G. *Special issue: The message and the media: Impact of alcohol advertising and media exposure on adolescent alcohol use: A systematic review of longitudinal studies*. Alcohol 2009; 44: 229–43.

Anderson P, Laurant M., Kaner E., Wensing M., & Grol R. (2003). Engaging general practitioners in the management of hazardous and harmful alcohol consumption: results of a meta-analysis. *Journal of Studies on Alcohol*, 65(2):191-9.

Anderson VA, Anderson P, Northam E, et al. *Development of executive functions through late childhood and adolescence in an Australian sample*. Dev Neuropsychol 2001;20:385–406.

Babor, T. et al. (2010) *Alcohol: No ordinary commodity research and public policy* (2nd ed). New York: Oxford University Press.

Babor T. F., Xuan Z., Damon D. *Changes in the selfregulation guidelines of US Beer Code reduce the number of content violations reported in TV advertisements*. J Public Aff 2010; 10: 6–18.

Baumberg, B. (2009) *How will alcohol sales in the UK be affected if drinkers follow government guidelines?* Alcohol and Alcoholism, 44(5):523-528.

BBC. (2012) *Russia slaps ban on alcohol advertising in media*. Available at: <http://www.bbc.com/news/world-europe-18960770>.

Bezuidenhout, F.J. 2008. *A reader on selected social issues*. 4th Edition. Pretoria: Van Schaik Publishers.

Bouchery, E.E., Harwood, H.J., Sacks, J.J., Simon, C.J., & Brewer, R.D. (2011) *Economic costs of excessive alcohol consumption in the U.S., 2006*. *American Journal of Preventive Medicine*, 41(5):516-524.

Business day live. (2013) <http://www.bdlive.co.za/economy/2013/01/11/road-accidents-rob-sa-of-10th-of-gdp> accessed on 18 August 2014.

Casswell, S. (2012). *Current status of alcohol marketing policy-an urgent challenge for global governance*. *Addiction*, 107(3): 478-485.

Center on Alcohol Marketing and Youth. *Youth Exposure to Alcohol Advertising on Television, 2001–2009*. Baltimore, MD: Center on Alcohol Marketing and Youth, 2010.

Chaloupka, F. J., Grossman, M., & Saffer, H. (2002). *The effects of price on alcohol consumption and alcohol-related problems*. Retrieved from: <http://pubs.niaaa.nih.gov.ezproxy.welch.jhmi.edu/publications/arh26-1/22-34.htm>.

Charman, A., Petersen, L., Hartnack, A. & Clark, A. 2009. *A rapid assessment of the potential socioeconomic impact of the Western Cape Liquor Act*. Sustainable Livelihood Consultants.

City of Cape Town: *Control of undertakings that sell liquor to the public, 2013*.

Constitution of the Republic of South Africa, 1996.

Cunradi, C.B., Mair, C., & Todd, M. (2014) *Alcohol Outlet Density, Drinking Contexts and Intimate Partner Violence A Review of Environmental Risk Factors*. *Journal of drug education*, 44, (1-2) 19-33.

Darke, S. (2010). *The Toxicology of Homicide Offenders and Victims: A review*. *Drug and Alcohol Review*, 29(2):202-215.

De Bruijn A, van den Wildenberg E, van den Broeck A. *Commercial promotion of drinking in Europe*. 2012.

http://www.amphoraproject.net/w2box/data/AMPHORA%20Reports/Ammie_repport_2012.pdf.

Department of Trade and Industry. (2011) *Baseline study of the liquor industry including the National Liquor Act 2003*.

Devenish G.E., Govender K. & Hulme D.H. (2001) *Administrative Law and Justice in South Africa*, Butterworths, Durban, p 19.

De Vries, M.M., Joubert, B., Cloete, M., Roux, S., Baca, B.A., Hasken, J.M., Barnard, R., Buckley, D., Kalberg, W.O., Snell, C.L., Marais, A-S., Seedat, S., Parry, C.D.H., May, P.A. (2015). *Indicated Prevention of Foetal Alcohol Spectrum Disorders in South Africa: Effectiveness of Case Management*.

Duailibi S, Ponicki W, Grube J, Pinsky I, Laranjeira R, Raw M. The effect of restricting opening hours on alcohol-related violence. *American journal of public health*. 2007;97(12):2276–80.

Dultz LA, Frangos S, Foltin G, et al. *Alcohol use by pedestrians who are struck by motor vehicles: how drinking influences behaviors, medical management, and outcomes*. *J Trauma*. 2011;71:1252–1257.

Erke A, Goldenbelt C, Vaa T. The effects of drink-driving checkpoints on crashes—A meta-analysis. *Accid Ana Prev* 2009;41:914.

Financial times, <http://markets.ft.com/research/Markets/Tearsheets/Financials?s=DST:JNB>.

Foran, H.M. & O’Leary, K.D., *Alcohol and intimate partner violence: A meta-analytic review*, *Clinical Psychology Review*, Volume 28, Issue 7, October 2008, Pages 1222-1234.

Forensic Pathology Services (2014) *Report on Road Traffic Fatalities*.

Freiden, T. (2010). *A Framework for Public Health Action: The Health Impact Pyramid*. *American Journal of Public Health*, 100(4): 590–595.

Giesbrecht, N., Huguet, N., Ogden, L., Kaplan, M.S., McFarland, B.H., Caetano, R., Conner, K.R., & Nolte, K.B. 2015. *Acute alcohol use among suicide decedents in 14 US states: impacts of off-premise and on-premise alcohol outlet density*. *Addiction*, 110, (2) 300-307.

Global Burden of Disease Study 2013 Collaborators. (2015) *Global, regional and national comparative risk assessment of 79 behavioural, environmental/occupational and metabolic risks or clusters of risks in 188 countries 1990-2013: a systematic analysis for the GBD 2013*. *The Lancet*, 386, 2287-2323.

Graham, K.; West, P. (2001). *Alcohol and crime: Examining the link*. In Heather, N., Peters, T., & Stockwell, T. (Eds), *International handbook of alcohol dependence and problems*, Wiley. (pp. 439-470).

Grenard J. L., Dent C. W., Stacy A. W. *Exposure to alcohol advertisements and teenage alcohol-*

Griggs, R.A. (2007) *An evaluation of nine pilot sites to propose a South African Model of Community Prosecution*, page 27, 28,101, 113.

- Grubestic, T. H. & Pridemore, W. A. (2011). *Alcohol Outlets and Clusters of Violence*. *International Journal of Health Geographics*, 10:30. Available at: <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3098133/pdf/1476-072X-10-30.pdf>.
- Hahn RA, Kuzara JL, Elder R, Brewer R, Chattopadhyay S, Fielding J, Naimi TS, Toomey T, Middleton JC, Lawrence B. (2010) "Effectiveness of Policies Restricting Hours of Alcohol Sales in Preventing Excessive Alcohol." *Consumption and Related Harms Task Force on Community Preventive Services*.
- Harker, N., Myers, B., & Parry, C. (2008). *Audit of prevention programmes targeting substance abuse among young people in the greater Cape Town metropole: Technical report*. Parow: SAMRC.
- Hingson RW, Edwards EM, Heeren T, & Rosenbloom D. (2009). Age of Drinking Onset and Injuries, Motor Vehicle Crashes, and Physical Fights After Drinking and When Not Drinking. *Alcoholism: Clinical & Experimental Research*, 33(5): 783-790. Available at: <http://www.ncbi.nlm.nih.gov/pubmed/19298330>.
- Hollingworth W., Ebel B. E., McCarty C. A., Garrison M. M., Christakis D. A., Rivara F. P. *Prevention of deaths from harmful drinking in the United States: the potential effects of tax increases and advertising bans on young drinkers*. *J Stud Alcohol* 2006; 67: 300–8.
- Hughes, K., Anderson, Z., Morleo, M., & Bellis, M.A. (2008) *Alcohol, nightlife and violence: the relative contributions of drinking before and during nights out to negative health and criminal justice outcomes*, Volume 103, Issue 1, pages 60–65.
- Hutchinson TP. (2010). *Countermeasures to the problem of accidents to intoxicated pedestrians*. *Journal of Forensic and Legal Medicine*, 17(3):115-119.
- IOGT International, Obstacle to development. <http://iogt.org/the-issues/advocacy/obstacle-to-development/> accessed on 24 March 2016.
- IOM. (2004). Reducing underage drinking: A collective responsibility. Retrieved from: http://www.nap.edu.ezproxy.welch.jhmi.edu/catalog.php?record_id=10729.
- Johnson M., Jackson R., Guillaume L., Meier P., & Goyder E. (2011). Barriers and facilitators to implementing screening and brief intervention for alcohol misuse: a systematic review of qualitative evidence. *Journal of Public Health*, 33(3):412-21.
- Johnson SB, Blum RW, Giedd JN. 2009. *Adolescent maturity and the brain: the promise and pitfalls of neuroscience research in adolescent health policy*. *J. Adolesc. Heal.* 45(3):216.
- Jones-Webb, R., Nelson, T., McKee, P., & Toomey, T. 2014. *An implementation model to increase the effectiveness of alcohol control policies*. *American Journal of Health Promotion*, 28, (5) 328-335.
- Killoran, A., Canning, U., Doyle, N., & Sheppard, L. (2010) *Review of effectiveness of laws limiting blood alcohol concentration levels to reduce alcohol-related road injuries and deaths*. London: Centre for Public Health Excellence NICE.
- Kuhns, J. B., Exum, M. L., Clodfelter, T. A., & Bottia, M. C. (2014). *The Prevalence of Alcohol-Involved Homicide Offending: A Meta-Analytic Review*. *Homicide Studies*, 18(3):251-270.
- Kumpfer, Karol L.; Whiteside, Henry O.; Greene, Jeanie Ahearn; Allen, Keely Cofrin, *Effectiveness outcomes of four age versions of the Strengthening Families Program in statewide field sites*. *Group Dynamics: Theory, Research, and Practice*, Vol 14(3), Sep 2010, 211-229. <http://dx.doi.org/10.1037/a0020602>.
- Liquor Products Act, 1989 (Act 60 OF 1989).

London, L., Mazok, C., Adam, H., Parry, C. *If the alcohol doesn't get you, then the toxins will: The health impacts of bulk wine provision in the Western Cape province of South Africa*. Poster presented at the American Public Health Association Conference, Boston, November 2006.

Marques, PR (2010). Ignition interlocks: Review of the evidence. *Blutalkohol*, 47(5): 318-327.

Matzopoulos, R, Truen, S, Bowman, B and Corrigan, J. (2014) *The cost of harmful alcohol use in South Africa* South African Medical Journal Vol 104, no 2, 127-132.

May, P.A. de Vries, M., Marais, A-S., Buckley, D., Kalberg, W.O., Adams, C.M., Hasken, J.M., Robinson, L.K., Manning, M.A., Jones, K.L., Hoyme, D., Seedat, S., Parry, C.D.H., Hoyme, H.E. (2016). *The continuum of fetal alcohol spectrum disorders in four rural communities in South Africa: Prevalence and characteristics*. *Drug & Alcohol Dependence*, 159, 207-218.

McClure A. C., Stoolmiller M., Tanski S. E., Engels R. C., Sargent J. D. Alcohol marketing receptivity, marketing specific cognitions, and underage binge drinking. *Alcohol Clin Exp Res* 2013; 37: E404–13.

Medical Research Council. (2012) *Injury Mortality Survey 2012* (2009 data).

Minister Dikobe Ben Martins. (2013) *Transport Minister Dikobe Ben Martins saddened by road accident and wishes the injured a speedy recovery*. Available from: <http://www.gov.za/transport-minister-dikobe-ben-martins-saddened-road-accident-and-wishes-injured-speedy-recovery>. [Accessed: 4th December 2015].

Morrison DS, Petticrew M, Thomson H. What are the most effective ways of improving population health through transport interventions? Evidence from systematic reviews. *J Epid Comm Health* 2003;57:327-333.

Myers, JE (2015) *Rapid review of the problem of alcohol harm reduction in the Western Cape province (available on request)*.

Naledi, T. (2016). *Concept note for teachable Moments intervention in Emergency Centres in the Western Cape to reduce harmful alcohol and substance use*. Western Cape Department of Health.

National Liquor Act, 2003 (Act 59 of 2003).

National Liquor Authority, database accessed in 2015. https://www.thedti.gov.za/business_regulation/nla_register.jsp.

National Treasury, South Africa. (2014) *A Review of the Taxation of Alcoholic Beverages in South Africa (2014) A Review of the Taxation of Alcoholic Beverages in South Africa*.

National Treasury website, http://www.treasury.gov.za/comm_media/press/monthly/1608/Table%201.pdf, accessed on 22 August 2014.

National Treasury website, 2015 budget speech by Minister Nhlanhla Nene, <http://www.treasury.gov.za/documents/national%20budget/2015/speech/speech.pdf>.

National Treasury website, 2016 budget speech by Minister Pravin Gordhan, <http://www.treasury.gov.za/documents/national%20budget/2016/speech/speech.pdf>.

News 24, *Forensic backlogs reduced, but still too high*: <http://www.news24.com/SouthAfrica/News/forensic-backlogs-reduced-but-still-too-high-20160406>, accessed on 7 April 2016.

- Nielson (2016). Total Audience Report: Q1. Available at: <http://www.nielsen.com/us/en/insights/reports/2016/the-total-audience-report-q1-2016.html>.
- Nolan, J.D., Houlihan, D., Wanzek, M., Jenson, W.R. (2014). *The Good Behaviour Game: A classroom-behaviour intervention effective across cultures*. *School Psychology International*, 35, 191-205.
- Ouimette, P C, Moos, R H, and Finney, J W. (1998) *Influence of outpatient treatment and 12-step group involvement on one-year substance abuse treatment outcomes*, *Journal of Studies on Alcohol*, Vol 59, no 5, 513–522.
- Oxley, J. Lenné, M. & Corben, B. (2006). *The effect of alcohol impairment on road-crossing behaviour*. *Traffic Psychology and Behavior*, 9(4):258-268.
- Panza F, Capurso C, D'Introno A, et al. (2008) *Vascular risk factors, alcohol intake, and cognitive decline* *Journal of Nutrition Health Aging* Vol 12 No 6: 376–81 accessed via https://en.wikipedia.org/wiki/Long-term_effects_of_alcohol_consumption.
- Parker R. N., Williams K. R., McCaffree K. J., Acensio, E. K., Browne, A., Strom, K. J., and Barrick, K. (2011) *Alcohol Availability and Youth Homicide in the 91 Largest US Cities, 1984-2006*. *Drug and Alcohol Review*,30(5):505-14.
- Parry, C.D.H. & Bennetts, A.L. (1998). *Alcohol policy and public health in South Africa*. Cape Town: Oxford University Press.
- Parry, C.D.H., Morojele, N., & Jernigan, D. (2008). *Creating a Sober South Africa*. In S. Pennington (Ed.) *Action for a Safe South Africa* (pp. 68-75). Paarl: SA Good News.
- Peck, RC., Gebers, MA., Voas, RB., & Romano, E. (2009). *The relationship between blood alcohol concentration (BAC), age, and crash risk*. *Journal of Safety Research*, 39(3): 311-319.
- Peden M et al., eds. (2014) *World report on road traffic injury prevention*. Geneva, WHO.
- Peer N, Matzopoulos R, Myers JE. (2009) *The Number of Motor Vehicle Crash Deaths Attributable to Alcohol-impaired Driving and its Cost to the Economy Between 2002 and 2006 in South Africa*. CapeTown: University of Cape Town.
- Plüddemann, A., Parry, C., Donson, H., Sukhai, A. (2004) *Alcohol use and trauma in Cape Town and Port Elizabeth, South Africa: 1999-200*. *Inj Control Saf Promotion*. 2004, 11(4), pp. 265-7. Cited in Corrigan, J., and Matzopoulos, R. (2012/2013) *Violence, Alcohol Misuse and mental Health: Gaps in the health system's response, SAHR 2012/12*, pp 103-114.
- Prevention of and Treatment for Substance Abuse Act, 2008 (Act 70 of 2008).
- Prof. C Parry, personal communication 4 June 2016.
- Promotion of Administrative Justice Act, 2000 (Act 2 of 2000).
- Provincial Injury Mortality Surveillance System: *Injury Mortality Report 2010*. (2013) Provincial Government of the Western Cape Burden of Disease Project.
- Reddy SP, James S, Sewpaul R, Sifunda S, Ellahebokus A, Kambaran NS, Omardien RG. *Umthente Uhlaba Usamila – The 3RD South African National Youth Risk Behaviour Survey 2011*. Cape Town: South African Medical Research Council, 2013, 126-127.
- Rehm J, Baliunas D, Borges GL, Graham K, Irving H, Kehoe T, Parry CD, Patra J, Popova S, Poznyak V, Roerecke M, Room R, Samokhvalov AV, Taylor B. (2010) *The relation between different dimensions of alcohol consumption and burden of disease: an overview* *Addiction* Vol 105, no 5, 817–843.

Rehm, J., Lachenmeier, D.W., Llopis, E.J., Imtiaz, S., Anderson, P. *Evidence of reducing ethanol content in beverages to reduce harmful use of alcohol*. The Lancet Gastroenterology & Hepatology, 1(1), 78 - 83 (2016).

Room, R., Carlini-Cotrim, B., Gureje, O., Jernigan, D., Mäkelä, K., Marshall, M., Medina-Mora, M.E., Monteiro, M., Parry, C.D.H., Partanen, J., Riley, L., & Saxena, S. (2002) *Alcohol and Developing Societies: A Public Health Perspective*. Helsinki: Finnish Foundation of Alcohol Studies in collaboration with the WHO.

Ross C., de Bruijn A., Jernigan D. *Time watersheds and youth alcohol advertising exposure: cautionary tales from the U.S. and the Netherlands*. J Public Aff; in press; 2013, DOI: 10.1002/pa.1452.

Rubia K, Overmeyer S, Taylor E, et al. *Functional frontalisation with age: Mapping neurodevelopmental trajectories with fMRI*. Neurosci Biobehav Rev 2000;24:13–9.

Russell, C. & van Walbeek, C. *An analysis of beer tax pass-through in South Africa*. Presentation at the Cape Town 6-monthly meeting of the South African Community Epidemiology Network on Drug Use (SACENDU) project, SAMRC Parow, 26/4/16]. See also Russell, C., & van Walbeek, C. (2016). *How does a change in the excise tax on beer impact beer retail prices in South Africa*. South African Journal of Economics. Doi: 10.1111/saje.12123.

SABMiller. "Preliminary Results 2014" http://www.sabmiller.com/docs/default-source/investor-documents/results/financial-year-2014-full-year-results-22-may-2014/newsrelease_hf_220514.pdf?sfvrsn=4 accessed on 21 March 2015.

Saffer H., Dave D. *Alcohol advertising and alcohol consumption by adolescents*. Health Econ 2006; 15: 617– 37.

SAMRC-UNISA (2009) *A Profile of Fatal Injuries in South Africa*.

SAPS information from South African Police Services Designated Liquor Officers, Sector Commanders, Neighbourhood Watches and Street Committees survey in respect of each policing area per police stations, 2015.

Shults RA, Elder RW, Sleet DA, Nichols JL, Alao MO, Carande-Kulis VG, Zaza S, Sosin DM, Thompson RS, Task Force on Community Preventive Services. Reviews of evidence regarding interventions to reduce alcohol-impaired driving. American journal of preventive medicine. 2001 Nov 30;21(4):66-88

Simbayi, personal communication, 03 June 2016.

Smith LA and Foxcroft DR. (2009). The effect of alcohol advertising, marketing and portrayal on drinking behaviour in young people: systematic review of prospective cohort studies. BioMedCentral 9(51). Available at: <http://bmcpublichealth.biomedcentral.com/articles/10.1186/1471-2458-9-51>.

Sorsdahl, K, Myers, B, Ward, C., Matzopoulos, R, Mtukushe, B, Nicol, A, Stein, D. *Screening and brief interventions for substance use in emergency departments in the Western Cape Province of South Africa: views of health care professionals*. 2013 Jul. International Journal of Injury Control and Safety Promotion. DOI. 10.1080/17457300.2013. 811267.

Sorsdahl, K., Stein, D.J., Corrigan, J., Cuijpers, P., Smits, N., Naledi, T., Myers, B. (2015). *The efficacy of a blended motivational interviewing and problem solving therapy intervention to reduce substance use among patients presenting for emergency services in South Africa: A randomized controlled trial*. Substance Abuse Treatment, Prevention and Policy, 2015. DOI: 10.1186/s13011-015-0042-1.

South African Police Service Act, 1995 (Act 68 of 1995).

South African Community Epidemiology Network on Drug Use. (2015) Update November 2015.

Sowell ER, Petersen BS, Thompson PM, et al. *Mapping cortical change across the human life span*. *Nature Neurosci* 2003;6:309–15.

Spirito, A (PhD), Monti, PM (PhD), Barnett, NP (PhD), Colby, SM (PhD), Sindelar, H (PhD), Rohsenow, DJ (PhD), Lewander, W (MD), Myers, M (PhD). (2004) *A randomized clinical trial of a brief motivational intervention for alcohol-positive adolescents treated in an emergency department* *The Journal of Paediatrics*, Vol 145, no 3, 396–402.

Statistics South Africa. (2016) *Crime statistics series Volume III: Exploration of selected contact crimes in South Africa, 2011-2014/15*, Report 03-04-01.

Stewart, K and Sweedler, B. (2018) *Worldwide Trends in Impaired Driving: Past Experience and Future Progress*, Safety and Policy Analysis International LLC.

Thomas N. *The Beer Giants are Toasting the Rise of Africa*. London: The Telegraph; 2012. Available at: <http://www.telegraph.co.uk/finance/newsbysector/retailandconsumer/9307598/The-beer-giants-are-toasting-the-rise-of-Africa.html>.

Truen S, Ramkolowan Y, Corrigan J, Matzopoulos R. (2011) *Baseline study of the liquor industry including the impact of the national liquor act 59 of 2003*. Pretoria, South Africa.

Truen S, Ramkolowan Y, Corrigan J, Matzopoulos R. *Baseline study of the liquor industry Including the impact of the National Liquor Act 59 of 2003*. Pretoria, South Africa, 2011.

Turning Point (1998) *An Evaluation of the Geelong Local Industry Accord*. Victoria: Alcohol and Drug Centre Inc.

United Nations Sustainable Development Goals,
<http://www.un.org/sustainabledevelopment/health/> (accessed on 15 June 2016).

United Nations, Sustainable Development Goals.
<http://www.un.org/sustainabledevelopment/sustainable-development-goals/> accessed on 24 March 2016.

U.S. Department of Health and Human Services. *The Surgeon General's Call to Action to Prevent and Reduce Underage Drinking: A Guide to Action for Educators*. U.S. Department of Health and Human Services, Office of the Surgeon General, 2007. Available at:
<http://www.surgeongeneral.gov/library/calls/underage-drinking-educator-guide.pdf>.

Van Walbeek, C and Daly, M. (2014). *Alcohol Advertising in South Africa: A Trend and Comparative Analysis*. WHO, Available at: <http://tobaccoecon.org/wp-content/uploads/2014/03/alcohol-advertising-in-south-africa-a-trend-and-comparative-analysis.pdf>.

Van Walbeek C, Blecher M. *The economics of alcohol use, misuse and policy in South Africa*. Cape Town, 2014.

Western Cape Government, Provincial Strategic Plan 2014-2019.

Western Cape Government, Social Development Department. (2012) *Survey on Substance Use, Risk Behaviour and Mental Health among Grade 8 - 10 Learners in Western Cape*. South African Medical Research Council.

Western Cape Liquor Act, 2008 (Act 4 of 2008).

Western Cape Liquor Authority, Register of Licenses accessed December 2015.

WHO. (2001) *Brief Intervention for Hazardous and Harmful Drinking*. Retrieved from:
http://whqlibdoc.who.int/hq/2001/who_msd_msb_01.6b.pdf.

WHO. (2010) *Global strategy to reduce the harmful use of alcohol*. WHO Press, WHO.

WHO. (2011). *From Burden to "Best Buys": Reducing the Economic Impact of Non-Communicable Diseases in Low- and Middle-Income Countries*. Available at:
http://www.who.int/nmh/publications/best_buys_summary.pdf.

WHO. (2014) *Global status report on alcohol and health*.

WHO. (2014) UN Road Safety Collaboration Meeting Road Safety Management Project Group Meeting Minutes. Available from: http://www.who.int/roadsafety/events/2014/Appendix_5.pdf. [Accessed: 11 December 2015].

WHO. (2015) Alcohol factsheet accessed 3 November 2015
<http://www.who.int/mediacentre/factsheets/fs349/en/>

WHO *Management of Substance Abuse*. (2010). *Report on the meeting on indicators for monitoring alcohol, drugs and other psychoactive substance use, substance-attributable harm and societal response*, Valencia, Spain, 19-21 October 2009. Geneva: WHO.

WHO Regional Office for Africa. (2013). *Alcohol consumption and harm in the African region status report*. Brazzaville, DRC: Author.

Annexure 1: Selected detailed indicators and data requirements on consumption and harm

At a macro-level clear indicators need to be developed and funding sought to ensure that the necessary data are collected in a timely and methodologically sound manner. Among other things, indicators are needed that:

1. Facilitate collection of **alcohol-consumption data from two sources:**

- a) Local data on alcohol sales
- b) Self-reported consumption of alcohol.

Having good information on local sales and information about the **proportion of the population who are drinkers** (lifetime, past 12 months, past 30 days) will facilitate measuring **adult (15+ years) per capita consumption in litres of pure alcohol** (among the whole population and drinkers). Being able to report on the number of (proportion of the population) who are **abstainers** will also be important as well as the **age of drinking initiation**. Household and school surveys will need to be undertaken on a regular basis (at least every 5 years) using measures that allow for comparisons across time.

2. Facilitate the collection of measures of harmful drinking practices such as:

- a) **Hazardous and harmful drinking** (as measured by drinking quantities on a typical day during the past 30 days)
- b) **Hazardous and harmful drinking** (as measured by drinking quantities on a typical day during the past 30 days **Binge drinking** (60 g AA per day or more) during the past 30 days)
- c) Age-standardised death rates for (*alcoholic*) **liver cirrhosis** (per 100 000)
- d) Age-standardised deaths from (*alcohol-related*) **road traffic accidents** (per 100 000)
- e) Age-standardised death rates for (*alcohol-related*) **poisoning** (per 100 000)
- f) Age-standardised death rates for (*alcohol-related*) **violence** (per 100 000)
- g) **Alcohol dependence** (past 12 months)
- h) **Percentage of cases – drunk driving out of all traffic offences**
- i) **Single-vehicle night-time fatal crashes** per 10 000 registered vehicles and per 100 000 population
- j) **Years of life lost due to premature, alcohol-attributable death.**

Annexure 2: Information from local, liquor and SAPS authorities with regard to licences, transgressions and actions

Note: the list is not exhaustive and would include:

(* - restricted access)

1) What information is required?

a. Current licensees:

- i. Name of liquor outlet
- ii. Address of liquor outlet
- iii. Phone number of premises *
- iv. GIS reference area
- v. Name of licensee
- vi. Registration (licence) number
- vii. Type of licence
- viii. Date licence issued or renewed
- ix. Issuing authority
- x. Date of expiry Date of expiry
- xi. Special conditions (if any)

b. New applications:

- i. Proposed site (address)
- ii. GIS reference area
- iii. Name of applicant(s)
- iv. Identity number of applicant(s)*
- v. Phone number of main applicant*
- vi. Home address of main applicant*
- vii. Type of licence applied for
- viii. Where has application been lodged
- ix. Proximity of proposed site to schools, places of worship

- x. Date of application
- xi. Date application entered on database
- xii. Date application to be heard by local authority
- xiii. Has application been forwarded to WCLA
- xiv. Date application to be heard by WCLA

c. Incidents:

- i. Date of incident
- ii. Day of week of incident
- iii. Time of incident
- iv. Type of outlet (on- or off-consumption or both)
- v. Name of investigating officer
- vi. Police station out of which officer works (if police)
- vii. Contact details of investigating officer*
- viii. Name of liquor outlet
- ix. Address of liquor outlet
- x. GIS reference area
- xi. Name of licensee
- xii. Registration (licence) number
- xiii. Name(s) of complainant*
- xiv. Address of complainant*
- xv. Phone number of complainant*
- xvi. Complainant code:
 - 1. Neighbour
 - 2. Other member of public
 - 3. Other licensee
 - 4. Public official

- xvii. Nature of incident (use codes)
 - 1. Disturbance of the peace
 - 2. Sale to under-age youth
 - 3. Operating without a licence
 - 4. Operating outside authorised trading hours
 - 5. Sale to intoxicated persons
 - 6. Sale of over a specified amount of alcohol to an unlicensed retailer
 - xviii. Disposition of the incident (use codes)
 - 1. Dealt with informally
 - 2. Verbal warning
 - 3. Written compliance notice
 - 4. Referred to WCLA
 - 5. Closure order obtained from magistrate
 - 6. Refer to public prosecutor (as well as Liquor Board)
- d. Compliance notices:
- i. Date of hearing
 - ii. Name of liquor outlet
 - iii. Address of liquor outlet
 - iv. GIS reference area
 - v. Name of licensee
 - vi. Name of liquor outlet
 - vii. Address of liquor outlet
 - viii. GIS reference area
 - ix. Name of licensee
 - x. Registration (license) number
 - xi. Conditions of compliance notice (use codes)

1. Outlet closed with immediate effect
2. Remedy selected problem(s)
3. etc.

e. Liquor Board hearings to deal with complaints:

- i. Date of hearing
- ii. Name of liquor outlet
- iii. Address of liquor outlet
- iv. GIS reference area
- v. Name of licensee
- vi. Registration (licence) number
- vii. Name of prosecutor*
- viii. Contact details of prosecutor*
- ix. Name(s) of complainant (if any)*
- x. Address of complainant*
- xi. Phone number of complainant*
- xii. Complainant code:
 1. Neighbour
 2. Other member of public
 3. Other licence
 4. Public official
- xiii. Nature of incident (use codes)
- xiv. Disposition of the case (use codes)
 1. Case dismissed
 2. Verbal warning
 3. Written warning
 4. Mandated attendance at training sessions

5. Licence suspended (length of suspension)
 6. Licence revoked
 7. Special condition placed on licensee (will then need to be entered in licensee database)
- f. List of persons disqualified from holding a licence: (may need to be linked to national database)
- i. Name of person
 - ii. Identity number
 - iii. Reason(s) for disqualification
 1. Suspension of previous liquor licence
 2. Withdrawal of previous licence
 - iv. Period of disqualification
- g. Education and training initiatives:
- i. Type of initiatives
 - ii. Provider details
 - iii. Numbers attending each type of initiative
- 2) How should the information be accessible?
- a. Internet access (with some access restrictions)
 - b. GIS capability
 - c. Annual report to Provincial Legislature that will, among other things, include twelve-monthly statistics on:
 - i. Number of licence holders (overall and via GIS area) broken down into licence type
 - ii. Number of new applications (overall and via GIS area) broken down into licence type
 - iii. Number of new licenses granted (overall and via GIS area) broken down into by licence type

- iv. Number of incident reports (overall and by GIS area)
 - v. Nature of incidents (by GIS area) including by time of licence, day of week, time of day, type of complaint
 - vi. Number of compliance notices issued
 - vii. Summary of conditions imposed by compliance notice
 - viii. Number of complaints heard before the WCLA LLT
 - ix. Summary of how WCLA disposed of these cases
 - x. General information on alcohol-related fatal and non-fatal injuries, drunk-driving arrests (from SAMRC and DoCS)
- d. In addition, the results of relevant research (both funded by the DoCS and research funded by other sources) should also be presented.

3) Who should input data into the system

- a. Local authorities/ municipalities
- b. DoCS and WCLA
- c. SAPS

The provision of information on an annual basis should not only be presented orally to the Provincial Legislature but should also be made available in written format and on the Department's website.

Any person or organisation wishing to comment can do as follows:

Contact Person: Ms Vicki-Lee Erfort

Phone number: 021 4386287; or

Email address: (alcohol.greenpaper@westerncape.gov.za)

Comments may also be delivered to the walk in centre and dropped in the specially marked box.