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Western Cape Government

Department of the Premier
Western Cape Government
Strategic Programmes Branch
Policy and Strategy Chief-Directorate

Western Cape alcohol-related harms reduction policy

White Paper

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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 White Paper*. The Green Paper was published for written comment and a number of channels were used to create public awareness for the comment process. The purpose was to elicit comments from a wide range of sources, including comments from communities most fundamentally affected by alcohol-related harms. Comments from public submissions were used to further develop the White Paper. A Regulatory Impact Assessment was undertaken and analysed. The contents were considered and incorporated in finalising the White 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. The shortcoming that the general focus of legislation does not adequately consider the impact of alcohol-related harms on society or address the consequences of alcohol-related harms is pointed out. It also discusses the links and differences between the national and provincial alcohol-harms related processes.

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. Alcohol was identified as the fifth leading risk factor for death and disability in South Africa that contributes substantially to the top 10 risk factors. Alcohol-related harms include brain development impairment in children and adolescents, is linked to increased violence, transport-related deaths and suicide. The financial cost of alcohol-related harms to South Africa's economy was estimated at a net loss of approximately seven to ten per cent of the GDP, or between R165 to 236 billion in 2009. 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, guided by the WHO's *Global strategy to reduce the harmful use of alcohol*, 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 provide interventions with the goal to contribute to the reduction of alcohol-related harms in the Western Cape. A further purpose is to provide for ancillary matters to increase the efficiency and effectiveness of supplementary supporting structures that are related to alcohol-related harms reduction.

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, and that – along with the other social harms – necessitates 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 events organised by the WCG. Progressively increasing the coverage 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 put forward. To address supply drivers, the policy will seek 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. Municipalities would still be able to influence trading hours through the licensing process. Reducing the availability of alcohol by regulating trading days and hours is put forward. 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 also recommended. Lobbying national government to increase the price of alcohol through increasing excise tax and/or introducing minimum unit pricing, to tighten definitions and regulations of ales and beer, to incentivise the reduction of the ethanol content and to implement a tracking system of liquor products are proposed. A provincial tax will also be considered due to the effectiveness of the tax mechanism.

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. Liquor enforcement units are to be capacitated and strengthened through increased resources and an integrated liquor enforcement approach, 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 by-laws 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, and legislating for sentencing in line with the seriousness of the harms are mooted. Increasing the roll-out of mobile testing for breath and/or blood by an approved, legally admissible device and increasing the enforcement of underage drinking laws are among the further interventions.

Chapter 4: Alcohol and the road environment acknowledges the trend that there is a consistently 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 and lobbying national government to implement a graduated alcohol limit for drivers with a zero tolerance for young or novice drivers are mooted. The introduction of alcohol interlocks, increasing random breath testing and requiring mandatory blood samples to be obtained from all those involved in road crashes as soon as possible are among the interventions.

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 the family and community. Interventions include providing equitably distributed emergency medical services for alcohol-related conditions, strengthening 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 Western Cape Department of Health, the Western Cape Department of Social Development, other departments and non-profit organisations 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 must be expanded. The capacity of municipalities should be strengthened and institutionalised through the establishment of local drug action committees, and the Provincial Substance Abuse Forum together with local drug action committees will coordinate integrated community programmes. Among the other interventions presented is that the successful aspects of the AHR (alcohol harms reduction) community-based action projects are to be rolled out progressively to other areas is another among the interventions.

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 local drug action committees as platforms for integration, referral pathways and reciprocal communication, continuing and strengthening the Western Cape Education Department 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 policy.

Chapter 8: Information, data collection, monitoring and evaluation highlights the need for an efficient and coordinated collection, management and analytic 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 policy requires obtaining funding for the implementation of a purpose-built monitoring-and-surveillance system. The system will 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 approved an efficient and effective institutional structure. 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 chapters that pertain to the issue areas.

Acronyms

ADR	Alternative dispute resolution
AHR	Alcohol harms reduction
BAC	Blood alcohol concentration
BrAC	Breath alcohol concentration
CPF	Community police forum
DoCS	Western Cape Department of Community Safety
DoH	Western Cape Department of Health
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
MUP	Minimum unit pricing
NDMP	National Drug Master Plan
NPA	National Prosecuting Authority
NPO	Non-profit organisation
PNP	Policing needs and priorities
PSAF	Provincial Substance Abuse Forum
PSP	Provincial Strategic Plan 2014 – 2019
SAMRC	South African Medical Research Council

SAPS	South African Police Service
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 on terminology

The terms “alcohol” and “liquor” are both used in this document. “Alcohol” is preferred by researchers whereas legislators prefer “liquor”. In order to be regarded as liquor, a product must contain a set percentage of alcohol, also referred to as ethyl alcohol. “Alcohol”, however, for the purposes of this policy document, has the same meaning as “liquor”.

Introduction

In 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 *Alcohol-related harms reduction White Paper*. The working group comprised representatives from relevant provincial departments, local government, the South African Police Service (SAPS), the Western Cape Liquor Authority (WCLA), the South African Medical Research Council and academia. Stakeholder groups were met with and contributed to the process. The development of the White Paper 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 provincial departments that would be responsible for implementing the proposals in their focus areas.

Once approved by the Cabinet, a Green Paper was gazetted for public comment and a three-month public participation process undertaken. The Green Paper was published on 19 September 2016 and the closing date for written comments was extended to 15 December 2016. Public awareness of the Green Paper was leveraged off advertisements placed in newspapers, taxis and social media, radio stations, the Western Cape Government website and emailed directly to numerous sector groups inviting written comment. In addition, the Green Paper was circulated to sector representatives and distributed at community information sessions. The purpose was to elicit widespread comments, including those from communities most fundamentally affected by alcohol-related harms. Approximately 200 comments from public submissions were received and used to further develop the White Paper. In March 2017 a service provider was contracted to lead a WCG project team to undertake a regulatory impact assessment (RIA). The RIA was analysed and its contents considered and incorporated in finalising the White Paper where the opinions were persuasive on the merit of the argument and on quality evidence.

The policy begins by providing a brief *Background* section that considers the emphasis and shortcomings of the current legislative framework. It also discusses the links and differences between the national and provincial alcohol-harms related processes.

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 Chapters 1 to 9, which provide 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.

At a national level, the Liquor Act, 2003 (Act 59 of 2003), governs macro-manufacturing by large-scale manufacturers and the distribution of liquor. Micro-manufacturing and -retail are governed at a provincial level.

Currently alcohol legislation largely regulates the activities of licensing and enforcement of the production, distribution and sale of alcohol. The focus of alcohol legislation is that of the registration of manufacturers and distributors of liquor,[1] regulation and compliance of, among other aspects, the production and composition for sale of certain liquor products,[2] the granting of licences to retailers to sell[3] or the setting of trading times in respect of licensed premises.[4] The focus of the legislation does not adequately take into consideration the impact of alcohol-related harms on society, nor does it address the consequences.

In the past there have been attempts to address the harmful use of alcohol in the Western Cape. Despite these efforts, however, problem drinking and its associated negative consequences remain a substantial health, social and economic burden to the province.[5]

Among other initiatives, the issue is on the global agenda, through the World Health Organisation (WHO)'s *Global strategy to reduce the harmful use of alcohol*, the national agenda, through the National Liquor Policy and the National Liquor Amendment Bill, 2016 and 2017,[6] and the provincial agenda, through the WCG Alcohol-Harms Reduction White Paper. The concurrence of such initiatives reflects the increasingly recognised importance of the issue.

The national government is currently also undertaking a process to review and develop policies, legislation and regulations on alcohol, with a focus on tackling alcohol abuse and harms nationally. National government, as the competent authority, leads on manufacturing and distribution and this is reflected in the recent draft of the National Liquor Amendment Bill, 2017.

It should be noted that a hierarchy between the spheres of government does not exist. The Constitution of the Republic of South Africa provides that government is constituted as national, provincial and local spheres of government, which are distinctive, interdependent and interrelated. The WCG policy positions in this White Paper relating to national competence matters have been included as 'lobbying' proposals. Lobbying on an issue falls within the competence of the WCG, and its inclusion in a policy paper to set out its position is both permissible and appropriate. It should be noted that lobbying has already resulted in changes to the National Liquor Amendment Bill, 2017, and has also

[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.
[6] National Liquor Amendment Bill, 2017, circulated to provincial governments for comment and not publicly published.

resulted in, for example, the extension of enforcement powers to the province, as originally proposed in the Green Paper version of this document.

Retail regulations and micro-manufacturing fall under provincial competence; most of the policy statements in the White Paper relate to functions within the WCG's competence. The province is legally and practically the best placed to provide policy for alcohol-related harms issues and ancillary matters it is facing with regard to its competency.

The WCG recognises that it is important to work with all spheres of government in tackling such a complex social issue. Different spheres of government cooperate through constitutionally mandated cooperative government principles, and the area of alcohol-harms reduction is one that is developing into a positive example of cooperative governance.

Problem Statement

Context of alcohol-related harms reduction

Alcohol-related harm is an intractable problem that is destroying lives, tearing apart the social fabric and hampering socio-economic development. It needs to be addressed by providing effective interventions and by providing for ancillary matters to contribute to the reduction of alcohol-related harms.

The WHO ranks South Africa as the country with the highest per capita alcohol consumption in Africa, referring to the total recorded and unrecorded litres of alcohol consumed as an average of the 15+ year population.[7] The average consumption of pure alcohol *per drinker*, which excludes abstainers in the population, is estimated at 27,1 litres per year; this places South African *drinkers* in the fifth highest position on the continent and at the upper end of global consumption.[8]

The WHO provides figures for the recorded and unrecorded litres of pure alcohol consumption for South Africa per capita. While there was a decrease in recorded consumption when compared to 2005, from 8,69 litres to 7,38 litres, the trend of recorded consumption from 2010 to 2014, the latest available data, showed a slight increase from 2010 to 2011, from 7,28 litres to 7,38 litres, followed by a stagnation from 2011 to 2014, to 7,38 litres.[9] Unrecorded alcohol consumption showed an increase from 2,5 litres in 2005 to 2,9 litres in 2010 – with no record for 2014.[10] The data also projects that alcohol consumption in South Africa is expected to increase per capita from 2015 to 2025, to 12,1 litres.[11]

A review in the medical journal *The Lancet*[12] points out why such an increase is problematic:

> *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.* [13]

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 per cent of alcohol is consumed in excess of current government guidelines, and 50 per cent is consumed during

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[7] WHO. (2014) *Global status report on alcohol and health* at 289-290.
[8] *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.
[9] Global Health Observatory data repository. (2016, May). Retrieved from WHO: http://apps.who.int/gho/data/node.main.A1026?lang=en
[10] *Ibid.*
[11] Global Health Observatory data repository. (2016, March 3). Retrieved from WHO: http://apps.who.int/gho/data/node.main.A1043?lang=en
[12] 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.
[13] *Ibid.* at 2236.

binge drinking.[14] At least half of alcohol consumption, and the 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 South African Medical Research Council (SAMRC),[15] for example, found that roughly 66 per cent drank six or more drinks on a typical drinking occasion and that 86 per cent 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 per cent[16], compared to only 33,6 per cent of Europeans[17] and 31,1 per cent of the US population.[18] In Brazil, a country comparable to South Africa because of similar socio-economic circumstances, drinkers consume 15,1 litres per year, but the country has an abstention rate of 42,3 per cent – approximately 17 per cent lower than that of South Africa. What this means is that South Africans, at 27,1 litres of pure alcohol per year, consume almost 80 per cent 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 riskier patterns of drinking.[19]

The issue is exacerbated by socio-economic conditions. Less risky drinking patterns, with a pattern of drinking score lower than 3 drinks, are mainly found in the upper middle and high-income countries. More than 95 per cent of low-income and lower-middle income countries have a score of 3, while South Africa had a score of 4 in 2010.[20]

The WHO indicates that 40,6 per cent of South Africans are current drinkers,[21] 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 litres of pure alcohol per year – over 50 per cent more than the world average of 21,2 litres.[22] South African female drinkers each consume 16 litres of pure alcohol per year on average, which is approximately 80 per cent above the world average of 8,9 litres.[23] Approximately 5,6 per cent of South African alcohol users suffered from alcohol use disorders, including dependence and harmful use, according to twelve-month prevalence estimates. [24]

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

[14] Baumberg, B. (2009) *How will alcohol sales in the UK be affected if drinkers follow government guidelines?* Alcohol and Alcoholism, 44(5) :523-528.
[15] Prof. C Parry, personal communication, 4 June 2016.
[16] Note 7 at 128.
[17] *Ibid.* at 33.
[18] *Ibid.* at 170.
[19] *Ibid.* at 143.
[20] *Ibid.* at 36 and 128.
[21] Current drinkers are those who had an alcoholic drink in the past 12 months.
[22] WHO. (2015) *Alcohol factsheet*, accessed 3 November 2015.
http://www.who.int/mediacentre/factsheets/fs349/en/ and *ibid*. at 128.
[23] *Ibid*. at 128.
[24] *Ibid.* at 128.

monthly) were the highest in the Free State and Western Cape (at 16 per cent).[25] A recently published report by Statistics South Africa (Stats SA), the South African Demographic and Health Survey 2016 provides further data for analysis.[26] It found that 22,8 per cent of men and 9 per cent of women drunk five or more drinks on at least one occasion in the past 30 days.

Further, while most of the developed world has stable alcohol consumption, the developing world is increasing its consumption and the alcohol industry is looking to increase it further.[27]

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 wine[28] 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.

Although alcohol is legal, it is the most widely abused drug in South Africa. In 2015 alcohol was identified as the fifth leading risk factor for death and disability in South Africa, following unsafe sex, high body mass index (obesity), fasting plasma glucose, and blood pressure, and contributes substantially to the top 10 risk factors.[29] This confirms earlier research from 2000 that found alcohol was the third leading risk factor for death and disability in South Africa, following only unsafe sex (and the associated sexually transmitted infections) and interpersonal violence.[30] The latter two are, however, themselves influenced by alcohol consumption.[31]

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 drugs when combining harms to both users and others.[32]

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[25] Simbayi, personal communication, 3 June 2016.

[26] National Department of Health (NDoH), Statistics South Africa (Stats SA), South African Medical Research Council (SAMRC) & ICF. (2017). *South African Demographic and Health Survey 2016: Key indicators report*. Pretoria, South Africa, and Rockville, Maryland, USA. Retrieved from http://abstemious.statssa.gov.za/publications/Report 03-00-09/Report 03-00-092016.pdf

[27] 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).

[28] 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.

[29] Global Burden of Disease 2015 Risk Factors Collaborators (2016). *Global, regional and national comparative risk assessment of 79 behavioural, environmental and occupational, and metabolic risks or clusters of risks in 195 countries, 1990-2015: a systematic analysis for the Global Burden of Disease Study 2015*. Lancet, 388, 1659-1724.

[30] Matzopoulos, R, Truen, S, Bowman, B and Corrigall, 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.

[31] *Ibid.* at 128.

[32] *Supra* note 30 at 131 from Nutt DJ, King LA, Phillips LD. *Drug harms in the UK: A multicriteria decision analysis.* The Lancet. 2010; 376 (9752) :1558-1565. [http://dx.doi.org/10.1016/S0140-6736(10)61462-6].

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 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 to10 Learners in Western Cape Provincial Schools, 2012*[33] sampled 20 227 learners.[34] The survey found that the most frequently reported substance used was alcohol, with 66 per cent of learners reporting use.[35] In comparison, cannabis use was reported by 23,6 per cent of learners[36] and less than 6,1 per cent of the learners reported taking hard drugs.[37] Between a fifth and a quarter (22,3 per cent) reported binge drinking in the two weeks prior to the study and 10 per cent being drunk on a weekly basis.[38] 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 past-month binge drinking in this province among learners in grades 8 to 11 was 35,2 per cent, substantially higher than the national average of 25,1 per cent and more than any of the other provinces.[39]

Neurologically, the brain is still developing up until the early 20s,[40] particularly the prefrontal cortex that coordinates higher-order cognitive processes and executive functioning.[41] In adolescence these include supervisory cognitive skills needed for goal-directed behaviour, including planning, response inhibition, working memory, and attention. Poor executive functioning leads to difficulty with planning, attention, using feedback, and mental inflexibility,[42] which undermines judgment and decision making. Chronic heavy alcohol consumption impairs brain development in children and adolescents, causes brain shrinkage, dementia, physical dependence, increases neuropsychiatric and cognitive disorders and causes distortion of the brain chemistry.[43] A study found that patterns of heavy episodic drinking increase the risk for some diseases and for all injury outcomes.[44]

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[33] Western Cape Government, Social Development Department. (2012) *Survey on Substance Use, Risk Behaviour and Mental Health among Grade 8 – 10 Learners in Western Cape.* SAMRC executive summary.
[34] *Ibid.* at 1.
[35] *Ibid.* at 2.
[36] *Ibid.* at 3.
[37] *Ibid.* at 4.
[38] *Ibid.* at 3.
[39] 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: SAMRC, 2013, 126-127.
[40] 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.
[41] Rubia K, Overmeyer S, Taylor E, et al. *Functional frontalisation with age: Mapping neurodevelopmental trajectories with fMRI*. Neurosci Biobehav Rev 2000; 24:13–9 and Sowell ER, Petersen BS, Thompson PM, et al. *Mapping cortical change across the human life span*. Nature Neurosci 2003; 6:309–15.
[42] 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.
[43] 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.
[44] 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.

The prevalence of Foetal Alcohol Spectrum Disorder (FASD) recorded in the Western Cape is among the highest, with levels as high as 18 per cent to 26 per cent among grade-1 learners in certain high-risk, rural communities.[45]

Alcohol risk contributes significantly to four of the five major components of the Western Cape Burden of Disease pattern.[46]

The report *A profile of fatal injuries in South Africa*[47], which analysed data from the National Injury Mortality Surveillance System 2008, indicated that 54 per cent (5,701 out of 10,613) of injury-related deaths in South Africa involved persons with positive blood alcohol concentration (BAC) levels.[48] The average BAC for those who tested positive was 0,18 (± 0,10 g/100ml), at least double the current legal limit of 0,05 g per 100 ml for driving. Levels of BAC were high for violent fatalities (61 per cent), transport-related deaths (56 per cent) and suicide (41 per cent).[49]

While mortality 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 and "patients injured as a result of violence were consistently most likely to test positive for alcohol in all sites."[50] 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.[51] 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 per cent of sexual violence incidents taking place outdoors and 23,3 per cent of incidents taking place at home, with the victim being under the influence during 63,9 per cent of the incidents in the street.[52]

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 and injuries by 50 per cent was adopted.[53]

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[45] May, PA de Vries, M, Marais, A-S, Buckley, D, Kalberg, WO, Adnams, CM, Hasken, JM, Robinson, LK, Manning, MA, Jones, KL, Hoyme, D, Seedat, S, Parry, CDH, Hoyme, HE (2016). *The continuum of fetal alcohol spectrum disorders in four rural communities in South Africa: Prevalence and characteristics*. Drug & Alcohol Dependence, 159, 207-218.

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

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

[48] *Ibid.* at 12.

[49] *Ibid.* at 12.

[50] 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. 265-269.

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

[52] 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.

[53] *United Nations Sustainable Development Goals*, http://www.un.org/sustainabledevelopment/health/ (accessed on 15 June 2016).

Approximately 17 000 people are killed on South African roads every year, of which approximately 3000 are children.[54] A further 68 300 people are seriously injured. SAMRC figures show 50 per cent of drivers and over 60 per cent 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 per cent of South African driver deaths and non-fatal injuries would be prevented.[55] Previously, the total estimated annual vehicular-related damage cost of alcohol-involved crashes in SA was R7,9 billion in terms of 2009 estimates.[56] More recently, the Road Management Traffic Corporation estimated that South Africa's alcohol-related crashes had an economic cost of R180 billion per annum in 2010.[57]

The tangible financial cost of harmful alcohol use is estimated to be R37,9 billion or 1,6 per cent 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 and 280 billion, representing 10 to 12 per cent of the 2009 GDP.[58] Intangible costs were the largest contributor to the cost estimate and should be interpreted with caution because they cannot be translated into monetary figures and are thus imperfect by definition. In this instance, the largest intangible cost related to premature mortality and morbidity was calculated from a value of statistical life (VSL) of R3,5 million.

In contrast to the costs to the South African economy, the National Treasury[59] estimates that the economic contribution of the alcoholic beverages sector for the year 2009/10 was R73 billion, or 2,9 per cent of GDP.[60] The estimates point to a net cost to the economy of between 7 per cent to 10 per cent of GDP, or R165 to 236 billion in 2009.

[54] South African Medical Research Council (2012) *Injury Mortality Survey 2012* (2009 data).
[55] 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*. Cape Town: University of Cape Town.
[56] *Supra* note 30 at 130.
[57] 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.
[58] *Supra* note 30 at 130.
[59] Truen S, Ramkolowan Y, Corrigall 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*.
[60] *Ibid*.

Tangible and intangible cost table[61]

Cost category	R millions	
	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	

The alcohol-related harms reduction approach in the Western Cape

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".[62] 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 approach to date has been the regulation of the distribution of alcohol while maximising the contribution of the liquor industry to the economy.[63] 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.[64]

International studies indicate that social harms dominate individual harms,[65] 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."[66]

[61] *Supra* note 30 at 130.
[62] WCG, *Provincial Strategic Plan 2014-2019* at 2 and 13.
[63] *Supra* note 30 at 132.
[64] *Supra* note 30 at 132.
[65] Note 30.
[66] Note 12 at 2240.

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 the risk is substantial in all the major health burden components. Therefore, while it may be necessary to target high-risk groups with particular interventions, given the evidence that alcohol harms are a societal problem, a targeted population-orientated approach was pursued for the Western Cape, in line with the WHO's *Global strategy to reduce harmful use of alcohol*.

An international study found that policies that regulate the alcohol environment are effective in reducing alcohol-related harm.[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]

The WCG regulates alcohol, but alcohol-related harm in the province is an ongoing challenge. 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 and plans 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.

Dealing with alcohol-related harms requires using not only the province's legislative competence but all forms of provincial competence. This is the approach of this new policy. 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 in life as free as possible from alcohol-related harm.

[67] Note 12 at 2443.
[68] *Supra* note 30 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.

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. This rights-based approach seeks to respect, protect and promote a number of constitutional rights,[70] 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 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 was a key element in the development of the policy.

The WHO's Global strategy to reduce harmful use of alcohol encompasses 10 recommended target areas which guided our policy development process. While the strategy recommends a national approach, the target areas were adapted to the provincial context as it related to matters within the WCG competence.

The WHO's ten recommended target areas for policy and intervention 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.

Given the evidence that alcohol harms are a societal problem, with a broad range of health and social conditions affected by alcohol use, population-based policy options commensurate to the problem were developed.

As discussed in the WHO's global strategy:

> *A substantial body of knowledge has accumulated during recent years on the feasibility, effectiveness and cost-effectiveness of different policy options and interventions shown to reduce the harmful use of alcohol ... The accumulated research findings indicate that*

[70] Constitution of the Republic of South Africa, 1996.

population-based policy options – such as the use of taxation to regulate the demand for alcoholic beverages, restricting their availability and implementing bans on alcohol advertising – are the "best buys" in reducing the harmful use of alcohol as they are highly cost-effective in reducing the alcohol attributable deaths and disabilities at population level.[71]

Developing and implementing integrated governance systems and cooperative governance were also emphasised, with the acknowledgement that the reduction of harms requires integrated action, collaborative research, seamless enforcement and community engagement.

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,[72] because alcohol-related harm is an obstacle to the achievement of the goals.[73] Nationally, fundamental rights entrenched in the Constitution of the Republic of South Africa, 1996, 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).[74] 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.[75]

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, once agreed by policy makers, are relatively easy to implement and typically cost-effective".[76]

It is acknowledged that the causes of alcohol abuse and misuse are varied and include 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 was developed.

[71]WHO. (2014*) Global status report on alcohol and health,* WHO, at 19
[72] *United Nations Sustainable Development Goals*. http://www.un.org/sustainabledevelopment/sustainable-development-goals/ accessed on 24 March 2016.
[73] IOGT International, *Obstacle to development*. http://iogt.org/the-issues/advocacy/obstacle-to-development/ accessed on 24 March 2016.
[74]WCG, *Provincial Strategic Plan 2014-2019*
[75]*Ibid.*
[76] Note 46 at 9.

Purpose and goals of the policy

The purpose of the policy is to provide interventions to contribute to the reduction of alcohol-related harms in the Western Cape. A further purpose is to provide for ancillary matters to increase the efficiency and effectiveness of supplementary supporting structures that are related to alcohol-related harms reduction.

The PSP is the priority plan for the province and includes the strategic goals, "*increasing wellness, safety and tackling social ills"*, "*creating opportunities for growth and jobs*", and "*improving education outcomes and opportunities for youth development*", which translate into programmes and projects with targets across all departments. This policy recognises that the PSP, from a provincial perspective, seeks to address the broader contributing, systemic challenges on a large scale.

This White Paper provides policy that evidence has shown to be effective in reducing alcohol-related harm. Policy proposals as consulted through the Green Paper as statements of intent are now presented for implementation over time. Short-, medium- and long-term plans are being identified for the White Paper to be rolled out. The policy is moving towards being operationalised, in consultation with relevant stakeholders, through project plans and commensurate budgets. The detail will be addressed through the finalisation of responsibilities, implementing agents, targets, costing, human resources and time-frames on the basis of progressive realisation.

Chapter 1: Pricing and the economy

The alcohol industry 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 South African economy in 2009, or 2,9 per cent of the GDP.[77]

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 the increasing demand driven by the export market. The export market accounted for 55 per cent of wine production in 2009 compared to just 24 per cent in 1998.[78]

The policy seeks to be applied in an economic context that does not have an unreasonably negative impact on the existing contribution to the GDP or limits 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. The exceptions for tourism and export in relation to some of the proposals reflect that the WCG, while taking leadership and doing the best it can to protect its residents, also understands the realities of its economic strategies for job creation through tourism and export. 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 to 280 billion in 2009 (10 – 12 per cent of GDP).[79] Death and disability related to violence, transport and suicide, along with other harms, were also discussed, with 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 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 volume 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 form

[77] Truen S, Ramkolowan Y, Corrigall 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] SAWIS (2010) cited in Truen S, Ramkolowan Y, Corrigall J, Matzopoulos R. (2011) *Baseline study of the liquor industry including the impact of the national liquor act 59 of 2003*. Pretoria, South Africa.
[79] *Supra* note 30 at 127–132.

the world's largest beer company, had a net income of US$3,65 billion, approximately R40,15 billion[80], in 2014 and was a multi-national with its primary listing on the London Stock Exchange rather than in South Africa.[81] Distell, the country's major wine and spirits producer, had a net income of R1,53 billion in 2016.[82] Compare this to the lower end of the market, where alcohol is retailed as a means to survival with very low profit margins. In rural areas, farmworkers are among the country's lowest paid workers.[83]

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, after deducting the contribution, was approximately 7 per cent to 10 per cent of the GDP. The bulk of the harm costs arising from alcohol consumption are borne by the public.[84] The public sector thus effectively subsidises the liquor industry in South Africa.

The challenge for government is to develop mechanisms to disincentivise local consumption, especially in respect of the cheaper products and the 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 person under the age of 18 and for restrictions on sports advertising and promotion that links alcohol to aspirational achievement.

> Implementing advertising bans is a WHO ''best buy'' in reducing the harmful use of alcohol. 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.[85] The youth are particularly vulnerable to the effects of advertising, and there is evidence that one-third to two-thirds of young people's exposure to alcohol advertising is in excess of adult exposure.[86] Systematic reviews of longitudinal studies found that alcohol advertising and promotion are linked to underage consumption, and that "one study, drawing on data from Organisation for Economic Cooperation and Development (OECD) countries, reported that total

[80] The exchange rate of R11 to one US Dollar was used for the estimation in accordance with reserve bank figures https://wwwrs.resbank.co.za/webindicators/ExchangeRateDetail.aspx?DataItem=EXCX135D.
[81] *Preliminary Results 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.
[82] Financial times, http://markets.ft.com/research/Markets/Tearsheets/Financials?s=DST:JNB.
[83] 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.
[84] *Supra* note 30 at 127 – 132.
[85] McClure AC, Stoolmiller M, Tanski SE, Engels RC, Sargent JD. *Alcohol marketing receptivity, marketing specific cognitions, and underage binge drinking*. Alcohol Clin Exp Res 2013; 37: E404 – 13.
[86] 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 per cent20Reports/Ammie_repport_2012.pdf.

expenditure on alcohol advertising is linked to higher consumption".[87] This increases the likelihood that, because of alcohol advertising, adolescents will start to use alcohol and to drink more if they are already using alcohol.[88] It was also found that young people's exposure to alcohol advertising raised the likelihood of experiencing alcohol-related harms in the subsequent three years.[89]

With the growth of social-media platforms, there is a move of youth usage from formal to social-media platforms,[90] which has been accompanied by an upsurge in the alcohol industry's use of social media.[91] This has resulted in countries incorporating social-media bans in advertising regulations. Finland, for example, banned interactive alcohol advertisements on social media.[92] Russia banned alcohol advertisements on the Internet.[93] It is hoped that national government will retain the social media provision in the National Liquor Amendment Bill.

Similar to the ban on tobacco advertising, restrictions on alcohol in sports advertising and promotion are recommended. Sporting events sponsored by the alcohol industry are associated with higher levels of consumption among sport spectators.[94] The use of sports stars in alcohol advertising leads to young people associating drinking with sporting success.[95]

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.[96] An overall restriction on televised alcohol advertising to protect young people is preferable,[97] because total advertising bans have been shown to have the potential to have a modest decline in youth alcohol consumption[98] and prevent youth deaths.[99]

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[87] 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.

[88] 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.

[89] Grenard JL, Dent CW, Stacy AW. *Exposure to alcohol advertisements and teenage alcohol-related problems*. Pediatrics 2013; 131: e369 – 79.

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

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

[92] http://eucam.info/2014/02/27/finland-bans-alcohol-branded-social-media-communication-in-2015/.

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

[94] Note 86 at 26.

[95] 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.

[96] 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.

[97] Note 95.

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

[99] 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 advertising in adult venues such as night clubs, casinos and liquor outlets. Variations related to the tourism and the export industry would be considered.

The analogous ban on tobacco advertising showed a negligible impact on the media and the marketing sector, which turned to advertising other sectors of the economy.

The alcohol industry often suggests self-regulation as an alternative to advertising policies. However, these codes can become weakened over time,[100] and audits show that the industry frequently does not conform to self-imposed standards. For example, audits from the US and Europe found that advertisements were consistently placed where young people were more likely to view them than adults.[101, 102] Further, social media and sponsorship are often excluded from these codes.[103] Key findings from a collection of peer-reviewed research papers by leading experts include:[104] "Exposure to alcohol marketing is associated with youth alcohol consumption; analysis of alcohol promotion during the 2014 FIFA World Cup indicates alcohol marketing practices frequently appeared to breach industry voluntary codes of practice," and "alcohol industry self-regulatory codes do not sufficiently protect children and adolescents from exposure to alcohol promotions, especially through social media". For these reasons, voluntary or self-regulation is not recommended.

The WCG would support national government to stringently regulate alcohol advertising, with exceptions, however, for the tourism and export industries within spaces rarely frequented by underage persons.

Prohibit advertising, marketing and promotion of alcohol products and companies at all events organised by the WCG.

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

The proposal allows for exemptions for public facilities and events directly related to tourism and the promotion of exporting locally made alcohol products. However, the exemptions should include measures to ensure that promotional material is not visible to minors.

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[100] Babor TF, 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.

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

[102] 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 per cent20Reports/Ammie_repport_2012.pdf

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

[104] *Current controls on alcohol marketing are not protecting youth, warn public health experts*. (accessed 10 January 2017). Retrieved from Addiction: Society for the Study of Addiction: http://www.addictionjournal.org/press-releases/current-controls-on-alcohol-marketing-are-not-protecting-youth-warn-public-heal

Support the application of (national) levies on marketing and promotional spending to cover alcohol-related harms counter-messaging.

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, but not to produce the content or have any indication of their participation visible to the public.

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.

Progressively increase the coverage of 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 that 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 H*ealth 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 per cent to 80 per cent 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.

[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.

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

The WCG presents the following policy interventions:

Provincially determine a 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, and the relevant authorities would be able to reduce trading hours within the framework.

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 policy 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 variation, such as different trading hours and days in residential areas versus in business nodes or for tourism purposes (e.g. wine farms). Exemptions will be included to allow for flexibility based on set criteria.

Municipalities would be able to influence trading hours through their inputs during the liquor licence application process.

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

The WCG will provide a framework for the regulation of trading hours for on- and off-consumption outlets, and pilot limiting the density of outlets in any particular area taking into account zoning requirements and the population size and density. The proposal would provide for variation based on residential areas versus business nodes or outlets that cater for tourism purposes. Exemptions will 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 violence[111] and murder.[112]

The policy proposes a nuanced approach that involves two broad considerations to evaluate whether licences are approved. The first takes into account the type of area, including whether it is a residential area versus a business node or one that caters for tourism purposes. The second consideration is the weighing up of context-specific factors. The factors would include the distance

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[108] 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.

[109] Grubesic, TH & Pridemore, WA. (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, MS, McFarland, BH, Caetano, R, Conner, KR & 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, CB, 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 RN, Williams KR, McCaffree KJ, Acensio, EK, Browne, A, Strom, KJ, 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.

from educational, health, religious or other public institutions and alcohol-related harms in the area. A statistically determined harms-based norm, discussed under the *Institutional arrangements* chapter, would be a factor.

The question arises whether these considerations would apply only to future applications for a liquor licence or even to the renewal of licences. In answering this question, it is important to note that licences are deemed as property rights. The policy therefore takes the position that the considerations above would not be detrimental in a renewal application. However, the considerations would be relevant in a determination of placing conditions on existing outlets. For example, if an existing outlet is near a school a trading hour condition could be placed on the licence. Existing legislative provisions that deal with complaints of licensed outlets transgressing conditions or that pertain to licence-renewal processes would remain avenues of recourse for communities.

Cutting hours and days of trade reduces the consumption of alcohol and leads to reduced alcohol-related harms. 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 23:00 had the effect of reducing murders by 106 per year, or 30 per 100 000 of the 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 approximately 360 000 located near to São Paolo 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 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 per cent 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

[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 political leadership and a sustained approach.

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

close by 21:00. The drop in violent crimes correlated closely with 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 broad business community's interest. Alcohol is related to 72 per cent of lost productivity in general, and diminished workplace productivity accounted for 45,9 per cent of alcohol-related costs.[117]

There should also be strict penalties for selling liquor for off consumption from premises licensed to sell only on consumption, with suspension of a licence as a consequence for multiple offences.

Lobby national government to increase the price of alcohol through increasing excise tax and/or introducing minimum unit pricing and consider a provincial tax. The increased tax revenue would be ring-fenced for alcohol-harms reduction investments.

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 relation to household income.[121] A South African study of price elasticity for alcohol concluded 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 households.[122]

The two main strategies to regulate prices are:

1. tax and excise; and
2. minimum unit pricing.

Both policies must be lobbied for and considered at the national level, however a provincial tax is also to be considered.

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

[117] Bouchery, EE, Harwood, HJ, Sacks, JJ, Simon, CJ, & Brewer, RD. (2011) *Economic costs of excessive alcohol consumption in the U.S., 2006*. American Journal of Preventive Medicine, 41(5):516-524 at 519 and 520 where lost productivity includes impaired productivity at work, mortality, incarceration of perpetrators, impaired productivity at home, absenteeism, crime victims, fetal alcohol syndrome and impaired productivity of institutions. Up to 72 per cent of alcohol-related costs are incurred from diminished workplace productivity.

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

[119] Chaloupka, FJ, 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 or https://www.nap.edu/catalog/10729/reducing-underage-drinking-a-collective-responsibility.

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

[122] *Ibid.*

Excise taxes: In South Africa excise taxes are the preferred mechanism to curtail alcohol consumption.[123] 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.[124] In addition, an excise tax increase would generate additional revenue. A 10 per cent increase in the alcohol price is expected to decrease consumption of beer by 4 per cent, low-priced wine by 11 per cent, medium-priced wine by 8 per cent and spirits by 8 per cent.[125]

Provincial tax: A provincial tax in terms of section 228 of the Constitution of the Republic of South Africa will also be considered due to the effectiveness of the tax mechanism for alcohol-related harms reduction.

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 according to the volume of ethanol/alcohol in the beverage rather than the volume of the alcoholic beverage.

A portion of the tax revenue in both instances, national or provincial, should be ring-fenced for alcohol-harms reduction programmes (e.g. rehabilitation centres or capacitating enforcement). National government is to be lobbied for a portion of the ring-fenced revenue to be distributed to provinces for implementation of their Alcohol Harms Reduction (AHR) programmes.

Lobby the 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.[126] The study discussed a reduction of the alcohol level in beer to 4 per cent, and comparative experiences in Brazil support the effectiveness of the decrease.

Lobby the national government to tighten the 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

[123] Most excise taxes are derived from beer sales (59 per cent), compared to wine (27 per cent) and spirits (14 per cent). Sorghum beer is taxed at very low rates.
[124] 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.
[125] Van Walbeek C, Blecher M. *The economics of alcohol use, misuse and policy in South Africa*. Cape Town, 2014.
[126] Rehm, J, Lachenmeier, DW, Llopis, EJ, 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).

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 requires evaluating 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 must include mechanisms that will reduce the incentivisation of the sale of volume-based discounted liquor to consumers.

Lobby the 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 also 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.

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 licences issued by the WCLA [127] and 408 issued by the National Liquor Authority.[128] In a 2015 survey, the number of *unlicensed* liquor outlets in 2015 in the Western Cape was determined as 3 483, the equivalent of 37 per cent 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 some 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 a disproportionate risk due to a lack of regulation. They are not incentivised to obtain a licence and to comply with requirements relating to the prohibition of sales to underage or drunk 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.

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 outlets as well as the consequences of not becoming licensed. The application process for liquor licences must be simplified and streamlined.[131] The aim of the Western Cape Liquor Act, 2008,[132] must be to support the responsible sale and consumption of liquor in line with a

[127] WCLA, Register of Licences, accessed December 2015.
[128] National Liquor Authority, database accessed in 2015.https://www.thedti.gov.za/business_regulation/nla_register.jsp.
[129] Information from SAPS 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 per cent201.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] See chapter on *Institutional arrangements.*
[132] Western Cape Liquor Act, 2008 (Act 4 of 2008).

greater alcohol-harms reduction focus. Likewise, 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, working with municipalities, 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. Zoning is a municipal competence. The issuing of liquor licences is a provincial competence and the proposal is to ensure collaboration between the two spheres of government in order to reduce harm, while bringing a predictable and regulated environment, particularly for 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 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 down.

As discussed in the *Problem statement* section, alcohol's mind-altering effects are drivers of various and extensive harms, including violence[133, 134, 135] and criminal activities[136] such as robbery, murder[137] and assault.

The courts need to take cognisance of this, and to that effect prosecutors need to be assisted with evidence, such as academic studies and statistics, to be placed before the courts.

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

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

[134] Foran, HM & O'Leary, KD, *Alcohol and intimate partner violence: A meta-analytic review*, Clinical Psychology Review, Volume 28, Issue 7, October 2008, Pages 1222 – 1234.

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

[136] 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).

[137] Kuhns, JB, Exum, ML, Clodfelter, TA, & Bottia, MC. (2014). *The Prevalence of Alcohol-Involved Homicide Offending: A Meta-Analytic Review*. *Homicide Studies,* 18(3):251 – 270.

Create awareness of alternative economic opportunities 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, including information on relevant business support programmes.[138]

[138] Refer to the *Community-based action* chapter.

Chapter 3: Enforcement

Law enforcement is an integral part of a comprehensive approach to reduce alcohol-related harms.[139]

The role of enforcement is far-reaching. It includes both regulatory compliance, which ensures liquor licence holders and applicants comply with the legislation, and criminal prosecution, 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 is committed to the following policy interventions:

Reduce unlicensed liquor outlets and focus on problematic outlets.

Capacitate and strengthen liquor enforcement units further through increased resources.

As discussed under the *Institutional arrangements* chapter, renewal fees based on volume category will provide additional resources for enforcement officers.

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

The intervention is discussed under the *Unlicensed liquor outlets and the illicit liquor trade* chapter.

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 is to bring some sustainable, currently unlicensed liquor outlets into the regulated environment on condition that they comply with the minimum requirements. More outlets than currently exist are not desirable and licensing unlicensed outlets 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 results of the piloted nuanced density approach in this policy, to ensure a sustainable and responsible absorption into the regulated space.

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[139] 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.

Clamp down on unlicensed outlets and the supply of liquor to unlicensed outlets. All spheres of government and relevant departments must contribute to the clamp-down. Information from community-based organisations and structures as well as the enforcement opportunities from municipal zoning schemes, the Western Cape Land Use Planning Act, 2014 (Act 3 of 2014) (LUPA), and the Spatial Planning and Land Use Management Act, 2013 (Act 16 of 2013) (SPLUMA), must 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 such as 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 a 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.

Increase enforcement of underage drinking laws.

Introduce a legislative intervention that requires the mandatory inspection of the identification of patrons at all establishment entrances (clubs, pubs and similar) or points of purchase (liquor stores) of liquor licensed outlets.

It is recommended that fining and the lobbying for the prosecuting of liquor outlets that continually flout regulations regarding the sale of alcohol to persons who are under the legal age are prioritised.

Implement 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 to access the WCLA complaints mechanisms.

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. Greater awareness should therefore be created of WCLA complaints mechanisms that would encompass communication channels such as telephonic, email, cell phone app, SMS and others. Information of these mechanisms must be made readily available to communities at police stations, libraries, through neighbourhood watch structures and other relevant platforms.

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 prosecution process.

Successful prosecution requires that police dockets must be well prepared and that prosecutors are well informed and prepared for the matters.

Appropriate evidence needs to be led in court matters to ensure the sanction is appropriate. As proposed under the *Unlicensed liquor outlets and the illicit liquor trade* chapter, prosecutors need to be assisted with evidence, such as academic studies and statistics, to be placed before the courts. This would include evidence of the strong correlation between crime and alcohol, as well as the harms caused by alcohol.

Address the fragmented liquor legislation and strengthen unity to harness available resources.

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.

Create delegations, agency agreements and memorandums of cooperation 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 competencies[140] 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, whereas the interpretation of liquor licence conditions and requirements would be best known to the WCLA liquor inspectors. National

[140] Schedules 4 and 5 of the Constitution of the Republic of South Africa, 1996.

requirements in respect of liquor products and labelling would again be best known to the administering officers of the national Department of Agriculture, Forestry and Fisheries.

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

Train all enforcement officials in all aspects of liquor legislation, liquor control and liquor enforcement. Develop a guide and make it available to prosecutors and other state officials.

Training all enforcement officials in all aspects of liquor legislation will provide the technical knowledge to maximise the enforcement of liquor legislation.

Establish one overarching liquor law enforcement centre for operational coherence, with the WCLA providing the sector-specific guidance for operations.

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 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 coordination of enforcement information, to serve as reference point for all units and to supply expert advice on liquor enforcement matters.

The policy proposes that it would be beneficial if the WCLA, due to its unique knowledge on liquor, liquor products and the liquor trade and industry, provides the sector-specific guidance for operations to the combined enforcement effort within the Western Cape.

Bring the hours of work of enforcement officials 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 alcohol on society. Strategies and the hours of work of enforcement officials must be brought in line with these operational requirements.

Amend the requirements of obtaining a liquor licence to ensure that licence holders, and the managers or staff member in charge 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.

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 or in charge of the undertaking on behalf of licence holders, are aware of the applicable laws and obligations.

The licence holder or the relevant manager(s) or staff member(s) in charge, who must be natural persons, must be on site at all times when the outlet is open for business. The proposal addresses the issue of persons in the position of managers obtaining the training and found to

be competent in understanding the outlet's obligations not being present during day-to-day trading to ensure compliance.

The test will be in all three official languages of the Western Cape and administered by the WCLA. Provision will be made for illiterate persons. The test may have to be repeated after a stipulated time period.

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 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.

Simplify the process to prove alcohol-related offences while increasing the sanctions.

Legislation will 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 alcohol-related offences, such as selling to unlicensed outlets, 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.

Increase the roll-out of mobile testing for breath and/or blood by an approved, legally admissible device. Use suitably qualified provincial officials at roadblocks in the Western Cape.

One of the reasons for cases of "driving under the influence of liquor" being delayed is the backlog in the analysis of blood alcohol samples at the Forensic Chemistry Laboratory of the national Department of Health.[141]

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 increasingly 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.

[141] 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.

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 its use is being increased 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.

Implement diversion or alternative dispute resolution (ADR) as a sanction negotiated by prosecutors for lower-level alcohol transgressions such as drinking and/or being drunk in public.

Courts are backlogged with a variety of serious matters. Individuals detained for drinking and/or being drunk 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 per cent of pedestrians killed on the road who were tested were found to have alcohol present.[142]

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 for first-time offenders where no serious harm has been caused. Prosecutors can negotiate these sanctions, and these matters need not go before a magistrate.

Rigorous use of compliance fines[143] by empowered enforcement officers to address poor compliance with the law.

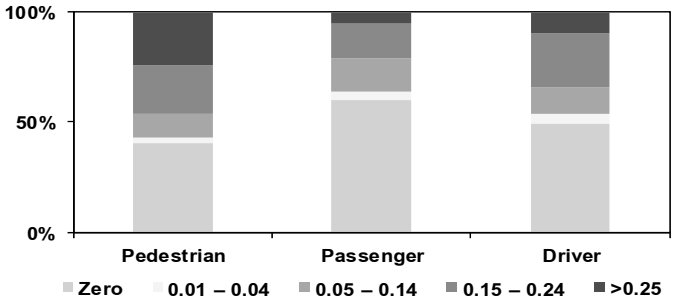
The purpose of this proposal is to facilitate a more compliance-orientated environment. The annual report of the WCG must provide statistics regarding the number and type of fines issued and any further steps taken. An example of steps taken may include requiring further responsible beverage training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

[142] Provincial Injury Mortality Surveillance System: *Injury Mortality Report 2010*. (2013) Provincial Government of the Western Cape Burden of Disease Project.
[143] Western Cape Liquor Act, 2008, Chapter 11.

Chapter 4: Alcohol and the road environment

Numerous reports and studies on fatalities on Western Cape roads illustrate the trend that there is a consistently high prevalence of alcohol in road traffic fatalities. Forensic Pathology Services (FPS) data[144] indicate, for example, that alcohol is present in approximately 50 per cent of crash victims, with concentrations of alcohol present in a significant number of pedestrians, passengers and drivers. Pedestrians, who make up approximately 43 per cent of road traffic injury fatalities in the Western Cape,[145] have the highest prevalence of markedly high concentrations of alcohol (**Figure: Fatalities by road user category and by BAC level**).

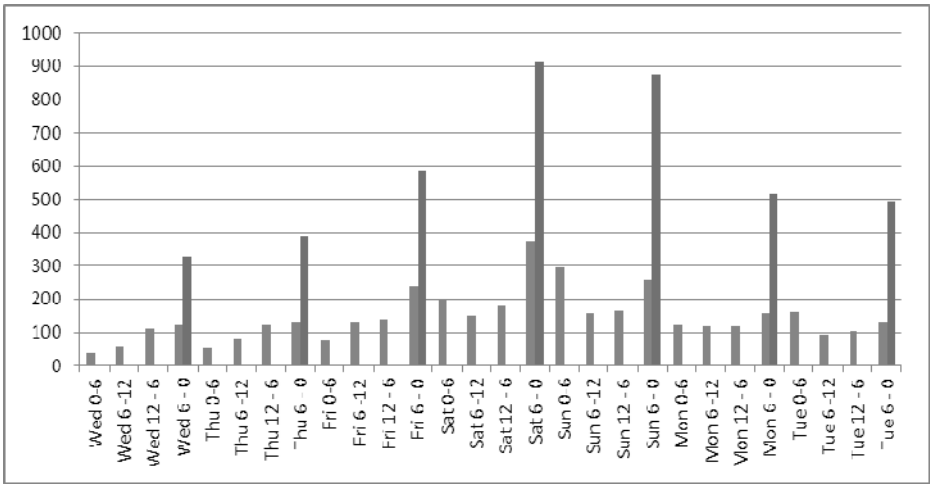
Fatalities by road user category and by BAC level (n=2432).



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



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

[144] Forensic Pathology Services (2014) *Report on Road Traffic Fatalities.*
[145] *Ibid.*

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.[146] 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 WHO[147] and the United Nations favour the Safe Systems approach, which identifies a number of pillars to achieve effects in road safety. The approach is supported by this policy.

The WCG confirms 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 licences 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 will be considered, including:

1. A relationship between liquor licensing, trading hours and lighting can be introduced. Trading hours can then be restricted where on premises lighting and infrastructure is poor, and licences and renewals can be denied if inadequate lighting is provided outside venues on a case-by-case basis. The aim of these conditions should be to encourage liquor traders to take responsibility for the safety of their clients exiting their venues. Often external premises lighting and infrastructure is the responsibility of local or provincial government. Collaboration would be required with the relevant departments to highlight areas where lighting infrastructure is an inhibitor.

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 offsets. For example, a trader whose licence cannot be renewed due to a high prevalence of alcohol-linked road deaths in the vicinity could provide proof of a contract with an approved public transport operator who is responsible for safely transporting patrons from the surrounding area home at the expense of the patrons.

[146] 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].

[147] 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].

Consider imposing restrictions on the sale of alcohol on premises that are on national or provincial roads (e.g. at petrol stations).[148]

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

Lobby 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, Portugal and the Federal Republic of Germany, have taken a more nuanced approach, with some success.[149] First, these countries have introduced non-criminal alcohol limits in addition to the already existent criminal limits.

In Brazilian provinces the *Lei Seca* has been implemented: drivers who are screened with a positive breath alcohol concentration (BrAC) below or equal to a 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 driving under the influence (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.[150]

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.

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[148] Room, R, Carlini-Cotrim, B, Gureje, O, Jernigan, D, Mäkelä, K, Marshall, M, Medina-Mora, ME, Monteiro, M, Parry, CDH, 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.

[149] 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 per cent reduction in alcohol-related traffic fatalities between 1995 and 2005, against an overall drop in road crash fatalities of 43 per cent.

[150] 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.

Notwithstanding the proposal above, this 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, probably because they lack crash avoidance skills or because youth who drink engage in riskier behaviours.[151] Young, inexperienced drivers with a BAC of 0,05 g per 100 ml have nearly twice the risk of older, more experienced drivers at similar BACs.[152]

Consider the introduction of legislation or local government by-laws 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,[153] and sustain more severe injuries.[154] 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.

Consideration is to 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, unless pedestrian 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.[155] 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. Legislation could also be designed to target specific hotspots, or to cover specific classes of roads.

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[151] 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.

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

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

[154] 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.

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

The introduction of alcohol interlocks[156] 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,[157] 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 installed for all public transport vehicles, including scholar transport vehicles and school busses, all government and government agency vehicles[158] 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 for 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 increasing random breath testing.

Random breath testing is among the most effective DUI interventions[159, 160] and can reduce fatal traffic crashes by 20 per cent.[161] A Random Breath Testing programme has been designed for alcohol-related harms reduction in the province, which should be strengthened.

Integrate law enforcement and road safety awareness action.

Legislation cannot make a significant behavioural change impact without the public being made aware of it and it being enforced. It is therefore important that the public is educated about the

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[156] 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.

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

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

[159] 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.

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

[161] 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.

consequences of alcohol and road-user behaviours – and that it is widely publicised when law enforcement action is taken.[162]

In line with WHO recommendations, budgets should be identified and allocated to law enforcement 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.

Legislation must make it mandatory to collect blood samples for BAC testing if a crash involves a fatality or injury. Blood samples must 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.

This requires passing legislation that makes it mandatory for law enforcement and/or first responders to collect blood samples for BAC testing if a crash involves a fatality or injury.

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 that new drivers can be aware and take preventative measures from causing harms.

Develop interventions for first-time DUI offenders.

This 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 and where no injury or fatality occurred.[163] If an injury or fatality has occurred the driver should be subject to usual prosecution processes.

[162] Bergen et al*. Publicized sobriety checkpoint programs: A Community Guide systematic review*. American Journal of Preventive Medicine 2014; 46:529-539.
[163] Parry, CDH, 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 confirms the following policy interventions:

The following interventions as recommended by the WHO[166] 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.

Progressively 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 Western Cape Department of Health and the Western Cape 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 programme focuses on individuals and families at risk.

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

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[164] Prevention of and Treatment for Substance Abuse Act, 2008 (Act 70 of 2008).
[165] Section 9(1).
[166] Chapters 4, 6 and 7.
[167] South African Community Epidemiology Network on Drug Use. (2015) Update November 2015 at 1.
[168] South African Community Epidemiology Network on Drug Use. (2015) Update November 2015 at 1.

Provide programmes for screening, provision of information, brief motivational interventions[169] *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-to-moderate and moderate-to-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-to-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 and the challenge of patients returning to the facilities for follow-up care requires consideration.

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. Few emergency centres are 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 and perceived time constraints can impede implementation.[174] A systematic review found that adequate financial and managerial support and training are critical to successful implementation. While the cost of this approach is moderate, there is the

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[169] Spirito, A, Monti, PM, Barnett, NP, Colby, SM, Sindelar, H, Rohsenow, DJ, Lewander, W, Myers, M. (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] WHO. (2010) *Global strategy to reduce the harmful use of alcohol.* WHO 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, DJ, Corrigal, 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.

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.

Included in the measures are: (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 attend antenatal clinics who are at higher risk of an alcohol-exposed pregnancy. 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 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.*

Young people who begin drinking before the age of 15 are five times more likely to develop an alcohol use disorder than those who wait until the age of 21.[178] The odds that young people who start drinking when they are younger than 14 will suffer an alcohol-related injury are five times greater, the odds of their ever being in a traffic crash are 6,3 times greater, and the odds of their being in a fight are 4,6 times greater than young people who wait until the 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 per cent of learners reporting use[180] and approximately 25 per cent reporting 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.

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[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, MM, Joubert, B, Cloete, M, Roux, S, Baca, BA, Hasken, JM, Barnard, R, Buckley, D, Kalberg, WO, Snell, CL, Marais, A-S, Seedat, S, Parry, CDH, May, PA. (2015). *Indicated Prevention of Foetal Alcohol Spectrum Disorders in South Africa: Effectiveness of Case Management;* International Journal of Environmental Research and Public Health. 2015 Dec 23; 13(1): 76.

[177] Note 51 at 1.

[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 33 at 1.

[181] Note 51 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 is required.

The DSD, through the Provincial Substance Abuse Forum (PSAF) and the local drug action committees (LDACs),[184] *will coordinate an integrated transversal approach to determine gaps and coordinate 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.[185]

[182] Note 166 at 12.
[183] Ouimette, PC, Moos, RH, and Finney, JW. (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] Established in terms of the Prevention of and Treatment for Substance Abuse Act, 2008, and in line with the National Drug Master Plan (2013-2017), approved by the Provincial Cabinet on 26 June 2013.
[185] Note 166 at 12.

Chapter 6: Community-based action

Community-based initiatives recognise the specific and unique needs of communities. These strategies 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. [186] 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 plans the following policy interventions:

The community-based model for substance abuse treatment and rehabilitation is 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 and[187] creates awareness of the facts relating to alcohol abuse and alcohol-related harms.[188]

The capacity of municipalities to be strengthened and institutionalised through the establishment of LDACs – with accountability mechanisms based on intergovernmental relations lobbied 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 non-governmental organisations",[189] as recommended by the WHO.

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

> The PSAF, already established by the WCG, is the forum established in terms of section 57 of the Prevention of and Treatment for Substance Abuse Act, 2008, by an MEC in order to give effect to the National Drug Master Plan (NDMP).[190] The PSAF's core function is to strengthen member organisations to carry out functions related directly or indirectly to addressing the problem of substance abuse. LDACs link to the PSAF, which in turn is the high-level link to the WCG and the national government.

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[186] Bezuidenhout, F.J. 2008. *A reader on selected social issues*. (4th ed.) Pretoria: Van Schaik Publishers. P. 138.
[187] Note 166 at 12.
[188] Note 166 at 13.
[189] Note 166 at 13.
[190] Prevention of and Treatment for Substance Abuse, 2008.

According to the NDMP 2013-2017 every 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 include broader stakeholders such as representatives from NPOs and the legal, professional, business, research, and traditional-authority sectors. The feasibility of including representation from other appropriate structures, such as the CPFs, is supported.

LDACs are to 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 (comprising social workers, 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 mobilisation, strengths-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 parents with substance-abuse problems.

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 copy 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,[191] and this cross-community sharing could spark additional interventions. Other countries have acted on this recommendation, including Slovenia, which created the website *Mobilising society for more responsible attitudes towards alcohol* (http://www.infomosa.si/) to share best practices.

[191] Note 166 at 13.

Provide further support for 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.[192]

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

Neighbourhood watches, which the Province is capacitating though 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, along with NGO and community structures.

Increasing community input in the management of conflicts arising from 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 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 licensed 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.

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[192] Kumpfer, KL, Whiteside, HO, Greene, JA, Allen, Keely C, *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.

[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 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 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: Enforcement: (reduce access to alcohol), recreational and economic (enhance quality and participation in recreational alternatives and facilitate access of outlet owners to alternative economic activities), health and social services (create awareness of and access to health and social-support services to those who have alcohol-related problems).

The Policing Needs and Priorities meetings to 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 who 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 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 and community representatives, 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.

Community police forums to play a more active role in problem liquor outlet identification and the licensing application process.

CPFs are established in terms of section 18(1) of the South African Police Service Act, 1995.[195] CPFs 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. CPFs 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, NGOs, 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 disseminate an understanding of 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]

A whole-of-society, multi-sectoral approach to education and awareness, integrated appropriately, is supported 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 commits to the following policy interventions:

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

As discussed above in chapter 6, the WCG PSAF has been established.[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, information or effective interventions and strategies that are successful may be useful to other LDAC geographic areas; relevant information should be disseminated to all LDAC areas so that they may make use of the shared knowledge and experiences.

LDACs, as discussed under Chapter 6, will be used as a vehicle to coordinate education and raise awareness about alcohol risk, interventions and resources 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.

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[196] The WHO supports this position in its *Global Strategy to reduce the harmful use of alcohol* (note 170 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 mobilising public opinion and support for effective alcohol policies". This position is echoed by Anderson et al. (note 12) (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 for Substance Abuse, 2008.

[199] *Ibid.*, clause 58(a).

Continue and strengthen 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 is to be upgraded.

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.[200] There is some evidence that the Good Behaviour Game prevents later substance abuse, with a strong cost-benefit ratio.[201]

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 is to be promoted through educator training or information sharing.

The WCED Safe Schools call centre[202] 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 is to 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 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, is supported. The LDACs are a valuable platform to facilitate this resource sharing and networking for integration opportunities.

Develop norms and standards 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 per cent 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 per cent conducting follow-up sessions, and respondents displayed a poor understanding of evaluating their risks. One of the key recommendations coming out of the study was that an effective

[200] 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.
[201] Nolan, JD, Houlihan, D, Wanzek, M, Jenson, WR. (2014). *The Good Behaviour Game: A classroom-behaviour intervention effective across cultures*. School Psychology International, 35, 191-205.
[202] https://www.westerncape.gov.za/service/safe-schools-programme; Safe Schools Call Centre: 0800 45 46 47.

regulatory regime in the form of minimum norms and standards for primary prevention activities should be developed.[203]

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.[204]

Leverage the after-school space for education and awareness targeted at youth and the provision of, or referral to, interventions.

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 targeted at youth in the after-school space should be promoted. The space must include the provision of or referral to interventions where needed. Representation from the different after-school centres on their community's LDACs is supported.

Support 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. Post-school education institutions in the province will be supported in relation to education and awareness programmes, particularly in relation to sharing effective interventions.

Promote a clean fun campaign.

A Clean Fun campaign, in collaboration with the private and civil sectors, should be promoted that targets youth and young adults through various media channels with the messaging of having sober fun. The inclusion of celebrity support to make it aspirational should be sought.

Mainstream 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, including Health, Agriculture, Transport, Education and Community Safety are in a good position to disseminate information and implement education and awareness campaigns.

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[203] 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.

[204] Parry, CDH & Bennetts, AL. (1998). *Alcohol policy and public health in South Africa.* Cape Town: Oxford University Press.

Promote and strengthen education and awareness programmes with 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 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 include 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 of meetings and to tailor education and awareness to community needs.

A requirement of obtaining a liquor licence is to 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 managers who had been trained and found to be competent in understanding their outlets' obligations but who were not 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*[205] and must be continually updated.

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 engaging in hazardous or harmful drinking.

Different and innovative strategies to improve the reach and ease of access to education and awareness material are to 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, is a priority. Innovative new forms of communication, such as on social media platforms and the use of mobile applications should be pursued to extend the reach of education and awareness and facilitate engagement and learning. This is to counter the extensive use of these media by the liquor industry.

[205] https://www.westerncape.gov.za/dept/social-development/services/956/38612

Greater resources should also be obtained to expand these campaigns. All funding must be received by an independent entity and content must be independent. The alcohol industry, as part of their social responsibility, may provide funding. However, in order to maintain credibility and integrity of the information, no funding may be ring-fenced to particular issues, and branding of alcohol companies may not form part of the campaigns and associated materials.

Materials, including pamphlets and posters, about the dangers of alcohol should be required to be displayed within licensed outlets. The material should include contact numbers of rehabilitation centres and the link to the *WC Substance Abuse Resource Directory.*

Expand and strategically direct addiction care education courses.

The WCG funds two courses at tertiary level in order to capacitate persons working in 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 continue to focus on education programmes on FASD in collaboration with 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 coordinated 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".[206] 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 is 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 and monitor and report on the alcohol economy, including production, distribution, 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 the impact of liquor.
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.

[206] Note 12 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 10[207] to keep track of relevant data to evaluate alcohol-related harms and interventions.

The WCG is exploring the feasibility of implementing the following:

A purpose-built monitoring-and-surveillance system

The system would 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) Because reducing alcohol-related harms is multidimensional, the system should be coordinated by a designated transversal structure, 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.)[208] 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.

[207] Note 178 at 18.
[208] 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 coordinates 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.

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, school and community surveys;

iii. Partnering with and utilising information from universities, think tanks and service providers, such as Statistics SA, the HSRC, SAMRC and CSIR;[209]

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;

[209] There are existing su-rveillance systems run by the SAMRC that should be tapped into: such as the South African Demographic and Health Survey, 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, which assesses drug treatment demand related to alcohol and other drug use; the Youth Risk Behaviour Survey, which assesses drinking habits of persons in grades 8 to 11 and some alcohol-related negative consequences; and the National Non-Natural Mortality Surveillance System, which among other things assesses alcohol involvement in non-natural deaths. Provincial (or subprovincial) 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.

d) 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.

e) An intersectoral working group will be established to set up the system and draw on the various agencies producing and using the data. The group could provide an oversight function at a later stage, giving insight into analysis and recommendations for reviews and improvements in order to ensure a more effective alcohol-related harms reduction system in the future.

f) 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.

g) 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 focuses on cooperation across spheres of government and relevant departments and supports effective measures that give due regard to alcohol-related harms reduction.

The WCG supports the following interventions:

Institutional structure form

An efficient and effective institutional structure

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. **The governing Board** to manage the business of the WCLA, with an established administration. The administration is responsible for the administration of liquor licence applications, support functions and the enforcement of the Act.[210]

2. The **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.[211] The rationale for establishing an independent tribunal is based on ensuring non-discriminatory treatment of all parties. The LLT therefore has an arm's-length relationship with the liquor industry, political authorities and other interested parties. The LLT is empowered to act against transgressors in the liquor industry.[212] The sanctions imposed by the LLT for non-compliance with licence conditions enable enforcement.

3. The **Appeals Tribunal**, comprising an independent person, affords 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

[210] Sections 3 to 14 of the Western Cape Liquor Act, 2008.
[211] Sections 16 to 24 of the Western Cape Liquor Act, 2008.
[212] Section 20(1)*(d)* and *(e)* of the Western Cape Liquor Act, 2008.

from the Western Cape Department of Economic Development and Tourism to the DoCS, with effect from 1 April 2016.[213]

The Western Cape Liquor Act, 2008, provides a clear distinction between legislative, judicial and administrative powers in line with administrative law. [214] 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.[215] 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.[216]

The following considerations were taken into account when considering and selecting the new structural form:

1. Good governance and integrated service delivery embedded through partnerships and spatial alignment.
2. Limited available public resources 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 current model

The current structure was established five years ago, when the first Governing Board was appointed with effect from 11 March 2012.

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

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.

[213] See Proclamation 3/2016 published in *Provincial Gazette* 7564 of 12 February 2016.
[214] Devenish GE, Govender, K & Hulme, DH. (2001) *Administrative Law and Justice in South Africa*, Butterworths, Durban, p 19.
[215] The trias politica principle or the separation-of-powers principle.
[216] Promotion of Administrative Justice Act, 2000 (Act 3 of 2000).

The hybrid model proposed

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

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

This option offers a number of positive elements.

1. 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.
2. 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,[217] the 2015 budget speech by Minister Nhlanhla Nene[218] and the 24 February 2016 budget speech by Minister Pravin Gordhan,[219] all of which advocate fewer public entities. Minister Gordhan recommended "reduced transfers for operating budgets of public entities".[220]
3. The approach, due to economies of scale, would increase efficiency and reduce costs.

General matters

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

The application procedure is intended to 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 for required advertisements. The comments of these stakeholders are to be submitted to the WCLA directly.

[217] Established in 2011.
[218] National Treasury website, 2015 budget speech by Minister Nhlanhla Nene, http://www.treasury.gov.za/documents/national per cent20budget/2015/speech/speech.pdf.
[219] National Treasury website, 2016 budget speech by Minister Pravin Gordhan, http://www.treasury.gov.za/documents/national per cent20budget/2016/speech/speech.pdf.
[220] *Ibid*. at 14.

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 will 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 and managers.

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.[221]

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.

A nuanced approach that considers the type of area and weighing up of contextual factors should be used to determine if new liquor licences should be approved in that municipal ward.

As discussed in Chapter 1, this White Paper proposes a nuanced approach that involves two broad considerations to evaluate whether to approve a licence. The first takes into account the type of area, including whether it is a residential area versus a business node or one that caters for tourism purposes. The second consideration is the weighing up of context-specific factors. The factors would include the distance from educational-, health-, religious- or other public institutions and alcohol-related harms in the area. A statistically determined harm-based norm would be a factor. An example would be a 10 per 100 000 alcohol-related mortality ratio. The purpose is to ensure sustainable and responsible licensing allocations.

In informal areas where, due to zoning issues, there were never any licences, the policy proposes identifying mechanisms and criteria that would enable the rezoning of outlets for liquor sales in appropriate residential areas. For these purposes, initially a minimum number of licences should be determined based on population levels and the nuanced approach discussed above. However, enforcement strategies should then be focused to deter and stifle illegal outlet trading.

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.

[221] The test will be in all three official languages of the Western Cape and provision will be made for illiterate persons.

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 licensing is one of very few areas in which the provincial government can generate income to contribute to society and offset 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 is introduced. The sliding scale or categorisation is to be determined by the relevant provincial department. The outlets selling higher volumes would pay higher fees and the outlets selling lower volumes would pay 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 and capacitating structures (e.g. neighbourhood watches) or transferring conditional grants to other departments or spheres of government 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 to 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 licences 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

The policy proposes the phasing out of grocer liquor licences over five years where there is an off-consumption liquor outlet within 50 meters from that grocery store. A phasing is being undertaken by the Eastern Cape Provincial Government. The Constitutional Court found that the provisions were not unconstitutional.[222] 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 this instance 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 licences

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

[222]Shoprite 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 to 10 per cent of the 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, guided by the WHO's global strategy to reduce the harmful use of alcohol, 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 economic importance of the alcohol industry, particularly in the Western Cape. The economic contribution is, however, dwarfed by the costs of alcohol-related harms and that – along with the other social harms – necessitated 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 would prohibit advertising, marketing and promotion of alcohol products and companies at all WCG public facilities and events organised by the WCG. 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 supported. To address supply drivers, the policy endorses 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 piloting the regulation of the density of outlets, 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 confirmed.

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 endorsed.

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 confirmed bringing responsible unlicensed liquor outlets into the regulated space in a sustainable and responsible manner, identifying mechanisms and criteria that would 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. Liquor enforcement units are to be capacitated and strengthened through increased resources and an integrated liquor enforcement approach to implement the provisions.

Chapter 3: Enforcement recognised both regulatory compliance and criminal enforcement as integral parts of a comprehensive approach to reduce alcohol-related harms. All spheres of government and relevant departments should contribute to the clamp-down, and 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 would be undertaken. Lobbying for well-prepared police dockets, increasing the number of trained liquor law enforcement officers, establishing one overarching liquor enforcement centre for operational coherence and legislating for sentencing in line with the seriousness of the harms were mooted. Increasing the roll-out of mobile testing for breath and/or blood by an approved, legally admissible device and increasing the enforcement of underage drinking laws are among the further interventions.

Chapter 4: Alcohol and the road environment acknowledged the trend that there is a consistently 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 and lobbying national government to implement a graduated alcohol limit for drivers, with a zero tolerance for young or novice drivers, are mooted. The introduction of alcohol interlocks, increasing random breath testing and requiring mandatory blood samples to be obtained from all those involved in road crashes as soon as possible are among the interventions.

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. Proposed interventions include providing equitably distributed emergency medical services for alcohol-related conditions, strengthening 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 to 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.

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 actions planned.

Chapter 8: Information, data collection, monitoring and evaluation highlighted the need for an efficient and coordinated collection, management and analytic system and the 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 would 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 this White Paper. The policy approved an efficient and effective institutional structure. 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 mooted.

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 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.

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

Public comments have been considered on the draft *Alcohol-related harms reduction Green Paper*, and this White Paper will be published once approved by the Provincial Cabinet. 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. This *Alcohol-related harms reduction white 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 in life as free as possible from alcohol-related harm.

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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 (proportion of the population) who are **abstainers** will also be important as well as the **age of drinking onset**. Household and school surveys will need to be undertaken regularly (at least every five 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, including **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 rated 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 of 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
      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 application was 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 underage 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 (licence) 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 licensee
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 licences granted (overall and via GIS area), broken down into 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 a twelve-monthly basis should not only be presented orally to the Provincial Parliament but should also be made available in written format and on the Department's website.

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