REPUBLIC OF GHANA

NATIONAL ALCOHOL POLICY

MINISTRY OF HEALTH

DECEMBER 2016

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FOREWORD

Scientific evidence has proven that before the age of 25 years, the human brain is still undergoing development. The prefrontal cortex is the area of the brain that governs judgment and decision-making, and it is the last part of the brain to develop. This amongst other reasons why people less than 25 years old are more prone to risk-taking behaviours like the use of psychoactive substances leading to addiction. This also explains why persons 25 years and below are particularly vulnerable to alcohol and drug abuse, and why exposure to alcohol and other psychoactive drugs before this critical time of their lives may cause future substance use issues.

It is recognized that some segments of the population such as children and pregnant women are more vulnerable to developing alcohol related conditions. The use of alcohol by women in their child- bearing years can negatively affect both maternal and child health. Alcohol is a recognized teratogen. Teratogens adversely affect the development of the embryo or fetus causing birth defects in children and may halt the development of pregnancy. There is good evidence that children and youth with Fetal Alcohol Syndrome (FAS) have significantly lower health and quality of life outcomes than children and youth whose mothers did not consume alcohol during pregnancy. What is of even greater concern is the fact that women may not be aware that they are pregnant until after a month or more by which time the harmful

effects of alcohol on the foetus would already be taking place.

The effects of loss of productivity due to the harmful use of alcohol cannot be overemphasized. The misuse of alcohol affects productivity in various ways. The relevant physiological effects of alcohol misuse include intoxication, hangovers, withdrawal (abstinence syndrome) after long-term abuse, and residual physical, mental, or social disabilities due to abuse or chronic dependence. The most important effects of intoxication, clumsiness, sleepiness, difficulty in processing new information or communicating ideas, impaired physical safety and cognitive capability. Both effects can lead to poor performance, absenteeism, and job loss. Hangovers or periods of withdrawal can have similar results. Liver and heart damage, stroke, irreparable injuries, fits and psychoses are the most common physical and mental disabilities of alcohol abuse. The most common social disability includes withdrawal of trust by associates, family breakdown, economic hardship and road traffic accidents. By restricting the harmful use of alcohol among the workforce, Government will spend less in terms of rehabilitating those who have fallen victim.

Political and societal commitment is required to ensure a change in social norms and values. Communities are essential partners in the implementation of any policy. Their involvement is crucial to ownership and effectiveness of programmes aimed at reducing the harmful effects of alcohol. Multi-sectoral coordination is

essential for harnessing advantages and strengths towards the common goal of reducing alcohol related harm to society.

The interventions and programmes will be based on evidence locally and internationally sourced and sustainable implementation mechanisms. Effective services should be available, accessible and affordable for those affected by the harmful use of alcohol.

Honorable Alex Segbefia
Minister of Health

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GLOSSARY OF TERMS

Alcoholism – a state of physical dependence on alcohol to the extent that stopping alcohol use will bring withdrawal symptoms.

Alcohol abuse – deliberate or unintentional use of alcohol which results in any degree of physical, mental, emotional, or social impairment of the user, the users family, or society in general.

Alcohol/Ethanol – a toxic substance in terms of its direct and indirect effects on a wide range of body organs and systems**.** This is the psychoactive/intoxicating ingredient found in alcoholic beverages.

Alcoholic beverage – any drink that contains more than 0.5% ethyl alcohol.

Alcohol consumption – the general uptake of alcohol.

Advertising – the specific mention of, or any public notice, representation or activity with the intention to attract attention to and promote an alcoholic beverage or any other form of edible alcohol. Advertise and advertisements have corresponding meanings.

Alcohol dependence – psychological and/or physical need for alcohol characterized by compulsive use, tolerance, and physical dependence manifest by withdrawal syndrome.

Alcohol misuse – unintentional or inappropriate use of alcohol resulting in the impaired physical, mental, emotional or social well-being of the user. This includes any of the following;

- Hazardous use: there is potential for harm but there is no existing harm
- Harmful use: use despite harm
- Addiction: use with withdrawal effects
- Dependence: requires alcohol to function effectively

Alcohol-related harm – a wide range of social and health problems for drinkers and non-drinkers at individual and collective level.

Alcohol use – the consumption of alcohol within some socially prescribed or ritualistic context.

Edible alcohol – means any other edible product that contains more than 0.5% ethyl alcohol.

Good Manufacturing Practices (GMP) – means the minimum set of requirements needed to ensure the safety and wholesomeness of alcohol during its manufacture or processing.

Harmful use of alcohol – relates to alcohol misuse and alcohol abuse.

Intoxication – a state in which a person's normal capacity to act or reason is inhibited by alcohol consumption.

On-License – means a license permitting the sale of alcohol for consumption on or off the premises and is attached mainly to restaurants, pubs and hotels.

Off-License – means a license permitting the sale of alcohol for consumption off the premises and is mainly attached to supermarkets and shops.

Public Service Advertising – means any advertising, carrying a strong message against irresponsible use of alcohol/liquor.

Social harm – state of undermining the completeness of the physical, mental and social well-being of an individual.

LIST OF ABBREVIATIONS AND ACRONYMS

AA – Adult Accompaniment

AFRCD – Armed Forces Revolutionary Council Decree

AIDS – Acquired Immune Deficiency Syndrome

CNS – Central Nervous System

EAP – Employee Assistance Programme

F – Family

FAS – Fetal Alcohol Syndrome

FASD – Fetal Alcohol Spectrum Disorders

FDA – Food and Drugs Authority

GDHS – Ghana Demographic and Health Survey

GMP – Good Manufacturing Practices

GNAC – Ghana National Alcohol Commission

GPRTU – Ghana Private Road Transport Union

GSA – Ghana Standards Authority

HIV – Human Immunodeficiency Virus

ICAP – International Centre for Alcohol Policies

ID – Identity

LI – Legislative Instrument

LLA – Liquor Licensing Act

MDA – Ministries, Departments and Agencies

NCD – Non Communicable Disease

NGO – Non-Governmental Organization

PG – Parental Guidance

PNDCL – Provisional National Defence Council Law

PSA – Public Service Announcement

PTA – Parent Teacher Association

R – Restricted

S, M, E – Surveillance, Monitoring and Evaluation

STD – Sexually Transmitted Disease

STI – Sexually Transmitted Infections

TV – Television

WHO – World Health Organization

WTO – World Trade Organization

1. INTRODUCTION

This policy document sets out policy direction aimed at regulating the production, distribution, sale, advertisement and consumption of alcohol with the aim to minimize the negative impact of alcohol consumption on the individual, family and society as a whole (especially the vulnerable) and thereby safeguarding and protecting the society.

This policy identifies major priority areas for the reduction of alcohol related harms. These include the WHO best buy areas such as taxation, regulating availability; and regulating marketing of alcohol. Other areas of focus include; prevention and management of health effects and social services actions; surveillance, research, monitoring and evaluation; drink driving measures and capacity building.

1.1 Background

The harmful use of alcohol has been a cause for great concern globally and nationally. Though alcohol use is part of the Ghanaian culture and society, the current trend of consumption and the inadequate regulation of alcohol advert in both the print and electronic media is a source of worry. Yet the seriousness of this issue does not seem to register with the general public thus not much has been done to regulate the sector. The informal sector, which produces alcoholic beverages with high

percentage of ethyl alcohol, is also largely unregulated. The misuse of alcohol causes many problems ranging from serious health effects to effects on the family, community and society as a whole. The effects are even worse in the unborn child, children and adolescents.

The health effects of alcohol misuse include neuropsychiatric complications, liver diseases, heart diseases and diabetes. The trend of non-communicable diseases many of which alcohol is a risk factor[1] is on the increase[2]. Alcohol is also used as a preservative for herbal products, many of which are advertised for their supposed aphrodisiac effects thereby inducing high patronage. Also, production of alcohol in the informal sector often with potentially lethal concoctions is a practice that needs to be checked.

Currently there are many policy issues and regulations on various aspects of alcohol including production and sale scattered in several legislations. There is therefore the need to pool all these and other policies into one document. There is also the need for a central coordinating body to ensure its implementation and enforcement.

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[1] Non-Communicable Diseases Fact Sheet: http://www.who.int/mediacentre/factsheets/fs355/en/index.html, http://www.hsph.harvard.edu/nutritionsource/what-should-you-eat/alcohol-full-story/index.html

[2] National Policy for the Prevention and Control of Chronic Non-Communicable Diseases in Ghana by NCD Unit of the Disease Control Department of the Ghana Health Service

1.2 Situation analysis

1.2.1 Global

Worldwide consumption of alcohol in 2010 was equal to 6.2 litres of pure alcohol consumed per person aged 15 years or older, which translates into 13.5 grams of pure alcohol per day. A quarter of this consumption (24.8%) was unrecorded, i.e., homemade alcohol, illegally produced or sold outside normal government controls. Of total recorded alcohol consumed worldwide, 50.1% was consumed in the form of spirits. In all WHO regions, females are more often lifetime abstainers than males. There is a considerable variation in prevalence of abstention across WHO regions. Worldwide about 16.0% of drinkers aged 15 years or older engage in heavy episodic drinking. In general, the greater the economic wealth of a country, the more alcohol is consumed and the smaller the number of abstainers. As a rule, high-income countries have the highest alcohol per capita consumption (APC) and the highest prevalence of heavy episodic drinking among drinkers[3].

In 2012, about 3.3 million deaths, or 5.9% of all global deaths, were attributable to alcohol consumption. There are significant sex differences in the proportion of global deaths attributable to alcohol, for example, in 2012 7.6% of deaths among males and 4.0% of deaths among females were attributable to alcohol.

[3] WHO Global Status Report on Alcohol and Health, 2014

In 2012 139 million DALYs (disability-adjusted life years), or 5.1% of the global burden of disease and injury, were attributable to alcohol consumption.

1.2.2 National level

Ghana's population is estimated at 24,658,823 with a majority (61.7%) aged 15 years and above[4]. 51% of Ghana's population live in urban areas. It is estimated that 76.7% of Ghanaians aged 15 years and above are either lifetime abstainers or have abstained from drinking alcohol in the past 12 months. This means that 23.3% of this population (aged 15years and above) take alcohol. It is also estimated that 2.1% of the population engage in heavy drinking among the same age group (15 years and above). Recorded per capita consumption (15 years and above) stands as follows[5];

a. Beer - 30%
b. Wine – 10%
c. Spirits – 3%
d. Others (locally brewed) – 57%

Per capita consumption of pure alcohol among heavy drinkers stood at 20 litres in 2010[6]. This implies the need for special strategies to tackle production, sale and consumption of locally brewed alcohol in addition to strategies for the formal industry.

[4] Population and Housing Census, 2010
[5] WHO Global Status Report on Alcohol and Health, 2014
[6] WHO Global Status Report on Alcohol and Health, 2014

Alcohol consumption by sex[7]

Findings from the 2008 GDHS indicate that more men than women drink alcoholic beverages and consumption varies substantially across the regions and subgroups.

Consumption among women

It is estimated that 18 percent of women in Ghana drink alcoholic beverages. Alcohol consumption varies by age, employment status, marital status and region. Consumption increases from 7% in the age group 15-19 to 26% in the age group 45-49.

Of the women who drink, employed women are twice as likely to drink alcohol (20%) as women who are not employed (10%). Similarly, formerly married women (26%) and currently married women (20%) are more likely to drink alcohol than never-married women (11%).

By level of education, women with Middle/JHS level of education are least likely to drink alcohol (15%) while women with no education (21%) and women with the highest education (20%) are most likely to drink alcohol.

Consumption among men

The proportion of men in Ghana who drink alcoholic beverages (35%) is higher than the proportion of women. Men who drink alcohol also tend to drink more frequently than women.

[7] Ghana Demographic and Health Survey, 2008

Consumption of alcoholic beverages by men increases rapidly from 8% in the age group 15-19, to 27% in the age group 20-24, to 44% in the age group 25-29. By their early 40s, over half of men in Ghana drink alcoholic beverages (52%).

Among men who drink there is little difference in alcohol consumption by background characteristics such as level of education, wealth quintile, and urban-rural residence.

As with women, men who are employed (41%) are more likely to drink alcohol than men who are not employed (9%), but the difference is considerably larger for men. Similarly, formerly married men (53%) and currently married men (47%) are more than twice as likely to drink alcohol, compared with never-married men (21%).

The GDHS data also shows that among men aged 15-49 who drink alcohol, 30% never get drunk, 65% get drunk sometimes, and 5% get drunk often.

Legal Documentation and Guidelines on Alcohol

A review of the 2014 WHO Global Status Report on Alcohol and Health revealed the following about Ghana;

1. No national alcohol policy
2. No Legal Purchasing age/drinking age for both on and off premises
3. No restrictions in terms of hours of sale, place of sale and density of alcohol retail outlets

1.3 Rationale

The rationale is to offer comprehensive set of measures to develop, and implement interventions that will mitigate the effects of harmful alcohol use on the individual, family, community and the nation as a whole. These include preventive and rehabilitative health measures, the use of cultural and social structures, best buy areas as well as coordinating, monitoring and evaluation and economic interventions.

The policy, therefore, intends to initiate programmes to improve quality and coverage of prevention, treatment and care interventions on harmful use of alcohol as well as increase awareness of the effects of alcohol and curb harmful consumption of alcohol including underage drinking and drink driving.

1.4 Purpose

The purpose of the Policy is to encourage and promote abstinence from alcohol, reduce harmful alcohol consumption and regulate production, marketing and sale of alcoholic beverages. This is in recognition that alcohol consumption can only be reduced if the government actively participates in and takes effective actions in ensuring that the general population complies with alcohol regulation.

1.5 Linkages with international and national legislative and policy framework

1.5.1 Linkages with international Instruments

This policy takes cognizance of the repository of data and information available from the WHO. This policy document recognizes the WHO best buy areas in reducing alcohol related harm. Though these best buy areas such as increasing taxes on alcoholic beverages; regulating availability; regulating marketing of alcoholic beverages and drink driving countermeasures have proved effective mainly in high income countries, such interventions have been proven to be both cost effective and have the most impact. The policy thus focuses on these best buy areas in addition to using locally designed cultural and social interventions in reducing alcohol related harm.

1.5.2 Linkages with National Laws and Sectoral Policies

Regulation and control of the production and consumption of alcohol is not new in Ghana. Several legislations are currently in existence but are not individually comprehensive; they are not coordinated and enforcement has not always been easy.
The Policy recognizes the existing laws and with regard to alcohol such as;

- Manufacture and Sale of Spirits Regulations, 1962(LI 239);

- Distillers of Refined Spirits (Nomination) Instrument, 1963(LI 278);
- Liquor Licensing Act, 1970 (Act 331);
- Liquor Licensing (Prohibited Hours) Regulations, 1974 (LI 958);
- Prohibition of Sale of Beer and Spirits (Private Houses) Decree, 1979 (AFRCD 33);
- Local Government Act, 1993 (Act 462), especially section 13;
- Public Holidays Act, 2001 (Act 601);
- Road Traffic Act, 2004 (Act 683).
- Public Health Act, 2012 (Act 851)

The implementation of these laws and enactments should take cognizance of the national alcohol policy. Laws pertaining to the informal sectors need to be reviewed and updated periodically. Specific efforts should be identified to drive enforcement.

1.6 Impact of Alcohol Supply and Use

1.6.1 Possible Positive Impact

This Policy recognizes the role of alcohol production, distribution and sales in generating revenue through taxes and personal incomes; social cohesion as well as providing employment across the supply chain.

Though some studies suggest health benefits for minimum alcohol consumption, it is worth noting that binge drinking can erode these benefits. It is also true that even minimal consumption has a potential of exposing a person to misuse and addiction.

It is estimated that about 76.7% of Ghanaians are either lifetime abstainers or have abstained for the past 12 months[8]. This large segment of non-drinkers is in itself a quite significant contribution to the prevention of alcohol-related harm in Ghana, contributing largely to a low average consumption level and also reduction in drinking pressure on others. The policy recognizes this as a valued asset for a national alcohol policy.

1.6.2 Negative Consequences

The Policy also recognizes that harmful use of alcohol is associated with public health and socio-economic development burdens. The hazardous and harmful use of alcohol is risky for both the drinker and other people. For the drinker it is through health impacts such as alcohol dependency, liver cirrhosis, cancers and injuries while for others it is through dangerous actions of intoxicated people such as drink-driving and violence.

It should be noted that harmful use of alcohol has been identified as a direct cause of gender based violence including sexual violence and violence in the home.

[8] Global Status Report on Alcohol and Health, 2014

1.6.2.1 Alcohol and Communicable and non-communicable diseases

Alcohol is first and foremost a psychoactive substance. Its use at certain stages e.g. before and during pregnancy; the misuse and abuse generally are implicated in the causation (directly or indirectly) of the following conditions, among others:

1. Neuropsychiatric disorders
2. Ulcers of the mouth and throat
3. Cancers of the mouth, throat, oesophagus, stomach, liver, pancreas, duodenum, jejunum
4. Liver disease, cirrhosis of the liver
5. Acute and chronic pancreatitis, diabetes mellitus Hypertension, cardiomyopathy (heart disease) and heart attack
6. Foetal Alcohol Spectrum Disorders FAS(D)[9]
7. Impotence, infertility
8. Sexual risky behaviour leading to STI/Ds
9. Other communicable diseases such as Tuberculosis due to a weakened immune system
10. Risky behaviour leading to intentional and unintentional injuries e.g.
    - Drink driving

[9] www.helpstartshere.org/kidsandfamilies

- Spousal abuse
- Domestic violence

11. Loss in productivity
12. Increase in crime

1.6.2.2 Alcohol and Development Costs

Alcohol consumption can affect productivity in many ways. The relevant physiological effects of alcohol consumption include intoxication, hangovers, withdrawal, abuse and residual physical, mental or social disabilities due to abuse or dependence. The most important effect of intoxication include clumsiness, sleepiness, difficulty in processing new information or communicating ideas, impaired physical safety and cognitive capability[10]. Productivity losses attributed to harmful use of alcohol have not been estimated for Ghana but it is known that alcohol abuse is of major concern to a number of organizations including the health sector. It is now an accepted fact that alcohol consumption contributes significantly to disease burden and that it requires greater attention than it is receiving at present.

In essence, harmful alcohol use not only takes away the required human resource through the associated alcohol-related harms, but also exerts disproportionate financial burden through prevention and rehabilitation programmes and enforcement services that could otherwise be avoided.

[10] www.bookrags.com/research/productivityeffectsofalcohol

2. BROAD POLICY DIRECTIONS

The main direction of this Policy is to reduce the harm caused by the use of alcohol.

2.1 Policy Goal

To contribute to a country where inhabitants are free of or are with minimal health complications and social consequences of harmful alcohol use.

2.2 Policy Outcomes

To encourage and promote abstinence from alcohol, reduction in consumption of alcohol, and also to regulate the production, marketing and sale of alcoholic beverages in such a way that harmful use is minimized.

2.3 Policy Objective

To improve public health and reduce the socioeconomic effects of alcohol consumption on the Ghanaian populace.

2.3.1 Specific Objectives :

1. To effectively regulate the availability and accessibility of alcohol products including informally brewed alcohol,
2. To improve health service response to harmful use of alcohol,

3. To reduce the harmful effects of alcohol use through a mix of multi-sectoral approaches
4. To reduce the impact of alcohol on the prevalence of communicable and non-communicable diseases including sexually transmitted diseases such as HIV and its co-morbidity, Tuberculosis.
5. To reduce gender based violence due to inappropriate and/or excessive use of alcohol.
6. To monitor, evaluate interventions; mount surveillance and collect data on harmful use of alcohol.
7. To identify key stakeholders for developing, implementing, coordinating, monitoring and evaluating interventions to reduce alcohol related harm;
8. To contribute to national development through reducing the pressure on national resources by socioeconomic and health problems caused by consumption of alcohol;
9. To protect the vulnerable including the reproductive age group, especially women in the fertility age
10. To eliminate road traffic accidents due to drink driving

2.4 Guiding Principles

This Policy shall be guided by the following principles:

2.4.1 Needs assessment and Evidence-Based interventions:

The Policy shall address the specific needs of target groups based on sound scientific evidence;

2.4.2 Supply and Demand:

The Policy shall mainstream alcohol-related interventions based on the supply and demand chain;

2.4.3 Prevention and Protection:

This Policy prioritizes prevention and protection interventions in addition to treatment and rehabilitation;

2.4.4 Partnership & Cooperation:

The Policy recognizes that alcohol related interventions are multi-sectoral in nature and shall therefore, encourage a multi-faceted approach in the design, implementation, monitoring and evaluation of programmes;

2.4.5 Rights-Based:

The Policy shall promote and protect the rights of all persons including vulnerable groups from alcohol-related harm in accordance with the provisions of the constitution of Ghana

2.4.6 Governance

The Policy shall adopt an implementation framework suitable for all levels, from the community to national levels

2.5 Policy Priority Areas

Major policy issues which need to be addressed to meet the policy objective and outcome are: taxation, regulating availability; and regulating marketing of alcohol. Other areas of focus include; prevention and management of health effects and social services actions; surveillance, research, monitoring and evaluation; drink driving measures and capacity building.

Increased alcohol taxes have both immediate and long-term effects, by reducing alcohol consumption and therefore alcohol-related violence and trauma often due to single episodes of alcohol impairment, as well as alcohol related morbidity and mortality resulting from chronic heavy drinking[11]. Research evidence indicates that raising alcohol taxes is one of the most effective measures for reducing alcohol-related problems, particularly among young people[12].

Reducing availability and accessibility are other proven methods of reducing alcohol related harms. Reducing

[11] Babor et. al, 2003; Edwards et al., 1994; Chaloupka et al., 2002; Grossman & Markowitz, 1999

[12] Chaloupka, Saffer & Grossman, 1993, Holder, 1998

availability and accessibility includes interventions that reduce the density of alcohol retail outlets; eliminating the proximity of retail outlets to schools and other facilities and eliminating underage purchase and consumption.

Producers of alcoholic products employ convincing advertisement that tend to recruit new drinkers; enforce the habit in those who already drink whilst at the same time downplaying the harms and/or promoting benefits of taking alcohol. In this regard, regulating advertising has also proven effective in combating alcohol related issues.

Though the above mentioned best buy areas have proven effective, there is the need to seize other windows of opportunity in our local settings. These include:

1. Establishment of an independent body, the Ghana National Alcohol Commission (GNAC) to oversee the implementation of the relevant plans developed to achieve the strategies contained in this National Alcohol Policy; and to report, as required, to the President on progress in achieving the objectives of this National Alcohol Policy.

2. Use of cultural and traditional structures in facilitating the non-approval of alcohol abuse

3. Discouraging the harmful use of alcohol in Traditional Practices

4. Control disguised media adverts on alcohol especially the electronic media

5. Motivating and teaching children (10-14 year olds) and creating awareness in older persons (especially 15-19 year olds) on the dangers associated with alcohol

6. Campaigns and peer education not to succumb to social enticement to use alcohol, and insisting on a reduction in youth alcohol use

7. Mobilizing community groups and holding educational campaigns, and insisting on the safe and rational use of alcohol

8. Reporting on the harmful effects of alcohol and delinking alcohol use and sexual performance

9. Reporting from research institutions on consumption trends and its implications for personal, community and national productivity

2.5.1 Policy Area 1: Capacity building

Description of this priority area:

The implementation of this policy will require capacity building on a multi-sectoral level to enhance the capacity of the various stakeholders to ensure a comprehensive implementation of the policy strategy and action plans.

Challenges in this area:

Possible challenges to capacity building include;

a. Resource mobilization

b. Low capacity of stakeholders thus requiring more resources and time to develop the capacity of various stakeholders to an appreciable level; and

c. Harmonization of various legislation on alcohol

Policy Statement:

The government shall ensure that various stakeholders are equipped with the requisite knowledge and skills for the comprehensive implementation of this policy.

2.5.2 Policy Area 2: Education and Training on harmful use of alcohol

Description of this priority area:

The Policy recognizes that alcohol consumption patterns vary with respect to age, sex, culture, income level, type of alcohol. In order to make a positive impact on reducing alcohol related harms, education and sensitization programmes need to be structured according to differences in demographic characteristics. Thus, a multi-sectoral approach will be of immense value in designing such educational programmes.

Challenges in this area:

Since behaviour change communication on alcohol is not extensive, the capacity and availability of resource

persons is an anticipated challenge. Lack of local data on alcohol related topics is also a challenge.

Policy statement:

The government shall include alcohol related education in the curricula of all training institutions. Efforts should be made to use local structures to carry out alcohol education in the informal sector.

2.5.3 Policy Area 3: Commercial production, distribution and sales systems of alcohol products

Description of this priority area:

It is clear from available data that there are several legislations on the production, distribution, marketing and sale of alcoholic products. These legislations are not coordinated and enforcement has not always been easy. There is therefore the need to harmonize the scattered legislation into a comprehensive legal framework for easy enforcement. Of particular interest are legislation relating to legal purchase age and watershed for advertisement.

Challenges in this area:

Political commitment is key in addressing this area of the policy. Public support and the support of religious and traditional leaders are also anticipated challenges.

Policy Statement:

The government shall, review, integrate and enforce regulations on commercial production, distribution and

sales of alcohol products with particular emphasis on underage drinking and pre-natal exposure advertisement watersheds.

2.5.4 Policy Area 4: Marketing of alcohol products

Description of this priority area

Regulated marketing of alcoholic products has been identified as one of the best buy strategies in combating alcohol related harm. There is therefore the need to empower enforcement agencies from the national to the community levels in enforcing legislation pertaining to marketing alcoholic products especially where such marketing strategies seem to subtly target underage persons.

Challenges in this area:

Monitoring the various media houses for adherence to content and watersheds is an anticipated challenge.

Policy Statement:

The government shall ensure comprehensive regulation of marketing of alcohol products keeping in mind the ultimate responsibility to protect the vulnerable as well as the socioeconomic implications of alcohol misuse arising out of disguised marketing strategies.

2.5.5 Policy Area 5: Informally produced alcohol

Description of this priority area:

The local production of alcohol by cottage distillers is a substantial source of income to many communities. However, the potential for harm is immense when such products are not monitored for quality, percentage alcohol and raw materials. This policy therefore deems it important that local quality standards are developed.

Challenges in this area:

Challenges anticipated in this regard include:

1. Inadequate support from traditional and local structures
2. Strict enforcement of the regulations at the community level.
3. Developing alternative livelihood programmes; such as producing alcohol for industrial use as well as other means of income for local producers are also anticipated challenges.

Policy Statement:

The government shall regulate the production and sale of informally produced alcohol as stipulated in the Public Health Act (Act 851) and in collaboration with the local government structures such as the district assemblies with support from traditional authorities.

2.5.6 Policy Area 6: Drink-driving countermeasures

Description of this priority area:

The effects of alcohol related road traffic accidents cannot be overemphasized and thus the need for counter measures to address drink driving. Indeed this is one of the strategies that have been documented as effective.

Challenges in this area:

It is anticipated that inadequate financial, human and logistical resource to enforce such counter measures will be a challenge, especially in the rural setting.

Policy Statement:

The government shall ensure that alcohol related road traffic legislations are comprehensively enforced.

2.5.7 Policy Area 7: Health interventions

Description of this priority area:

Frontline health interventions for detoxification, dependence and rehabilitation are key components of any comprehensive alcohol policy. In this regard, there is the need to strengthen frontline healthcare institutions to offer such services so as to prevent avoidable morbidity and mortality arising out of alcohol related violence and injury. The Policy recognizes the need to strengthen healthcare providers in tackling harm at the individual-level among those at risk of or with alcohol-

use disorders and other conditions (e.g. NCDs) caused by harmful use of alcohol.

Challenges in this area:

Human resource and capacity in handling alcohol related morbidity and mortality are anticipated challenges.

Policy Statement:

The government in collaboration with other stakeholders shall ensure the provision of appropriately adapted interventions for the prevention and treatment of individuals and families at risk of, or affected by alcohol use disorders and any associated medical conditions.

2.5.8 Policy Area 8: Research, Monitoring & Evaluation

Description of this priority area:

Local, national and international data are needed in order to monitor the magnitude and trends of alcohol-related harms, evaluate interventions and provide requisite reliable data to strengthen advocacy and support for alcohol abuse related programmes. Information on local trends of harms caused by harmful alcohol use is not readily available. There is therefore the need to institute a comprehensive data collection system to gather data on both primary and secondary effects of alcohol abuse.

Challenges in this area:

Inadequate routine data on alcohol consumption, health and social impacts is a major challenge in this area. Additionally, there is no national governing body to monitor alcohol use and its effects as well as coordinate surveillance, research, monitoring and evaluation between the various agencies.

Policy Statement:

There is the need to promote evidence based interventions on alcohol-related social and public health harms. Government should set up a body (GNAC) to coordinate surveillance, research, monitoring and evaluation among the various agencies.

3. IMPLEMENTATION ARRANGEMENTS

The Policy recognizes the multi-sectoral dimensions of implementing a comprehensive alcohol policy. Such a policy requires broad consultation and collaboration among MDAs, the private sector, NGOs, Traditional Authorities among others. The Policy, therefore, calls for the institutionalization of alcohol programmes at all levels from the community to national level to ensure sustainable implementation of interventions as well as generate ownership and support at all levels.

3.1 Institutional Arrangements

3.1.1 Ghana National Alcohol Commission (GNAC)

The Government shall establish a Ghana National Alcohol Commission (GNAC) to oversee all aspects of the implementation of the policy. The GNAC shall report to the Office of the President of Ghana, and shall publish an annual report on progress. It shall draw its membership from Government Officials, representatives of the academic and Health Community, representatives of the Non-Government Sector and Civil Society, National Media Commission, Faith Based Organizations and representatives from the Alcoholic Beverage Industry. It shall monitor and where appropriate support the annual work plans for the relevant Government Ministries, Departments and Agencies (MDAs).

GNAC shall review this National Alcohol Policy every five years and may propose appropriate changes which will enhance the Government's ability to achieve the Vision of the Policy.

The Food and Drugs Authority (FDA) shall continue to enforce alcohol regulations in line with its mandate, pending the formation of the Ghana National Alcohol Commission (GNAC).

3.1.2 National Alcohol Taskforce (NAT)

1. There shall be a National Alcohol Taskforce (NAT) which shall be an arm of the Ghana National Alcohol Commission and responsible for providing technical direction and programme implementation.

2. There shall be a Secretariat for the NAT for the day-to-day operations.

3. There shall be sub-technical committees namely enforcement, prevention & treatment; policy & planning; communication & information systems within the NAT for operationalizing the Policy.

4. The NAT shall have a Director of Operations to ensure day-to-day activities.

Roles, Functions and Powers of GNAC (NAT)

The GNAC (NAT) shall:

1. Develop a comprehensive plan of action for implementing the Policy;

2. Coordinate alcohol-related programmes including the implementation of the plan of action in line with the policy;

3. Serve as a hub for local, regional and international cooperation on matters of alcohol programming;

4. Liaise with relevant authorities such as the MTTD; Pharmacy Council, FDA, CSRIPM; the Judiciary, Ghana Police Service, FDA, MLGRD/District Assemblies

5. Publish reports on the progress of interventions;

6. Collate Annual Reports from all the districts

3.1.3 Local Alcohol Taskforce (LAT)

1. There shall be Local Alcohol Taskforce (LAT) in all district which shall be responsible for community based actions on alcohol in partnership with stakeholders;

2. Local Alcohol Taskforce (LAT) shall coordinate with local authorities and partners, civil society

organizations during implementation of respective roles and responsibilities;

3. The Local Alcohol Taskforce (LAT) shall be under the District Assemblies and operate within the local Government set up.

3.2 Institutional Roles

The Policy recognizes the roles played by different MDAs, civil society organizations and international partners in the implementation of alcohol prevention and control programmes.

3.2.1 Lead Ministries

1. Ministry of Health
2. Ministry of Local Government and Rural Development
3. Ministry of Interior
4. Ministry of Finance
   Ministry of Gender, Children and Social Protection
5. Ministry Education
6. Ministry of Trade and Industry
7. Ministry of Youth and Sports
8. Ministry of Communications
9. Ministry of Transport

3.2.2 Private Sector and Non-Governmental Organizations

The Policy recognizes the roles of the private sector and NGOs through public-private partnerships as well as community based programmes that are aimed at the reduction of alcohol-related harms.

3.2.4 Statutory Institutions and Functions

1. Ghana Standards Authority
2. Food and Drugs Authority
3. Ghana Health Service
4. Mental Health Authority
5. Local Government Service
6. Local universities and research institutes shall conduct research and undertake capacity building on alcohol-related harm.

3.2.5 International Partnership

The Policy recognizes the role of global partners in strengthening national policies and interventions through technical, financial and other support

3.3 Implementation Plan

1. A National Alcohol Master Plan shall be developed to guide the implementation of this policy.

2. The GNAC shall disseminate the Alcohol Policy to stakeholders prior to the setting up of the National Alcohol Taskforce (NAT).

3. The GNAC shall mobilize resources for the implementation of alcohol intervention programmes.

4. There shall be a thorough review of all national policies to ensure complementarity and compatibility with this National Alcohol Policy. Likewise, a review of education and training curricula is necessary to ascertain the extent to which changes need to be made to give effect to this Policy. Finally, existing legislation regulating the trade and the alcohol industry must be reviewed. Eventually there should be a unified Alcohol Regulation Legislation to pool and coordinate various regulations on alcohol and give legal backing to this policy.

5. The GNAC shall develop and submit a proposed Alcohol Bill to Government for Cabinet consideration and onward submission to Parliament.

3.4 Resource Mobilization Arrangements

The Policy recognizes the need for mobilizing technical and financial resources for the implementation of policy

interventions and it shall collaborate with stakeholders (both local and international) in this regard.

1. The Policy identifies taxes, fines, sin-taxes and support from donors as potential sources of funding. However, this is not an exhaustive list. Other sources of funding may be sought.

3.5 Implementation Risks

The Policy anticipates the risk of limited political commitment, resistance and attempts by alcohol industry to influence interventions, reluctance of traditional authorities to support the policy and interventions (mainly because industry sponsors most traditional celebrations and other development projects) as well as inadequate funding to effectively deliver the proposed strategies.

4. MONITORING & EVALUATION

The implementation of the National Alcohol Policy requires effective monitoring and evaluation with appropriate feedback mechanisms amongst all stakeholders in order to ensure proper service delivery and capacity building.

In particular, the M & E frameworks shall prioritize *output, outcome and impact* indicators across alcohol consumption, consequences and response focus areas.
The MOH shall lead, coordinate, monitor, and ensure timely reporting and dissemination of alcohol-related performance and outcomes.

The Government shall follow-up with relevant actions upon the recommendations following the annual reports.

4.1 Review of Policy

The Policy may be reviewed after five years when the need arises.

NATIONAL ALCOHOL POLICY

GOVERNMENT OF GHANA

MINISTRY OF HEALTH