ISSN: 1118-8537

Journal of Health and Social Issues (JOHESI) Vol. 8 No. 1, March, 2019
Department of Sociology, Faculty of The Social Sciences
Ekiti State University, Ado-Ekiti (EKSU)

Lessening the Burden of Alcohol Misuse in Nigeria: Policy-Implementation Linkages and Dichotomy

Oluyinka Olutola Olajire,
Department of Behavioural Studies
Faculty of Social Sciences,
Redeemer's University, Ede, Osun State.

Abstract

In Nigeria, the spate of harmful use of alcoholic beverages, like in most countries in Sub-Saharan African region, is extensive and not much has been done to sufficiently address the issue in line with the dictates of Global relevant policy responses, strategies and action plans. In effect, the contributory role of alcohol misuse to the disease burden of infectious diseases such as sexually transmitted infections, Viral Hepatitis, HIV and tuberculosis in Nigeria is far from waning. This paper, utilizing secondary data, considers the levels and patterns of alcohol consumption in Nigeria and juxtaposes this with the existing policy levers made so far to reduce levels of alcohol misuse in the country. This was done in order to gauge whether the ongoing commitments of the governments has further improved the wellbeing of people and protect their health or not. The paper indicates that the absence of written National policy (adopted/revised) and National action plan in Nigeria deserves serious attention. It identifies the absence of National policy as a key component missing in the efforts of government towards achieving the reduction of alcohol-related harms. It concluded that Nigerian governments should consider strengthening national responses to public health issues caused by harmful alcohol use where necessary. It further recommends amendment of the existing alcohol strategies/interventions in Nigeria, and at the same time canvasses full adoption of global strategy on harmful use of alcohol that are based on evidence and best practices in order to protect at-risk populations and people affected by harmful drinking of others.

Keywords: *Alcohol, Alcohol misuse, Policy implementation, Linkages, Dichotomy, Nigeria*

A. Introduction

Alcohol consumption and its attendant effects on the broad spectrum of people is unarguably one of the most topical issues among discourses that border on substance use and abuse in the world. Simply put, harmful alcohol use is the consumption of alcohol beverages in a way that causes damage to human health physically or mentally. Alcohol misuse or harmful alcohol use is identified in the current body of research as a prominent and leading global health risk (WHO, 2014; 2018). Though, specifics differ from one country to another, harmful alcohol use which is often a corollary of heavy or excessive consumption of alcohol globally is linked with problems such as reduction in production, increased injuries, sexually transmitted diseases and aggravated violence (Bello, Moultrie, Somji, Chersich, Watts, 2017; Odukoya, Sekoni, Onajole, Upadhyay, 2013; Combes, Gerdtham, Jarl, 2011). In fact, past and recent research findings have linked alcohol consumption to 60 different acute and chronic diseases, which include gastrointestinal conditions, cardiovascular disease, cancers, immunological disorders, lung diseases, skeletal and muscular diseases, reproductive disorders and prenatal harm, mental and behavioural disorders (WHO, 2012; Ezzati, Hoorn, Lopez, 2006; Rehm, Room, Graham, Monteiro, Gmel, & Sempos, 2003; Rehm, Room, Monteiro,2003).

The practice of consuming alcohol is as old as humanity. Alcohol has become a vital part of human civilization from the Neolithic era and has since been prized and disparaged for reasons which have remained mostly unchanged over the years (MvGovern, 2010; OECD, 2015). From antiquity era till the turn of the 21st century, alcohol has been put to various uses by human beings in line with the prevailing culture, economics and social norms of different category of people in many parts of the world (Smart, 2007). For ages, humanity either as individuals or in groups has used alcoholic beverages to cater to various human needs, which include, among other things: recreational, religious, and social practices. More often, alcohol is used as a catalyst which acts on nervous systems to produce pleasurable sensations in many users (Cloninger, Sigvardsson & Bohman, 1988; Santrock, 2005; Awoyinfa, 2012).

Alcohol is socially accepted and enjoyed by many, especially when it is taken in moderation. In addition, it is equally an addictive substance with detrimental effects on its users, members of their family, and the general public as a whole. For a long time now, many countries in the world have experienced continuously rising-alcohol related problems caused by excessive or harmful consumption, particularly among young people and women (OECD, 2015). Excessive and detrimental alcoholic use has become one of the most daunting

social problems confronting the entire world, and has, therefore, become an essential area of research for academics and researchers (Freeman, 2011). As evident in the findings of study conducted by many individual researchers and other internationally recognised Organisations and bodies such as World Health Organisation (UNO), United Nations Office of Drugs and Crime (UNODC); the rising global alcohol consumption has remained a major global health challenge with a telling effect in the forms of burden of diseases and death on people from different walks of life (WHO, 2005; Rehm, Baliunas, and Borges 2010). This trend, however, has become more worrisome due to the harms such as traffic accidents and violence (which frequently affect other people apart from the drinkers), which are typically associated with excessive alcohol drinking.

Alcohol misuse is recognised to significantly impact on the lives of many people (Gmel & Rehm, 2003). The recently available statistics on alcoholic consumption puts it as the third world most significant risk factor for disease and disability. The above is in addition to the fact that it causes nearly 4 per cent of death worldwide (Rehm, Baliunas, and Borges 2010; WHO, 2011). The negative impact of alcohol consumption on the global burden of disease and injury by the 2009 comparative risk assessment conducted by the World Health Organisation (WHO) shows that only unsafe sex and childhood underweight status scored higher risk factors than alcohol consumption (WHO, 2009). Consistent with the previous systematic investigation, WHO's Global status report on alcohol and health in 2018 (this was developed based on the World Health Organisation's activities on global monitoring of alcohol consumption and alcohol-related harm and policy responses), provided overwhelming evidence that harmful use of alcohol is an essential leading risk factor for global population health. According to the report, harmful alcohol use has a direct way of wrongly influencing some of the health-related targets of the Sustainable Development Goals that include maternal and child health, non-communicable diseases, mental health, injuries and poisonings and many other infectious diseases (WHO, 2018).

The rising global alcohol consumption has been identified to be partly responsible for high morbidity and mortality in many parts of the world. This realisation, coupled with the fact that many countries were yet to put in place the relevant alcohol policies necessitated the call by World Health Assembly (WHA) in 2005 that member countries should adopt effective measures and strategies to tackle all forms of alcohol misuse and its associated problems (WHO, 2005). This call culminated in the 2010 agreement made by 193 delegates that attended the sixty-third WHA where it was agreed that policies necessary to ensure that harmful alcohol use and its attendant problems are tackled frontally or reduced to the barest minimum are formulated by member countries. To achieve the set goal, members countries signaled their commitment to take action in a range of ways, that include commitment of leaders (government) to policies made to curtail harmful alcohol use; controlling the marketing and availability of alcoholic beverages; and using legislation to achieve pricing policies which are targeted at reducing alcohol purchase (Chick, 2011; Poznyak, 2010).

Against the backdrop of WHA's resolution that member states should formulate relevant policies necessary to tackle harmful alcohol, this article, attempts to assess how Nigeria has fared in formulating and adopting such policies and guidelines to reduce harmful alcohol consumption in the country. This is necessary because Nigeria as one of the 193 delegates that adopted the resolution which c00ualls for tackling dangerous alcohol use and its associated health effects globally, still ranks high among the first thirty countries with the highest per capita consumption and alcohol-related problems in the world (Dumbili, 2013). In addition, harmful alcohol use and its accompanying problems in Nigeria remain mostly unstudied and therefore represent a considerable gap in knowledge. This article, however, attempts to add to frontiers of knowledge in this area.

B. Patterns and Levels of Alcohol Consumption in Nigeria

Alcohol, a substance that pleasures many of its users has for long been an integral part of the cultural, religious and social practices of people now known as Nigerians. Globally, the total amount of alcohol beverage/s consumed per time by individuals by mass, by mass per volume, or a combination of it determines whether drinking would cause harm or not. This in accordance with the work of Roerecke and Rehm (2014) is known as "pattern of drinking". The pattern of alcohol consumption in Nigeria is categorised into the following: moderate drinking, heavy drinking, hazardous, harmful, and binge, etc. Indeed, in

Nigeria, alcohol is known as an addictive substance which its misuse can cause various dose-related adverse harms, but which also causes feelings of relaxation and euphoria when it is moderately consumed. Indeed, moderate consumption of alcohol is not detrimental to human health. In this article, determining the meaning of the term "pattern of drinking" is essential because of the importance the phrase conveys in determining when the consumption of alcohol beverages is excessive and becomes a purveyor for severe injuries, intoxication and other alcohol-related disorders. In short, consumption pattern is a vital parameter in assessing the impact of alcohol consumption on peoples' health. For instance, binge drinking is harmful to human health because it increases the risk of alcohol dependence while constant heavy alcohol drinking among mothers has been identified to be a precursor for occurrence of a range of entirely preventable mental and physical birth defects known as Fetal Alcohol Spectrum Disorders (NIAAA, 2002; BMA, 2007).

For many decades in Nigeria, regular consumption of alcoholic beverages has become part of the culture of a significant number of people from different ethnic groupings, and this act is displayed regularly during festivals and celebrations (Gureje and Lasebikan, 2006; Umunna, 1967). Regular consumption of alcoholic beverages is witnessed in many social scenarios and across the different socio -economic groupings in the country. This form of alcohol consumption, however, is tolerated culturally in many parts of the country, especially in areas and localities where it is not forbidden by religion (Heap, 1998; Obot, 2000). Alcohol consumption is not gendered specific in Nigeria. Male and female folks participate in its use, and there seems to be no known law (written or unwritten) prohibiting both sexes, even the adolescents from drinking alcoholic beverages.

However, during the traditional era in many parts of Nigeria, consumption of alcoholic beverages (locally brewed) was, to some extent, age and gender-specific. Then, alcoholic beverages were mainly consumed by male adults, particularly during festive periods and other social engagements occasioned by people's traditions and culture (Heap, 1998; van Wolputte & Fumanti, 2010). Infrequently, however, women and youths in some communities and areas were allowed to participate in alcohol use, albeit under the watchful eyes of adults whose primary responsibility was to regulate and monitor the volume of alcoholic beverages that should be consumed by women and youths (Oshodin, 1995; Odejide, 2006).

In the 21st century Nigeria, there is now an upsurge in the rate at which alcoholic beverages are consumed by Nigerians particularly the youth who consume more alcoholic drinks on the guise of showing off their ability to drink and also as a form of contest among their peers (Obot, 2000). Literature is saturated with the claim that episodic consumption of alcoholic beverages among the users in the country has been on the rise. For instance, studies such as Room and Selling (2005) and Umoh, Obot, and Obot (2012) reported average per capita consumption for adults in Africa at 6.2 litres while the average per capita consumption for adults in Nigeria stands at 12.3 litres. In many parts of Nigeria, a significant number of young adults from all walks of life use and abuse alcohol. To this end, alcoholic beverages are the most abused psychoactive drugs by both young and older people in Nigeria (Gureje, Degenhardt, Olley, 2007; Makajuola, Aina, Onigbogi, 2014; Adekeye, Adeusi, Chenube, 2015). It is even more worrisome that students are not left out in this practice. In effect, a large body of research such as Bada and Adebiyi (2014) and Ekpenyong & Aakpege, (2014) have identified rising risky alcohol behaviour among University students as a serious public health issue in Nigeria.

According to the World Health Organisation's report in 2018 in Nigeria, there have been long-standing concerns about the rising level of alcohol consumption among Nigerians, especially from 1961 to 2016. Based on this report, Nigeria a low, middle-income country with an estimated population of over 186 million people and with 48% of her population living in urban areas has experienced a steady increase in the number of alcoholic beverages consumed by Nigerians from 1961 to 2016. Her recorded alcohol per capita among 15+ years old by consumption by type of alcohol beverages in litres in 2016 indicates that 1% used spirits, 8% consumed beer, 1% consumed wine, while 91% consumed other locally produced alcoholic beverages. Her recorded alcohol consumption per capita for 15+ was 10.3 in 2010 and 9.6 in 2016 while the volume of alcohol taken but not recorded for the same period stood at 1.2 and 3.8, respectively.

In 2016, 4.5.5% of her males and 12.0 of females 15+ years' experienced heavy episodic drinking because they were found to have consumed 60

grams of pure alcohol on at least one occasion within 30 days. The Nigerian's patterns of drinking score between 2010 and 2016 indicates that alcohol consumption in the country has gone from 'least risky' to 'risky' and her year of life lost score (YLL) in 2016 has moved to 5 (most) (WHO, 2018).

Closely related to the above, the 2018 WHO reports on alcohol consumption in Nigeria gave the health consequences of alcohol in terms of mortality and morbidity determined by Age-Standardized Death Rates (ASDR) and Alcohol-Attributable Fractions (AAF) for the year 2016 as thus: of the 116.1% males and 57.7% females that suffered Liver cirrhosis per 100,000 population (15+) based on ASDR, AAF caused 76.3% and 57.0% death in males and females respectively. In the same vein, of the 48.9% in males and 22.7% in females, Age-Standardized Death Rate occasioned by road traffic accidents per 100,000 population (15+) in 2016, 41.5% and 32.1% in males and females respectively are attributed to AAF.

C. Trends in Alcohol Consumption among Young-adults in Nigeria

There are grave concerns about health and other societal harms attributed to harmful alcohol use and drinking patterns of many Nigerians. Even though Nigeria was one of the 193 delegates to the Sixty-Third WHA that unanimously agreed to reduce harmful alcohol use among their population in the resolution subsequently adopted, a significant number of Nigerians continue to engage in hazardous alcohol use (Chick, 2011; Poznyak, 2010). Prominent factors responsible for changing pattern of alcohol consumption in Nigeria particularly among the young people are the wind of socio-political and economic changes ravaging the country, and the fact that use of alcoholic beverages among adolescents and women is no longer strictly restricted by custom and tradition (Demehin, 1984).

Alcohol is one of the most commonly used substances among the broad spectrum of Nigerian students. In the study conducted by Adelekan, Abiodun, Obayan, Oni and Ogunremi (1992), alcohol was the second most commonly used substance with a lifetime prevalence of 77%, while Cigarettes recorded 37.4%. In a related study conducted on alcoholic consumption among Medical students in a Nigerian university by Makanjuola, Daramola and Obembe in 2007, consumption of alcoholic beverages (13.6%) was ranked higher than sedatives (7.3%) and tobacco (3.2%). However, one common denominator among most studies conducted on the intake of alcoholic beverages among Nigerian students is that excessive alcohol consumption serves as a gateway to other illicit drugs and has remained a source of worry for parents, family members, schools and the government (Chikere and Mayowa, 2011; Klein, 2001). In relation to the above, findings of research of several scholars and researchers in Nigeria have attributed common factors responsible for high consumption of alcoholic beverages among students to issues such as young people's choice of using alcohol as a catalyst for becoming bold, confident, and staying alert at all times. Others see it as a means to facilitate socialization and reduce stress, while some others see it as a mark of maturity, and a readily available tool needed to avoid boredom (Abikoye and Osinowo, 2011). In the words of Adeoye, Adeoye, Ngozi et al. (2014), peer influence, family background and emotional statuses of students are some of the factors that predict alcohol usage of students.

For Chikere and Mayowa (2011), students in Nigeria consume alcoholic beverages due to factors such as parental drinking, enhancement of sexual pleasure, their desire to feel high, relaxation and stress reduction, and sense of belonging amid the popular group. Several other influencing factors of alcohol use among students and young people in Nigeria have also been identified in the literature. Chief among these predictors is the proliferation of breweries in Nigeria kick-started by the oil boom of the 1970s (Hathaway, 1997). Other factors are effects of globalisation (Ikusesan, 1994), aggressive marketing and advertising of alcoholic beverages by the media, and absence of workable policies regulating alcohol use in the country (Odejide et al., 1989; Jernigan and Obot, 2006; Obot, 2007; and Dumbilli, 2013).

Consequent upon the above, several studies have linked alcohol consumption and use among students with differing health and social outcomes. Abikoye and Osinowo (2011) highlighted alcoholic-related problems such as violence, injury and various forms of accident as common among students that consume alcoholic beverages, while Olley (2008) and Chikere and Mayowa (2011) attributed risky sexual behaviour, drunk driving, general weakness of the body, drowsy feeling, hangover, as part of the harmful effects or social harms relating to the misuse of alcohol by students.

Another dimension that the use of alcoholic beverages has recently assumed among students in Nigeria is that of gender relation. More than before, females influenced by feminism and globalisation have challenged the part of the custom and tradition which restricted their use of alcohol. Females, particularly students, partake heavily in the consumption of alcoholic beverages hence the revelation of severe drinking problems among this group (Adelekan et al., 1993; Room and Sellin, 2005). Closely related to the above is the report that some female students in Nigeria like their counterparts in South Africa now exchange sex for alcohol (Olley and Ajiteru, 2001). This development is more pronounced in South Africa, where alcohol is seen as currencies for sex among female students (Townsend et al., 2011).

There is a very high degree of agreement among scholars as to the claim that more male than female students engaged in alcohol consumption and that religiosity has dramatically influenced the use of alcohol among students. In line with the studies conducted by Adelekan, Abiodun, ImouokhomeObayan, Oni, & Ogunremi (1993), Makanjuola et al (2007) and Chikere and Mayowa (2011), students who were categorized in their studies as "very religious" were less likely to use alcohol than the others designated as "mere" religious.

D. Existing Policy Approaches in Tackling Alcohol-related Harms in Nigeria

Globally, the recent approval of the Framework Convention on Tobacco Control has made alcohol the only psychoactive and addictive substance not controlled internationally by the legally-binding regulatory framework in spite of its substantial harmful effects on the world population (WHO, 2018). No doubt, harmful alcohol use is recognised globally as one of the leading preventable human act causing significant physical and social harms in the world (Babor, 2010; WHO, 2010). This apparent problem has become more worrisome due to the fact that the ever-rising contributory role of unhealthy alcohol use to the disease burden of many infectious diseases such as HIV, sexually transmitted infections, tuberculosis, etc. is yet to be adequately recognised and addressed in the relevant global strategies and action plans. This glaring lacuna has in part actuated the World Health Assembly's call in 2005 for the control of the rising alcohol-related harms in all the parts of the world.

In relation to the above, the longstanding concerns about harmful alcohol use and its associated health and societal harms on the people; and the fact that legislation has helped substantially in addressing public health issues around the globe have all resulted to the enunciation of various cross-cutting steps and strategies targeted at tackling alcohol-related risks by policymakers in different parts of the world (Babor, 2010; WHO, 2010; Evans, 2017). The underlying assumption of all the global strategies, national policies and action plans aimed at tackling harmful alcohol use is that such provisos can only be effective when they are multilevel and multi-component pronged, focusing on multiple determinants of drinking and alcohol-related harms in the forms of availability, price, marketing and drink-driving. In addition, findings from related studies have equally shown that what determines whether such strategies would be useful or not depends how well these strategies and procedures are implemented, enforced and evaluated (Jones-Webb et al., 2014).

Based on the foregoing, the ultimate and the overarching goal of alcohol policy is to reduce alcohol-related harms advertently. To realise this goal, many countries of the world have developed strategies and approaches to addressing harmful drinking behaviour among their people. Most notably in Africa, a continent where harmful alcohol use has left its destructive imprints on people the most, countries such as South Africa, Lesotho, Uganda, Kenya, Botswana, just to mention a few have enacted relevant national policies to stem alcohol harms (Obot 2012; Pitso and Obot, 2011; Parry, 2010; Bakke and Endal, 2010). These countries and some others within the continent have introduced policies that range from an outright restriction on adverts and sales of alcohol to increasing prices of alcohol beverages to help in the control of units of alcoholic drinks made available to their citizens.

Specifically, in 2016, eighty countries in the world have enacted their national written alcohol policies, while another eight have completed their subnational policies and eleven others have outrightly banned the consumption of alcohol within their territories (WHO, 2018). In sharp contrast to the claim above, evidence already cited demonstrates the lacklustre reaction of most African countries to the issue of formulating their national written alcohol policies and action plan. For instance, Nigeria, despite her longstanding membership in WHO and the fact that the country

was part of the 193 delegates that adopted the 2010 resolution to reduce harmful alcohol use through legislation, evidence suggests that the country is yet to formulate any written national policy or action plan/s to reduce harmful alcohol use within her domain (WHO, 2004; 2014).

Even though some governments in Africa have played a prominent role in legislating and enforcing interventions necessary to restrict or eliminate harmful alcohol use; alcohol-related events in Nigeria are a pointer to the fact that the government has shunned any concerted effort to ensure that relevant alcohol policies and action plans are formulated and implemented in the country. Even in the face of rising alcohol-attributable diseases and the accompanying social harm they add to the social burden of injuries and death in Nigeria, there remains serious commitment on the part of the government to address the increasing harmful alcohol use in the country through relevant legislation (WHO, 2004; 2014).

The apathy of the Nigerian government to legislating against alcohol use is not a new event; it has been on for decades. Anumonye et al. (1977:27) unequivocally described this as thus:

> *So far, alcohol has not received the attention it deserves in Nigeria. It is increasingly abused. This abuse will become a severe problem within the next few years since: the prohibition on the formally illicit locally brewed gin has been lifted… beer breweries proliferated apparently for political purposes…. Local distilling of gin has recently received government blessing; bottling of imported spirits is very common now; the indigenous palm wine is gradually disappearing from the cities where more potent alcohol is being used.*

Though, findings from research have shown that no Nigerian government has ever used legislation as an essential component of the country's broader strategy to reduce alcohol-harm (Oluwaniyi, 2010), it should not be assumed that various successive Nigerian governments over the years have remained totally clueless and inactive as far as enacting strategies to reduce alcohol-related harm in the country is concerned.

More often, successive Nigerian governments had embraced guiding principles and features which include over-reliance on popular but ineffective policies and liberalisation of the major drivers of alcohol consumption in the forms of availability and price of alcoholic products. Consequently, the rate of alcohol consumption among Nigerians has significantly surged while the dearth of corresponding policy to control this unsavoury development has remained untroubled (Chikere and Mayowa, 2011). The stance above has generated concerns about health and societal harms caused by the harmful use of alcohol. According to Aworemi et al. (2010), many lives have been lost due to auto-accidents linked to harmful alcohol use among drivers. Similarly, Torayan (2009) gave an account of how alcohol misuse has been identified among drivers as the cause of rising cases of automobile accidents in Nigeria. According to him, harmful alcohol consumption caused cases of auto-accident to increase from 4,679 recorded in 2006 to 8,477 cases that comprised 17,794 injuries and 4673 deaths.

Studies in the area of alcohol use have identified numerous factors that reinforce the culture of excessive consumption of alcohol and alcohol-related harm in Nigeria. Notable ones are the supply and promotion of alcohol to people and absence of written national policy or action plan (either adopted or revised); lack of legally binding regulations on alcohol sponsorship, sales and promotion; absence of legally required health warning labels on alcohol advertisement; absence of national monitoring system/s; although the legal age limit for on-premise and off-premise alcohol purchase in Nigeria is 18 years there are no restrictions for on/off-premise sales of alcoholic beverages. Others are lack of restrictions to sell alcohol to intoxicated persons and in petrol stations; no restriction or policies on alcohol advertising and opening hours for on-trade outlets such as bars; no legally required health warning labels on alcohol advertisements/containers; there is 0.05% national maximum legal blood alcohol concentration (BAC) when driving a vehicle (general/young/professional), but this is not tightly enforced (WHO, 2014; 2018).

E. Harmful Alcohol Use in Nigeria: Policy-Implementation Linkages and Dichotomy

Globally, harmful alcohol consumption is a recognised leading preventable risk factor for physical and social harms. Therefore, relevant policies, laws, and regulations to counteract myriad of alcohol-related harms have been formulated at global, regional, international, national and

subnational levels (Babor, 2010; WHO, 2010). For instance, in many of the advanced and developed economies of the world such as the United States of America, Germany, Sweden and host of others, efforts aimed at reducing the harmful use of alcohol by 10 per cent by 2025 has been made priority and given premium. As much as possible, governments in the aforementioned countries have sharpened their existing approaches, making them more useful to curb harmful alcohol use. In addition, they have adopted a broad range of policy approaches that include information and education policies, traffic enforcement measures, health interventions, and many other innovative policy approaches to curb alcohol-related harms.

To achieve this set goal, some of these countries have embarked on the development and enforcement of comprehensive alcohol policy which is in tandem with the World Health Organisation's Global Strategy to reduce the harmful use of alcohol. This global strategy was developed and agreed on by States that are members of WHO in the year 2010. This strategy underscores the consensus and acceptance of WHO member countries that harmful use of alcohol and its concomitant health and social implications is a public health concern. The core importance of the strategy is to provide procedures and guiding principles for action for all member states to support and complement activities at country level. Specifically, the approach offers ten recommended target areas as critical markers for policy option and interventions necessary to enable member countries to formulate national action essential for the reduction of harmful use of alcohol (WHO, 2018).

The key target areas, as indicated in the WHO's Global Strategy for reduction of harmful alcohol use, are grouped into ten recommended areas, which are as follows: i. Leadership, awareness and commitment Area; ii. Health services' response Area; iii. Community action Area; iv. Drink-driving policies and countermeasures Area, v. Availability of alcohol Area, vi. Marketing of alcoholic beverages Area, vii. Pricing policies Area, viii. Reducing the negative consequences of drinking and alcohol intoxication Area, ix. Reducing the public health impact of illicit alcohol and informally produced alcohol Area, x. Monitoring and surveillance. The Global strategy for policy options and interventions for WHO member States as indicated above has consequently resulted in a new set of recommended actions that include increasing taxes on alcohol beverages, enacting and enforcing bans or all-inclusive restrictions on exposure to alcohol advertising in all media outlets, placing limits on the physical availability of retailed alcohol and many others. As a whole, WHO recommended that the recommended target areas should be seen as supportive and complementary to each other.

Consequent upon the above, attempts at gauging the policy-implementation linkages and dichotomy of harmful alcohol use in Nigeria in this article were done by appraising the country's policy options and interventions alongside the Global Strategy agreed on by members of World Health Organisation in 2010 or what is fondly referred to as the most cost-effective actions or 'best buys'.

The situational analysis of policies and interventions guiding the consumption of alcohol beverage in Nigeria as recorded by WHO in 2018 indicates that the country has recorded little or no success in leadership, awareness and commitment Area. Demonstrating leadership and generating appropriate awareness and commitment. In line with this key target area, WHO Member States are mandated to create awareness regarding the burden of alcohol use in their countries in order to significantly and continuously reduce alcohol-related harms (WHO, 2010). To achieve these demands, Member States are required to document interventions made to reduce alcohol-related harm in their enclave. Besides, Member States are expected to provide their adequately-funded national policies, which noticeably indicate their clear objectives, strategies, and goals to reduce the harms from alcohol consumption (WHO, 2010).

The above requirement is anchored on the stance of WHO, that, written national alcohol policy is a vital indicator of a country's willingness and commitment to reducing alcohol-related harm. In the light of this, evidence from Nigeria as evinced in the WHO (2018) documents indicate that there is virtually no political commitment from the governments at various levels towards Nationwide awareness-raising activities about the many ills associated with harmful alcohol use. The same WHO document highlights a lack of commitment and willingness of relevant leaders from civil society organisations, community organisations, cultural and religious leaders, and economic operators to use their positions to provide the necessary support needed to reduce the harmful use of alcohol in the country effectively. In line with the report from The Global Survey on Alcohol and

Health 2016, Nigeria is yet to formulate any written national alcohol policy (adopted or revised) or National action plan (WHO, 2018).

Health services' response is another essential Global Strategy for the reduction of harmful alcohol use. The understanding of this strategy is rooted in the belief that alcohol policies can be useful when it adopts multi-levels and multi-components approaches (Babor, 2010). The health sector is expected to play a role in delivering individual-level and group interventions to people that are at risk of or affected by harmful alcohol use (WHO, 2010). Unfortunately, there exists no policies or policy document mandating the health sector in Nigeria to raise awareness about alcohol-related harms. More worrisome is the fact that there is no Legally required health and safety warning labels on alcohol advertisements and containers in the country. Indeed, Nigeria is yet to formulate any policy to institutionalize the WHO's recommendation, which solicits governments and other stakeholders support to empower communities in taking necessary action to reduce harmful alcohol use and its concomitant problems.

In sharp contrast to the non-policy formulation stance of Nigeria in most of the vital target areas indicated in the WHO's Global Strategy for reduction of harmful alcohol use, policies in the form of drink-driving countermeasures are in existence in the country (WHO, 2018). In fact, the country has a drink-driving prevention legislation that is based on blood alcohol concentration (BAC). As a matter of fact, the National maximum legal blood alcohol concentration (BAC) when driving a vehicle (general/young/professional) in term of percentage is 0.08.

Another vital target area is addressing the marketing of alcohol beverages. But, despite the fact that restricting physical access to alcohol is one of the best buys or effective countermeasures to prevent harmful alcohol use in many parts of the world, Nigeria has fared badly in implementing this as a panacea to preventing or regulating harmful use of alcohol (WHO, 2018). Evidence abound in the literature that strict regulation on the hours, days that alcohol beverages can be bought and sold, the density of alcohol outlets, and the enforcement of the national legal age at which alcohol can be bought and consumed is one of the most influential methods for controlling alcohol consumption and misuse (Campbell et al., 2009; Popova et al., 2009; Sherk et al., 2018). Contrary to the position above, recent evaluation of alcohol policies in Nigeria shows that policy options restricting physical access to alcohol in the forms of National legal minimum age for off-premise sales of alcoholic beverages (beer, wine, spirits) and National legal minimum age for on-premise sales of alcoholic beverages (beer, wine, spirits) are yet to be put in place. Similarly, Nigeria has no known legislation to restrict on/off-premise sales of alcoholic beverages (beer, wine, spirits) at any hour, days, and density. In addition, there are no regulations restricting availability of alcohol in specific events, to intoxicated persons, and even in petrol/filling stations.

Another important Global Strategy and policy option for the reduction of harmful alcohol use is marketing restrictions. In many countries of the world, alcohol is marketed with vigor through various traditional and modern advertising and promotion means and techniques. More often, alcoholic beverages are linked to sports and other cultural events through sponsorships and products placements via new media such as podcasting, sms and e-mails. Studies have shown that majority of young people that are exposed to alcohol marketing have high tendency to start drinking, while the ones that are already drinking will drink more when exposed to alcohol marketing (Jernigan et al., 2016). In essence, exposing young people to alcohol marketing is seen as a contributory factor to normalizing drinking among this group in some contexts and cultures. To this end, legislation to regulate the content and volume of marketing, sponsorships, promotions and other related activities targeting young people are seen as one of the three best buys (WHO, 2010; 2011). In Nigeria, while the legally binding regulations on alcohol sponsorship is in place, there is no legally binding regulations on sales promotion of alcoholic beverages.

Facilitating the use of price mechanism as a means to reduce harmful use of alcoholic beverages is another Global Strategy recommendation. As evidence has shown in many parts of the world, increasing the price of alcoholic beverages has been shown to be a significant factor influencing alcohol use and misuse (WHO, 2010). Numerous studies have repeatedly shown that upward review of prices of alcoholic beverages is associated with reduction in alcohol-related morbidity and mortality (Wagenaar, Salois & Komro, 2009, Elder et al., 2010; Wagenaar, Salois & Komro, 2010; Xu & Chaloupka, 2011). As part of the recommendation

of the Global Strategy, all WHO Member States are encouraged to put in place domestic taxation that would ensure the reduction in consumption of alcoholic beverages by many people. At the same time, the strategy encourages countries to review prices regularly in line with inflation and income in order to restrict sales of alcoholic beverages below cost prices (WHO, 2010). But while Nigeria has successfully controlled and regulated price and availability of alcoholic beverages by placing excise tax on beer, wine and spirits much has not been done to ensure that alcoholic beverages are not sold below cost prices.

Another area in which the Nigerian government has performed creditably well is the implementation of the Global Strategy known as community action (WHO, 2018). For this target area, governments at all levels in WHO Member States are mandated to put machinery in motion to publicize alcohol-related harm at community level. The rationale behind this is to ensure that community institutions, and other non-governmental organisations go into partnerships to reduce the acceptability of public drunkenness, encourage quitting or reduction of use, and also provide care and support for individuals suffering from alcohol misuse and their family members.

Relatedly, another target area upon which reducing alcohol-related harm across WHO Member States is impinged as outlined in the Global Strategy is monitoring and surveillance activities. This target area requires appropriate implementation and evaluation of alcohol policies and interventions by Member States (WHO, 2010). To ensure that this target area is fully adhered to, Members States are mandated to engage in regular surveillance, information and research activities so that they can have at their disposal accurate information necessary for evidence-based policy-making. Indeed, Member States are directed to be involved in a regular systematic collection, collation and analysis of data and timely dissemination of ensuing recommendations to policy-makers and other relevant stakeholders so that the right and necessary action can be taken. Quite unfortunately, no Nigerian government has put in place any National monitoring systems or other initiatives necessary to provide the needed information to track alcohol consumption trends and at the same time evaluate alcohol policies and interventions in the country.

Conclusion

The costs (socially, economically, criminal justice service and reduction in productivity) attributed to alcohol-related harm in Nigeria are enormous and growing. To this end, the timely control of alcohol misuse and the concomitant alcohol-related harms in Nigeria is long overdue. To achieve this, the enactment and implementation of national strategies and policy options towards the reduction of aggregate alcohol consumption in the country cannot be overemphasized. Without a doubt, substantial body of evidence indicates that Nigeria is yet to formulate any written National policy or National action plan (WHO, 2018). So far, the current alcohol control strategies of the government are far from being effective and have also attracted a barrage of criticism due to the fact that they are not in consonance with the much touted evidence-based harm reduction policies globally. As evidently displayed in Russia, a country that had one of the riskiest patterns of consumption of alcoholic beverages which later employed a succession of evidence-based national alcohol policies; reducing the burden of alcohol misuse in Nigeria calls for a strong leadership and unalloyed implementation of alcohol control policies tailored largely towards reduction in overall consumption of alcoholic beverages.

In spite of the enormity of the body of proof that highlights harmful use of alcohol beverages as a prominent leading risk factor for human health globally, and the accompanying call by the WHO that all Members States should adopt the Global Strategy Policy Options and provide relevant infrastructure to successfully address alcohol-related harms within their domain; emphasis to reduce harmful use of alcohol in Nigeria is predominantly placed on using excise tax to the neglect of other policies and measures that have been proved effective in many countries of the world. Indeed, the strategy to reduce alcohol-related harm in Nigeria has seen an overreliance on popular (excise) but not too effective policies. This, however, signifies a glaring lacuna and deficiency on the part of the government.

Though, various successive governments in Nigeria have made some efforts to reduce harmful use of alcoholic beverages in the country, yet, the level of alcohol-related harms has remained a worrying concern. Indeed, one of the key components missing from the governmental efforts at reducing alcohol-related harm so far is the lack of political

will to fix the minimum price for alcoholic beverages through legislative instrument/s - a step which would have gone a long way in addressing the low price of alcohol and at the same time assist in helping to protect the health and wellbeing of individuals who engage in harmful and hazardous drinking by taking cheap high-strength alcoholic beverages.

More worrisome, however, is the fact, that Nigeria is yet to develop a comprehensive policy on alcohol. Indeed, the country is yet to identify and make effective, evidence-based policies necessary for the reduction of the burden of alcohol misuse. Indeed, the availability of a written national policy (adopted or revised) or national action plan is a key indicator of the commitment of countries to reducing alcohol-related harms. It is of utmost importance that the central government formulate a national strategy and appropriate legal frameworks to reduce the use of alcohol at all levels and at the same time implement alcohol control policies that are evidence -based and have been proven to reduce harmful alcohol use in other societies.

Also, it is essential that various governments in Nigeria be involved in awareness-raising activities regarding alcohol-related harms. At this stage, the government should enact policies that empower Non-governmental organisations and support them to develop and deliver coordinated and localized preventive measures for harmful alcohol use. In addition, alcohol industries should equally be involved in raising awareness about alcohol-related harms. There is also the need for the government work hand-in-hand with the primary and secondary healthcare system by providing adequately funded and resourced programme that would ensure prevention programmes, early detection, intervention and treatment/management of alcohol misuse.

Restricting physical access to alcohol by regulating the physical availability of alcoholic beverages in Nigeria by laws, policies and programmes are all essential in reducing public use of alcohol beverages. The fact that informal markets and illicit production of locally brewed alcoholic drinks are some of the primary sources of alcohol necessitates that these sources should be tightly regulated. Regulations should be made in the following areas: number and location of "on-premise" and "off-premise" alcohol centres; the days and hours for selling alcohol; retailing modes; sales in specific areas; establishment of minimum age for buying and consumption of alcohol; sales to intoxicated persons; regulating availability of illicit production of alcoholic beverages.

Another essential consideration through which harmful use of alcohol can be effectively reduced in Nigeria is by reducing the impact of alcoholic beverages' marketing, particularly on the youth. The fact that it is impossible to target adult consumers of alcohol with such rigorous marketing and promotion techniques without exposing the teeming adolescents who are under the legal age to the same marketing strategy has shown that there is the urgent need for the government at all levels to formulate precautionary approach that will ensure that young people are protected against the increasingly sophisticated advertising and promotion techniques adopted by alcohol industries. As an accompaniment to the above, the government must stop providing subsidies for all producers of alcoholic beverages, and outlaw direct and indirect price promotions, discount sales and sales below the cost price of alcoholic beverages. There should be the establishment of minimum prices for alcoholic beverages where applicable, while incentives should be given to non-alcoholic drinks.

Conclusively, the lack of commitment on the part of the central government to implement national strategies and policy options to tackle alcohol misuse in Nigeria can be held, among other factors, as issue responsible for the abysmal alcohol misuse among all and sundry in the country. Any environment in which such policies are lacking tends to encourage harmful use of alcoholic beverages.

References

Adekeye OA, Adeusi SO, Chenube OO, et al. (2015). Assessment of alcohol and substance use among undergraduates in selected private universities in Southwest Nigeria. IOSR-JHSS; 20:1–7.

Adelekan, M. L. et al. (1993). Psychosocial correlates of alcohol, tobacco and cannabis use: Findings from a Nigerian university. Drug and Alcohol Dependence, 33, 247-256

Adeoye, B.K, Adeoye, Ayodele, O., Ngozi, E. O. & Ani, F. (2014). Alcohol Use among Undergraduate Students in a Selected Private University in Nigeria: Prevalence and Associated Factors. International Journal of Health Sciences September 2014, Vol. 2, No. 3, pp. 71-80

Abikoye, G. E., & Osinowo, H. O. (2011). In the eye of the beholder: Alcohol use and perceptions among student patrons of 'Joints' in three Nigerian

university communities. Psychological Studies, 56(3), 258-265.

Adelekan, M. L., Abiodun, O. A., Obayan, A. O., Oni, G. and Ogunremi, O. O. (1992). Prevalence and pattern of substance use among undergraduates in a Nigerian University. Drug and Alcohol Dependence, 29(3):255 -61.

Awoyinfa, J. O. (2012). An Investigation into the Incidence of Alcohol Usage and Abuse among Female Student of the University of Lagos, Nigeria, West Africa. Journal of Emerging Trends in Educational Research and Policy Studies (JETERAPS) 3(2):174-178.

Babor TF (2010). Alcohol: no ordinary commodity – research and public policy. New York (NY): Oxford University Press.

Bada FO, Adebiyi DR. Alcohol consumption behaviour among high school students in Nigeria. J Educ Soc Res 2014; 3:507–10.

Bakke Ø and Endal D (2010) Vested interests in addiction research and policy alcohol policies out of context: Drinks industry supplanting government role in alcohol policies in sub-Saharan Africa. *Addiction* 105(1): 22-28.

Bello B, Moultrie H, Somji A, Chersich MF, Watts C. Alcohol use and sexual risk behaviour among men and women in inner-city Johannesburg, South Africa. BMC Public Health. 2017; 17(3):548.

British Medical Association (2007) *Fetal alcohol spectrum disorders – a guide for healthcare professionals*. London: British Medical Association.

Brook M, Walfish S, Stenmark D, Canger J. (1981). Personality variables in alcohol abuse in college students. J Drug Educ.11:185-9.

Chick J (2011) The WHO global strategy to reduce the harmful use of alcohol. *Alcohol and Alcoholism* 46(3): 223-223.

Chikere, E. I. C., & Mayowa, M. O. (2011). Prevalence and perceived health effect of alcohol use among male undergraduate students in Owerri, south-east Nigeria: A descriptive cross-sectional study. BMC Public Health, 11(1), 118.

Cloninger, C. R., Sigvardsson, S. and Bohman, M. (1988). Childhood personality predicts alcohol abuse in young adults. Alcoholism: Clinical and Experimental Research, 12: 494-505.

Combes JB, Gerdtham UG, Jarl J. Equalisation of alcohol participation among socioeconomic groups over time: an analysis based on the total differential approach and longitudinal data from Sweden. Int. J. of Equity Health. 2011;10(1):10.

Demehin, A. (1984). Drug abuse and its social impacts in Nigeria. Public Health, 98, 109- 116.

Dumbili, E. (2013). Changing patterns of alcohol consumption in Nigeria: An exploration of responsible factors and consequences. *Medical Sociology Online,7*(1), 20-33.

Ekpenyong, N. S. and Aakpege, N. Y. (2014). Alcohol Consumption Pattern and Risky Behaviour: A Study of the University of Port Harcourt. IOSR Journal of Humanities and Social Science (IOSR-JHSS), 19(3, 1): 25-32.

Elder RW, Lawrence B, Ferguson A, Naimi TS, Brewer RD, Chattopadhyay et al. (2010). The effectiveness of tax policy interventions for reducing excessive alcohol consumption and related harms. Am J Prev Med. 38(2):217–29.

Ezzati M, Hoorn SV, Lopez AD, et al. (2006). Comparative quantification of mortality and burden of disease attributable to selected risk factors. In: Lopez AD, Mathers CD, Ezzati M, Jamison DT, Murray CJ, eds. Global burden of disease and risk factors. Washington (DC): World Bank.

Evans, R. (2017). Explanatory Memorandum incorporating the Regulatory Impact Assessment and Explanatory Notes. A Document Prepared for the Welsh Department for Health and Social Services.

Freeman, D.G., (2011). "BG T B: U. –Level Analysis of E C C U " Journal of Wine Economics, 6(2), 231-251. *(PDF) Alcohol Consumption and Political Ideology: What's Party Got to Do with It?*. Available from: https://www.researchgate.net/publication/257730573_Alcohol_Consumption_and_Political_Ideology_What%27s_Party_Got_to_Do_with_It [accessed Nov 20 2018].

Gmel G & Rehm J (2003) Harmful alcohol use. Alcohol Research and Health 27: 52-62.

Gureje O, Degenhardt L, Olley B, et al. (2007). Descriptive epidemiology of substance use and substance use disorders in Nigeria during the early 21st century. Drug Alcohol Depend; 91:1–9.

Heap, S. (1998). "We think prohibition is a farce": Drinking in the alcohol-prohibited zone of colonial northern Nigeria. The International Journal of African Historical Studies, 31, 23-51.

Jernigan, D. H., & Obot, I. S. (2006). Thirsting for the African market. *African Journal of Drug and Alcohol Studies,5*(1), 57-70.

Jones-Webb R, Nelson T, McKee P, Toomey T (2014). An implementation model to increase the effectiveness of alcohol control policies. Am J Health Promot. 28(5):328– 35.

Klein, A. (2001). "Have a piss, drink ogogoro, smoke Igbo, but don't take gbana"-hard and soft drugs in Nigeria: A critical comparison of official policies and the view on the street. *Journal of Psychoactive Drugs, 33* (2), 111-119.

Makanjuola, A. B., Daramola, T. O. and Obembe, A. O. (2007). Psychoactive substance use among medical students in a Nigerian university. World Psychiatry, 6(2): 112–114.

Makajuola AB, Aina OF, Onigbogi L. (2014). Alcohol and other psychoactive substance use among Tanker drivers in Lagos, Nigeria. Eur Sci J; 10:545–59

McGovern, P.E. (2010), "Uncorking the Past: The Quest

for Wine, Beer, and Other Alcoholic Beverages", University of California Press, Oakland, United States.

National Institute on Alcohol Abuse and Alcoholism (2002) *Alcohol consumption and problems in the general population: findings from the 1992 National Longitudinal Alcohol Epidemiologic Survey*. Bethesda, MD: National Institute on Alcohol Abuse and Alcoholism.

Obot, I. S. (2000). The measurement of drinking patterns and alcohol problems in Nigeria. Journal of Substance Abuse, 12, 169-181.

Obot, I. S. (2007). Nigeria: Alcohol and society today. *Addiction, 102*(4), 519-522.

Obot IS (2012) Developing countries ignore drinking and driving problems at their own peril. *Addiction 107*(7): 1209-1210.

O' Conell D, Patterson H.A. (1989). Survey of current college alcohol abuse programs, attitudes and training needs. J Alcohol Drug Educ. 43 (2):61-9.

Odejide, A. O., Ohaeri, J. U., & Ikuesan, B. (1989). Alcohol use among Nigerian youths: The need for drug education and alcohol policy. *Drug and Alcohol Dependence, 23*(3), 231-235.

Odejide, A. (2006). Status of drug use/abuse in Africa: A review. International Journal of Mental Health and Addiction, 4, 87-102

OECD (2015). Tackling Harmful Alcohol Use: Economics and Public Health Policy, OECD Publishing. http//dx.doi.org/10.1787/9789264181069-en

Odukoya O, Sekoni A, Onajole A, Upadhyay R. Alcohol consumption and cigarette smoking pattern among brothel-based female sex workers in two local government areas in Lagos State, Nigeria. Afr. Health Sci. 2013; 13(2):490–7.

O. Gureje and V. O. Lasebikan (2006). "Alcohol beverage type, problem drinking and self-reported health status," *Nigerian Journal of Psychiatry*, vol. 4, no. 1, pp. 4–8.

Oluwaniyi OO (2010) Oil and youth militancy in Nigeria's Niger Delta region. *Journal of Asian and African Studies 45*(3): 309-325.

Oshodin, O. G. (1995). Nigeria. In B. D. Heath (Ed.), International handbook on alcohol and culture (First ed., pp. 213-223). Westport: Greenwood Press.

Parry CDH (2010) Alcohol policy in South Africa: A review of policy development processes between 1994 and 2009. *Addiction 105*(8): 1340-1345.

Pitso J and Obot IS (2011) Botswana alcohol policy and the presidential levy controversy. *Addiction 106*(5): 898-905.

Poznyak V (2010). *The WHO global strategy to reduce the harmful use of alcohol.* (WHO National Counterparts for Alcohol Policy and AMPHORA No. WHA63. 13). Geneva: WHO.

Roerecke, M. and J. Rehm (2014), "Alcohol Consumption, Drinking Patterns, and Ischemic Heart Disease: A Narrative Review of Meta-analyses and a Systematic Review and Meta-analysis of the Impact of Heavy Drinking Occasions on Risk for Moderate Drinkers", *BMC Medicine*, Vol. 12, No. 182, available at http://dx.doi.org/10.1186/s12916-014-0182-6.

Rehm J, Room R, Graham K, Monteiro M, Gmel G, Sempos CT. (2003). The relationship of average volume of alcohol consumption and patterns of drinking to burden of disease: an overview. *Addiction*; **98:** 1209–28.

Rehm J, Room R, Monteiro M, et al. (2003). Alcohol as a risk factor for the global burden of disease. *Eur Addict Res*; **9:** 157–64.

Rehm J, Baliunas D, Borges GLG, et al. (2010). The relation between different dimensions of alcohol consumption and burden of disease: an overview. Addiction, 105: 817–43.

Room, R., & Selin, K. H. (2005). Problems from women's and men's drinking in eight developing countries. In IS Obot and R. Room (Ed.), Alcohol, gender and drinking problems: Perspectives from low and middle-income countries (pp. 209-210). Geneva: World Health Organization.

Smart, L. (2007). *Alcohol and human health.* Oxford: Oxford University Press.

Toroyan, T (2009) *Global status report on road safety: Time for action.* Geneva: WHO.

Umoh, O. O., Obot, P. P., & Obot, I. (2012). Perception of alcohol availability, promotion and policy by Nigerian university students. African Journal of Drug Alcohol Studies, 11(2), 107-116.

Umunna, I. (1967). The drinking culture of a Nigerian community: Onitsha. *Quarterly Journal of Studies on Alcohol,28*(3), 529-537.

Van Wolputte, S., & Fumanti, M. (2010). Beer in Africa: Drinking spaces, states and selves LIT Verlag Münster.

Wagenaar AC, Salois MJ, Komro KA (2009). Effects of beverage alcohol price and tax levels on drinking: a meta-analysis of 1003 estimates from 112 studies. Addiction. 104(2):179–90.

Wagenaar AC, Salois MJ, Komro KA (2010). Effects of alcohol tax and price policies on morbidity and mortality: a systematic review. Am J Public Health. 100(11):2270–8.

WHO (2005) Public health problems caused by harmful use of alcohol. *Fifty-Eighth WHA. Geneva: WHO.*

World Health Organization (2009). Global Health Risks. Mortality and Burden of Disease Attributable to Selected Major Risks. Geneva, Switzerland

World Health Organization (2011). Global Status Report on Alcohol and Health. Geneva: WHO Press.

WHO (2010). Global strategy to reduce the harmful use of alcohol. Geneva: World HealthOrganization (http://www.who.int/substance_abuse/publications/gl

obal_strategy_reduce_harmful_use_alcohol/en/,accessed 06 April 2019).

WHO (2012). Alcohol in the European Union.

World Health Organization (2014). Global status report on non-communicable diseases 2014. Geneva: World Health Organization; 2014.

World Health Organization (2018). Global status report on alcohol and health 2018. Geneva: World Health Organization. ISBN 978-92-4-156563-9

Xu X, Chaloupka FJ (2011). The effects of prices on alcohol use and its consequences. Alcohol Res Health. 34(2):236–45

.